CareOne Platinum (HMO-POS)
H1019-110

2023

SUMMARY OF BENEFITS

ATLANTIC COAST:

Brevard
Indian River

CarePlus HEALTH PLANS

H1019_MKSB1102023REV_M

Snapshot of Benefits

CareOne Platinum (HMO-POS) H1019-110

Monthly Plan Premium	**$0**
Primary Care Physician Office Visit	**$0** copay
Specialist Office Visit	**$10** copay (in-network) **$20** copay (out-of-network)
OTC Allowance	**$40** monthly
Routine Dental, Vision and Hearing Coverage	**$0** copay
Inpatient Hospital Care	**$100** copay per day for days 1-7 (in-network) **$120** copay per day for days 1-7 (out-of-network)
Emergency Care	**$90** copay (in-network and out-of-network)

The next pages have more details on these benefits and more from CarePlus!

Licensed CarePlus Sales Agent Name: _____

Licensed CarePlus Sales Agent Phone Number: _____

Great news

Part B Insulin and Part B drug benefits on CarePlus' Medicare Advantage plans are getting even better in 2023.

At CarePlus, we strive to help our members achieve total health so that they may live their best lives, which includes efforts to provide our members with access to more affordable prescription drugs.

With the passing of the Inflation Reduction Act, all Medicare Advantage plans will have enhanced benefits in 2023:

Effective April 1, 2023, some rebatable Part B drugs may be subject to a lower coinsurance.

This means beginning April 1, 2023, some Part B drugs will have a lower coinsurance than your standard part B drug coinsurance to help avoid increased cost for your Part B drugs. Any coinsurance adjustments will be made by the pharmacy at the time of purchase.

Effective July 1, 2023, cost sharing for covered Part B Insulin furnished through a covered item of durable medical equipment will be no more than $35 for a one-month (up to 30-day) supply.

Part B Insulin is most commonly used through an insulin pump.

Note: Plan information provided in your previous member materials may not reflect these 2023 benefit enhancements from the passing of the Inflation Reduction Act.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules.

If you have any questions, you can call and speak to a Member Services representative at **1-800-794-4105** (TTY: **711**). From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday; 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **CarePlusHealthPlans.com/medicare-plans/2023** or call **1-800-794-4105** (TTY: **711**) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the provider directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. The Part B premium may be covered through the Florida Medicaid Program.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2024.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

2023 Summary of Benefits

This booklet gives you a summary of what **CareOne Platinum (HMO-POS)** covers and what you pay. It does not list all plan benefits or every limitation and exclusion. For a complete list of covered services, please refer to the plan's Evidence of Coverage on our website, **CarePlusHealthPlans.com/medicare-plans/2023**, or call us and we will send you a copy. We will automatically mail it to you after you enroll.

Tips for comparing your Medicare choices

- To compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets, or use the Medicare Plan Finder on **Medicare.gov**.
- To learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. You can view it online at **Medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY: **1-877-486-2048**.

Who can join CareOne Platinum (HMO-POS)?

To join **CareOne Platinum (HMO-POS)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Florida: Brevard and Indian River.

Which doctors, hospitals, and pharmacies can you use?

CareOne Platinum (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers; however, **this plan covers certain services received from out-of-network providers in Brevard and Indian River counties**. Benefits covered out-of-network within these counties are indicated in the benefit chart in this booklet.

Prior authorization or a referral may be required for covered medical services.

You must generally use network pharmacies to fill your prescriptions for Medicare-covered Part D drugs. There are network mail-order pharmacies that offer preferred cost-sharing. You may pay less if you use these pharmacies.

To see our provider directory, visit our website at **CarePlusHealthPlans.com/directories**, or call us and we will send you a copy.

What does this plan cover?

CareOne Platinum (HMO-POS) covers everything that Original Medicare covers - and *more*.

In addition to medical services, we cover certain Part D and Part B drugs such as chemotherapy and some drugs administered by your physician. See the Evidence of Coverage for more information.

