FAQs

Frequently Asked Questions

This booklet should provide you with answers to some of your frequently asked questions on how to access your plan benefits and services. If you have any questions or concerns, please refer to your Evidence of Coverage (EOC) or call Member Services at the phone number listed at the end of this booklet.

CarePlus HEALTH PLANS

Keeping the **HEALTH** in health care.

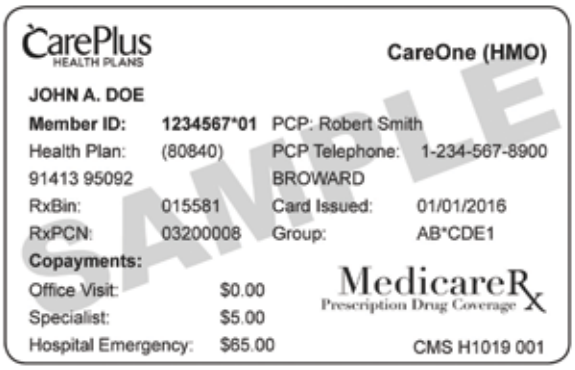
H1019_CPHPFAQ2016 Accepted

Table of Contents

Member Identification (ID) Card

Your CarePlus member ID card provides you with very important information, such as:

- Your CarePlus member identification (ID) number
- Your plan name
- Your primary care physician (PCP) name and contact information
- The copayment amounts for PCP, specialist office visits and emergency room services
- The Member Services phone number
- Important telephone numbers for your providers to contact us



Please make sure to use your CarePlus member ID card whenever you would like to access services covered by this plan and to fill your prescription drugs at network pharmacies.

Important phone numbers

For your convenience, the following is a list of helpful phone numbers you may use frequently, such as:

- Mail-Order Pharmacy – PrescribeIT Rx: 1-800-526-1490
- Hearing Services – HearUSA, Inc.: 1-800-442-8231
- Nursing Hotline: 1-800-819-8467
- Mental Health Services – Beacon Health Options: 1-800-221-5487
- Transportation Services – Access2Care (A2C):1-866-956-5635

Not all benefits listed may be available on all plans or in a single plan benefit package. Please refer to your Evidence of Coverage (EOC) for coverage details.

How often will I receive a new member ID card?

You will receive a new CarePlus member ID card at least once a year and whenever there are specific changes made to your membership, such as a change in your PCP or a benefit plan change.

How can I replace my CarePlus member ID card?

If your CarePlus member ID card is lost, damaged or stolen, you may request a new one by simply calling Member Services at the phone number listed on the back cover of this booklet.

Making Sure We Have Your Accurate Information

What types of changes do we need to know about?

- Changes to your name, address, or phone number
- Changes in any health insurance coverage you may have (such as from your employer, your spouse's employer, worker's compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services at the phone number listed on the back cover of this booklet.

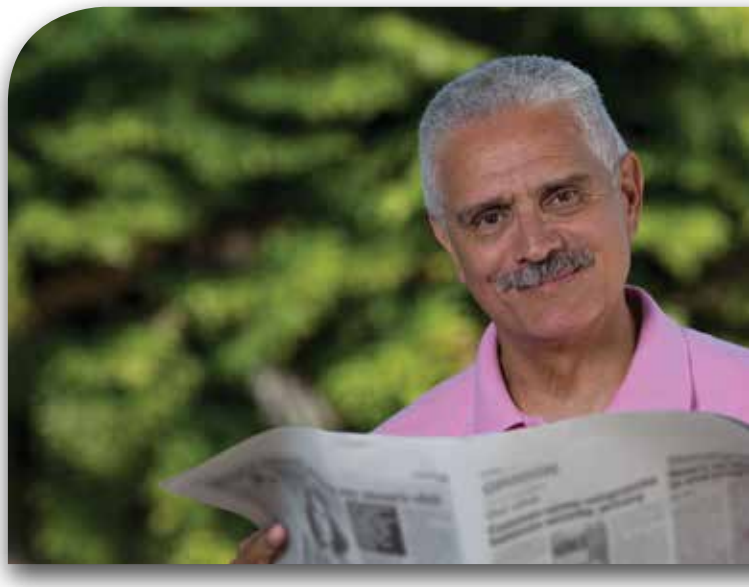
Privacy of Personal Health Information and Advance Directives

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

What is personal health information?

Personal health information (PHI) includes both medical information and individually identifiable information; such as name, address, telephone number, or Social Security number.

How do you protect the privacy of my health information?



In keeping with federal and state laws and our own policy, CarePlus has a responsibility to protect the privacy of your PHI. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your PHI;
- Limiting how we use or disclose your PHI;
- Authenticating all calls received by asking any of the following questions:
  - Mother's Maiden Name
  - Date of Birth
  - Address
- Informing you of our legal duties with respect to your PHI;
- Training our associates about company privacy policies and procedures.

What are Advance Directives?

Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends, and healthcare professionals, and to avoid confusion later on. There are different types of advance directives including:

- A health care proxy (durable power of attorney for health care)
- A living will

What is a Durable Power of Attorney for Health Care?

A durable power of attorney for health care is a document that names your healthcare proxy. It is used to name the person you wish to make healthcare decisions for you if you aren't able to make them yourself. Having a healthcare proxy is important because if you suddenly aren't able to make your own decisions, someone you trust will be able to make them for you.

What is a Living Will?

A Living Will tells how you feel about care intended to sustain life. This document states which medical treatment you would accept or refuse if you become unable to make your own decisions. Examples include: dialysis for kidney failure, a breathing machine if you can't breathe on your own, or a feeding tube if you can no longer eat.

Is one better than the other?

These are different documents that are used in varying situations. Both statements are to help your family and your doctors make decisions concerning your health care at a time when you are not able to make those decisions for yourself. You may use one or both of these forms to provide directions for your medical care.

Can I change my mind?

Yes, you can change your mind or cancel your advance directives at any time. Changes should be in writing, signed and dated. You can also make your changes known by making an oral statement (telling someone verbally), or by writing a new advance directive.

Do you need an advance directive? Here's what to do:

- Get the form. If you want an advance directive, you can get a form from your lawyer, a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that provide people with information about Medicare.
- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- Give copies to appropriate people. You should give a copy of the form to your PCP and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

Note: If you know ahead of time that you are going to be hospitalized and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your decision to fill out an advance directive or not (including when you are asked while in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with:

KEPRO

5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609-1822

1-844-455-8708 (Toll-free), 1-855-843-4776 (TTY), 1-844-834-7129 (Fax)

http://www.keproqio.com

Please refer to your Evidence of Coverage (EOC) for detailed information regarding your privacy rights and advance directive information.

Primary Care Physician (PCP)

What is the PCP's role?

Your PCP is the doctor you see first for most of your health concerns. Your PCP helps manage your health care and provides you with routine or basic medical care. Your PCP also coordinates the rest of the covered services you get as a plan member. The role of your PCP includes:

- Providing preventive care and teaching healthy lifestyle habits.
- Recognizing and treating common illnesses.
- Evaluating the urgency of your medical condition and directing you to the best place for care.
- Referring you to any other medical specialists, based on your needs.

When should I schedule my first visit with my PCP?

We recommend you schedule an appointment with your PCP within the first 30 days of enrollment in the plan. It is important that you get to know your PCP as he or she will take a very important role in coordinating your care. Please remember to take a list of the medications you are currently taking, including any over-the-counter medications, vitamins and/or supplements to your first PCP's appointment.

Can I change my PCP at any time?

You may change your PCP for any reason, at any time. Change requests received by the 21st day of the month usually will be effective the first day of the following month. To change your PCP, call Member Services at the phone number listed on the back cover of this booklet.

How can I find CarePlus network providers/pharmacies in my area?

CarePlus has a Provider Directory that lists the network providers and pharmacies. To obtain information about the network providers and/or pharmacies in your area, you may do any of the following:

- Access our online searchable directory at **www.careplushealthplans.com**
- Call our Member Services department and request a Provider Directory to be mailed to you.
- Email your request for a directory to **CPHP_MemberServices@CarePlus-HP.com** In your request, please make sure to include your name and mailing address along with the service area for the directory you're requesting such as Tampa area or South Florida. Do not use this email address to communicate confidential information.

The pharmacy and/or provider network may change at any time. You will receive notice when necessary.

Remember that your PCP's contact information is located on your CarePlus member ID card. For detailed information on the role of your PCP, please refer to your Evidence of Coverage (EOC).

Referrals and Authorizations

What are the basic rules for getting my medical care covered by CarePlus?