To see our list of covered prescription drugs and any restrictions, visit **CarePlusHealthPlans.com/medicare-plans/2023-prescription-drug-guides**, or call us and we will send you a copy.

How to determine your drug costs

Medications are listed in one of five tiers. Use our Drug Guide to determine the tier of your drug. The amount you pay depends on its tier and your stage of drug coverage.

Do you have Medicare and Medicaid? If you are enrolled in both Medicare and Medicaid, **you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower**. Please contact us to learn more about this.

Need more information or have questions?

Visit **CarePlusHealthPlans.com**, or call one of the numbers below.

If you are a member of this plan, call Member Services: **1-800-794-5907** (TTY: **711**).	**If you are not a member** of this plan, call a licensed CarePlus sales agent: **1-800-794-4105** (TTY: **711**).

October 1 - March 31: 7 days a week; 8 a.m. - 8 p.m.

April 1 - September 30: Monday - Friday; 8 a.m. - 8 p.m.

You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

CareOne Platinum (HMO-POS) H1019-110
Out-of-network coverage available in Brevard and Indian River counties only

MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUM OUT-OF-POCKET LIMIT

Monthly Plan Premium
- **$0**
- You must continue to pay your Medicare Part B premium. This premium may be covered by Medicaid, if you qualify.

Deductible
- **$0** - This plan does not have a deductible for medical services.

Maximum Out-of-Pocket Limit (combined in-network and out-of-network)
- **$3,750** per year.
- This amount is the most you will pay during the plan year for approved medical services under our plan. Once you (or others on your behalf) pay this amount, we pay 100% of your covered services for the rest of the plan year. Excludes costs for prescription drugs, services abroad, and supplemental benefits.

COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital Care

	In-network	Out-of-network
• Days **1 - 7.**	**$100** copay per day	**$120** copay per day
• Days **8 - 90.**	**$0** copay	**$0** copay
• Days **91** and beyond.	**$0** copay	**$0** copay

- Our plan covers an **unlimited** number of days for an inpatient hospital stay.
- See Evidence of Coverage for benefit period information.

Outpatient Hospital Care

	In-network	Out-of-network
• Mental health care group and individual therapy visits. • Physical, occupational, and speech therapy. • Cardiac and pulmonary rehabilitation services. • Supervised Exercise Therapy (SET) services.	**$10** copay	**$20** copay
• Diagnostic procedures and tests. See diagnostic services for additional details. • Surgery services.	**$80** copay	**$100** copay
• Chemotherapy drugs. • Renal dialysis.	**20%** coinsurance	**20%** coinsurance

Ambulatory Surgery Center

	In-network	Out-of-network
• Physician and professional services. • Diagnostic colonoscopy services. • Colorectal cancer screening.	**$0** copay	**$0** copay
• Surgery services.	**$80** copay	**$95** copay

Doctor Visits

	In-network	Out-of-network
• Primary care physician (PCP) visits. – Must select a PCP from our network.	**$0** copay	Not covered
• Specialist visits.	**$10** copay	**$20** copay

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Preventive Care (in-network* and out-of-network)

- **$0** copay for all Medicare-covered preventive services, including:
  - Abdominal aortic aneurysm screening
  - Alcohol misuse screening and counseling*
  - Annual Wellness Visit (AWV)*
  - Bone mass measurement
  - Breast cancer screening (mammogram)
  - Cardiovascular disease risk reduction visit*
  - Cardiovascular disease screening
  - Cervical and vaginal cancer screenings (pap tests, pelvic exams, HPV tests)
  - Colorectal cancer screening (i.e. colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
  - Depression screening*
  - Diabetes screening
  - Diabetes self-management training
  - Glaucoma screening
  - Hepatitis B virus (HBV) screening
  - Hepatitis C virus (HCV) screening
  - HIV screening
  - Lung cancer screening
  - Medical nutrition therapy services
  - Medicare Diabetes Prevention Program (MDPP)
  - Obesity screening and therapy*
  - Prostate cancer screening
  - Routine physical exam*
  - Screening for sexually transmitted infections (STIs) and counseling*
  - Tobacco use cessation counseling
  - Vaccines including Influenza (Flu), Hepatitis B Virus (HBV), Pneumococcal, COVID-19
  - "Welcome to Medicare" preventive visit (one-time)*
- Any additional preventive services approved by Medicare during the contract year will be covered.
- *Services provided by PCP are covered in-network only.

Emergency Care (in-network and out-of-network)

- **$90** copay for facility.
- **$0** copay for physician and professional services.
- Emergency coverage is the same worldwide.
- You do not pay the emergency care copay if you're admitted to the same hospital within 24 hours for the same condition.

Urgently Needed Services (in-network and out-of-network except PCP)

- **$0** copay at your in-network primary care physician's office.
- **$10** copay at a specialist's office.
- **$10** copay at an urgent care center.
- Coverage for urgently needed services is the same worldwide.

CareOne Platinum (HMO-POS) H1019-110
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Diagnostic Services

	In-network	Out-of-network
• **Diagnostic procedures and tests:**		
– At your in-network primary care physician's office	**$0** copay	Not covered
– At a specialist's office	**$10** copay	**$20** copay
– At an urgent care center	**$10** copay	**$20** copay
– At a hospital facility as an outpatient	**$80** copay	**$100** copay
• **Basic radiology (X-rays):**		
– At your in-network primary care physician's office	**$0** copay	Not covered
– At a specialist's office	**$10** copay	**$20** copay
– At an urgent care center	**$10** copay	**$20** copay
– At a freestanding radiological facility	**$10** copay	**$20** copay
– At a hospital facility as an outpatient	**$80** copay	**$100** copay
• **Diagnostic radiology** (e.g., MRI, MRA, CT Scans)**:**		
– At your in-network primary care physician's office	**$80** copay	Not covered
– At a specialist's office	**$80** copay	**$95** copay
– At a freestanding radiological facility	**$80** copay	**$95** copay
– At a hospital facility as an outpatient	**$80** copay	**$100** copay
• **Radiation therapy:**		
– At a specialist's office	**$10** copay	**$20** copay
– At a freestanding radiological facility	**20%** coinsurance	**20%** coinsurance
– At a hospital facility as an outpatient	**$55** copay	**$55** copay
• **Lab tests**	**$0** copay	**$0** copay
• **Diagnostic mammograms:** – At a specialist's office – At a freestanding radiological facility – At a hospital facility as an outpatient	**$0** copay	**$0** copay
• **Diagnostic colonoscopies:** – At an ambulatory surgical center – At a hospital facility as an outpatient	**$0** copay	**$0** copay
• **Nuclear medicine:**		
– At a freestanding radiological facility	**$60** copay	**$60** copay
– At a hospital facility as an outpatient	**$80** copay	**$100** copay

Hearing Services

	In-network	Out-of-network
• Medicare-covered exam to diagnose and treat hearing and balance issues.	**$10** copay	**$20** copay
• Supplemental routine hearing services: – Routine hearing exam, **1** per calendar year. – Hearing aid fitting/evaluation, **1** per calendar year. – **$600** allowance per ear for hearing aids, per calendar year. – **1**-month battery supply and **2**-year warranty included.	**$0** copay	Not covered

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Dental Services

	In-network	Out-of-network
• Medicare-covered services. Excludes preventive, restoration, removal and replacement services.	**$10** copay	**$20** copay
• Supplemental routine dental services: – Periodic oral evaluations, up to **2** per calendar year – Comprehensive oral evaluation, **1** every **3** calendar years – Emergency diagnostic exam, up to **2** per calendar year – Fluoride treatment, up to **2** per calendar year – Periodontal maintenance, up to **4** per calendar year – Prophylaxis cleanings, up to **2** per calendar year – Bitewing X-rays, **1** set per calendar year – Panoramic X-ray film, **1** per calendar year – Amalgam and/or composite fillings, up to **2** per calendar year – Scaling and root planing (deep cleaning), **1** per quadrant per calendar year – Simple or surgical extractions, up to **3** per calendar year – Denture reline, **1** per calendar year – Complete dentures (upper and/or lower), **1** set every **5** calendar years – Anesthesia • Partial dentures are not covered. • Total periodic and comprehensive oral evaluations limited to **2** per calendar year.	**$0** copay	Not covered

Vision Services

	In-network	Out-of-network
• Medicare-covered eye exams to diagnose and treat diseases and conditions of the eye.	**$10** copay	**$20** copay
• Diabetic eye exam.	**$0** copay	**$0** copay
• **1** pair of eyeglasses or contact lenses after cataract surgery.	**$0** copay	**$0** copay
• Supplemental routine vision services: – Routine eye exams with refraction, **1** per calendar year. – **$300** yearly allowance for contact lenses or eyeglasses of your choice; OR, you may choose **2** free pairs of select eyeglasses (**1** pair may be prescription sunglasses). – Ultraviolet protection, scratch resistant coating, and fitting included with eyeglasses. – You are responsible for any eyewear costs above the yearly allowance amount or the costs of any upgrades when a free pair is selected.	**$0** copay	Not covered

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Mental Health Services

	In-network	Out-of-network
• **Inpatient visit - general hospital:** – Days **1 - 7**. – Days **8 - 90**. – See Evidence of Coverage for maximum stays and lifetime reserve days.	**$100** daily copay **$0** daily copay	**$120** daily copay **$0** daily copay
• **Inpatient visit - psychiatric facility:** – Days **1 - 7**. – Days **8 - 90**. – Covers up to 190 days in a lifetime.	**$100** daily copay **$0** daily copay	**$120** daily copay **$0** daily copay
• **Outpatient visit:** – Group and individual therapy visits. – Partial hospitalization. – Includes treatment for mental illness and substance abuse.	**$10** copay	**$20** copay

Skilled Nursing Facility (SNF) (in-network and out-of-network)

- **$0** copay per day for days **1 - 20**.
- **$150** copay per day for days **21 - 100**.
- No prior hospital stay required.
- Covers up to **100** days per benefit period.
- See Evidence of Coverage for benefit period details.

Physical Therapy

In-network:
- **$10** copay per visit.

Out-of-network:
- **$20** copay per visit.

Ambulance Services (Ground Transportation) (in-network and out-of-network)

- **$150** copay per trip for emergencies.
- **$0** copay per trip for medically necessary non-emergencies.

Routine Transportation (in-network only)

- **$0** copay for up to **50** one-way trips per calendar year.
- Provided by participating vendor to approved locations.

Medicare Part B Drugs (in-network and out-of-network)

- **20%** coinsurance when purchased at a pharmacy, provided in a physician's office, or provided in a hospital facility as an outpatient.
- **$0** copay for allergy injections in a physician's office.
- **20%** coinsurance for chemotherapy drugs.

CareOne Platinum (HMO-POS) H1019-110
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PART D PRESCRIPTION DRUG BENEFITS (IN-NETWORK ONLY)

- **Important Message About What You Pay for Vaccines:** Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.
- **Important Message About What You Pay for Insulin:** You won't pay more than **$35** for a one-month (up to 30-day) supply of each Part D insulin product covered by our plan, no matter what cost-sharing tier it's on. This applies to all Part D covered insulins, including the Select Insulins covered under the Insulin Savings Program as described below. If you receive Extra Help, you will still pay no more than **$35** for a one-month supply for each Part D covered insulin. Please see your Prescription Drug Guide to find all Part D insulins covered by your plan.
- This plan uses a Drug Guide (formulary). Check it to see if your drugs are covered. Quantity limits and other restrictions/authorizations may apply.
- Nationwide network of pharmacies.
- Your cost for prescription drugs depends on where the prescription is filled, where it is administered, the drug's tier level, the supply needed, and which Part D drug stage you are in when the prescription is filled. Please see Evidence of Coverage for details.
- **If you have Extra Help, you pay whichever is less: your plan cost-share or the Low Income Subsidy (LIS) cost-share. Also, the Insulin Savings Program information (below) does not apply to you.**

Deductible

- **$0** - This plan does not have a deductible.

Insulin Savings Program

- Your plan participates in the Insulin Savings Program. You will pay no more than **$35** for a one-month (up to a 30-day) supply for Select Insulins, no matter what cost-sharing tier it's on. To identify which Select Insulins are included within the Insulin Savings Program, look for the ISP indicator in your Prescription Drug Guide. You are not eligible for this program if you receive Extra Help.
- Your plan also provides enhanced insulin coverage, which means you will pay no more than **$35** for a one-month (up to 30-day) supply for all Part D insulins covered by our plan, including Select Insulins, no matter what cost-sharing tier it's on. The enhanced insulin coverage is available, even if you receive Extra Help.
- Your cost for Select Insulins:

Tier	Supply	Retail Cost Sharing	Preferred Mail-Order Cost Sharing	Standard Mail-Order Cost Sharing
Tier 2 Generic	30-day	**$5**	**$5**	**$20**
	90-day	**$15**	**$0**	**$60**
Tier 3 Preferred Brand	30-day	**$30**	**$30**	**$35**
	90-day	**$90**	**$80**	**$105**

CareOne Platinum (HMO-POS) H1019-110
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Initial Coverage

- Your cost for all other covered drugs until you reach the Coverage Gap.

Tier	Supply	Retail Cost Sharing	Preferred Mail-Order Cost Sharing	Standard Mail-Order Cost Sharing
Tier 1 Preferred Generic	30-day	**$0**	**$0**	**$10**
	90-day	**$0**	**$0**	**$30**
Tier 2 Generic	30-day	**$5**	**$5**	**$20**
	90-day	**$15**	**$0**	**$60**
Tier 3 Preferred Brand	30-day	**$30**	**$30**	**$47**
	90-day	**$90**	**$80**	**$141**
Tier 4 Non-Preferred Drug	30-day	**$95**	**$95**	**$100**
	90-day	**$285**	**$275**	**$300**
Tier 5 Specialty Tier	30-day	**33%**	**33%**	**33%**
	90-day	N/A	N/A	N/A

Coverage Gap

- After total yearly drug costs (what you and the plan pay) reach **$4,660**, you enter the coverage gap.
- Gap coverage for Tiers 1 and 2: your cost is the same before and during the gap.
- You pay 25% of the plan's cost for all other covered drugs while in the Coverage Gap.

Catastrophic Coverage

- After your yearly out-of-pocket drug costs reach **$7,400**, you pay the greater of:
  – **5%** of the cost, or
  – **$4.15** copay for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs.
- See Evidence of Coverage for details.

Part D Excluded Prescription Drugs and Vitamins

- Tier 1 copay for certain erectile dysfunction drugs and certain prescription vitamins.
- Your cost stays the same through all stages and does not count toward your total annual drug cost. See Evidence of Coverage for details.

ADDITIONAL COVERED MEDICAL BENEFITS

Outpatient Surgery

	In-network	Out-of-network
• At your primary care physician's office.	**$0** copay	Not covered
• At a specialist's office.	**$10** copay	**$20** copay
• At an ambulatory surgical center.	**$80** copay	**$95** copay
• At a hospital facility as an outpatient.	**$80** copay	**$100** copay

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Additional Rehabilitation Services

	In-network	Out-of-network
• Occupational therapy (daily living activities), speech therapy, cardiac (heart) rehabilitation services and pulmonary (lungs) rehabilitation services. • Supervised Exercise Therapy (SET) services.	**$10** copay	**$20** copay

Foot Care (Podiatry Services)

	In-network	Out-of-network
• Medicare-covered exams and treatment.	**$10** copay	**$20** copay
• Unlimited visits to participating podiatrists for supplemental routine foot care to treat flat feet or misalignment; corn, wart or callus removal; and hygienic care. No referral required.	**$10** copay	Not covered

Medical Equipment/Supplies (in-network and out-of-network)

- **Durable medical equipment:**
  – **20%** coinsurance for power-operated or customized durable medical equipment (e.g., electric wheelchairs, scooters, insulin pumps).
  – **$0** copay for all other durable medical equipment.
- **Prosthetic devices (braces, artificial limbs, etc.) and other medical supplies:**
  – **20%** coinsurance for prosthetic devices.
  – **20%** coinsurance for other medical supplies.
- **Diabetic supplies:**
  – **$10** copay for therapeutic shoes and inserts.
  – **$0** copay for diabetic monitoring supplies.

Telehealth Services (in addition to Original Medicare) (in-network only)

- **$0** copay for primary care physician virtual visit.
- **$10** copay for specialist virtual visit.
- **$0** copay for behavioral health and substance abuse virtual visit.
- **$0** copay for urgent care virtual visit.
- This service may not be offered by all in-network plan providers. Check directly with your provider about the availability of telehealth services, or you can also visit our website at CarePlusHealthPlans.com/physician-finder to access our online, searchable directory.

Wellness Programs (in-network only)

- **Deliver Fresh Meals Program:**
  – **$0** copay for up to **14** home delivered meals after an overnight hospital or skilled nursing facility stay. Up to 4 times per year.
- **SilverSneakers® Fitness Program:**
  – **$0** copay for access to participating gyms, classes, videos, and more.
- **Over-the-Counter (OTC) Items:**
  – **$40** monthly allowance toward select OTC items such as vitamins and pain relievers.
  – Please visit our plan website to see our list of covered OTC items.
- **CarePlus Rewards:**
  – Earn a **$50** gift card for completing preventive screenings and other healthy activities.

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Acupuncture

	In-network	Out-of-network
• Up to **20** Medicare-covered treatments for chronic low back pain when ordered by a physician.	**$10** copay	**$20** copay
• Up to **25** routine visits per year.	**$0** copay	Not covered

Chiropractic Care

	In-network	Out-of-network
• Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position.)	**$10** copay	**$20** copay
• Routine chiropractic services: – Up to **12** routine visits in-network every year, no referral required.	**$10** copay	Not covered

Home Health Care (in-network and out-of-network)

- **$0** copay for limited Medicare-approved, in-home skilled nursing care.
- Number of covered visits is based on medical need as determined by your physician and authorized by the plan.

Hospice Care (in-network and out-of-network)

- **$0** copay for Medicare-certified hospice care.
- Hospice Care is covered by Original Medicare. See Evidence of Coverage for details.

Renal Dialysis (in-network and out-of-network)

- **20%** coinsurance
- **$0** copay for kidney disease education services.

IMPORTANT

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. CarePlus complies with applicable federal civil rights laws. If you believe that you have been discriminated against by CarePlus, there are ways to get help.

- You may file a complaint, also known as a grievance, with:
  CarePlus Health Plans, Inc. Attention: Grievances and Appeals department.
  PO Box 277810, Miramar, FL 33027.
  If you need help filing a grievance, call Member Services at **1-800-794-5907 (TTY: 711)**. October 1 - March 31, 7 days a week, 8 a.m. to 8 p.m. April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711).

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

CarePlus
HEALTH PLANS

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-794-5907 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-794-5907 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-794-5907 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-794-5907 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-794-5907 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-794-5907 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-794-5907 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-794-5907 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고있습니다 . 통역 서비스를 이용하려면 전화 1-800-794-5907 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-794-5907 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (برقياً: 711) 1-800-794-5907. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه هي خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-794-5907 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिंदी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-794-5907 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-794-5907 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-794-5907 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-794-5907 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-794-5907 (TTY: 711) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

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