As a Medicare health plan, we are required to cover all benefits covered by Original Medicare and follow Original Medicare's coverage rules. CarePlus will generally cover your medical care as long as:

- The care you receive is included in your plan's Evidence of Coverage (EOC);
- The care you receive is considered medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice;
- You use providers in the plan's network to get your care; except in emergency or urgently needed care situations or out-of-area dialysis services. Please refer to your EOC for further details.
- You have a network primary care physician (PCP) who is providing and overseeing your care.

What is a Referral?

A referral is a written order issued by your PCP for you to see other plan providers or receive certain services.

It is very important to get a referral from your PCP because if you don't have a referral before you get certain services from a specialist, you may have to pay for the services yourself. In addition, if you are seeing a network specialist for your care, please check to make sure that the referral you receive from your PCP covers all needed visits. If the network specialist wants you to come back for additional care, you may need to return to your PCP for a referral for additional services.

What is Prior Authorization?

For some types of services, your PCP may need to get approval in advance from CarePlus. This is called getting "prior authorization". You may need prior authorization before receiving certain services. Generally, this is different from a referral in that, prior authorization is the approval issued by CarePlus. A referral is generally a written document provided by your PCP before you can obtain specialty and other services. Please refer to your EOC for details regarding services that require prior authorization.

Do I always need approval in advance from my PCP to receive medical services?

There are some services that you can get without getting approval in advance from your PCP. However, we recommend that you consult with your PCP prior to receiving any medical services. Some of the services that may be accessed without a referral include, but are not limited to:

- Dermatology services from a network provider (up to five times per calendar year);
- Routine women's health care from a network provider;
- Emergency services or urgently needed services from network providers or from out-of-network providers;
- Flu shots and pneumonia vaccinations as long as you get them from network providers.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- All Medicare-covered preventive services from network providers. Refer to your EOC for a listing of the covered preventive services.

Please refer to your Evidence of Coverage (EOC) for a complete list of the services you may receive without getting approval in advance from your PCP and the specific benefits offered by your plan.

How long does it take to process an authorization after my PCP submits a request to CarePlus?

The Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program, provides health plans with 14 calendar days from the date the request is received to process a standard authorization request and 72 hours for an expedited authorization request for medical services.

Care Management

What is Care Management?

As a member of CarePlus, you may be eligible to participate in the Care Management program. This program is designed to help our members develop a support system, participate in recommended treatment plans, as well as become engaged in the management of their own healthcare needs. CarePlus Care Managers are available to provide guidance to help you with health-related conditions.

How do I qualify for the Care Management Program?

CarePlus members enrolled in Special Needs Plans (SNP) are automatically enrolled in the CarePlus Care Management Program with the option to withdraw at any time. All other CarePlus members may be eligible to participate in this program based on their current health condition and/or information provided by the Health Risk Assessment (HRA) questionnaire.

Participation in this program is voluntary and is available at no cost to you. If you would like additional information about the CarePlus Care Management Program, please call Care Management at 1-866-657-5625. Monday through Friday, from 8 a.m. to 6 p.m. TTY users should call 711. If you are a member currently enrolled in a SNP plan, please call 1-800-734-9592. Care Management is open Monday through Friday, from 8 a.m. to 5 p.m. TTY users should call 711.

What is a Health Risk Assessment (HRA) questionnaire and do I need to complete this form?

The HRA questionnaire is the assessment tool used to identify a member's potential risk factors and clinical/psycho-social needs. This tool helps us coordinate medical resources and any other healthcare needs you may have. Once you're active in the Care Management Program, the HRA also helps your Care Manager evaluate your health status in order to develop a care plan with your provider. Therefore, it is very important that you complete your HRA questionnaire.

Prescription Drug Coverage

What are the main factors I need to consider regarding my prescription drug coverage?

The key factors you may want to consider about your prescription drug plan include:

- **Coverage:**
  - Formulary: The formulary, or Prescription Drug Guide, is a list of covered drugs selected by CarePlus with the help of a team of healthcare providers. Review the CarePlus formulary to be sure your medicines are included.

- Prior Authorization: To make sure that certain drugs are used correctly and only when truly necessary, CarePlus may require a "prior authorization." This means that before we cover these drugs, your physician must first contact us and show that there is a "medically necessary" reason why you must use that specific drug for it to be covered. In addition, your plan may have other rules to ensure that your drug use is effective. Please review the CarePlus formulary for detailed information.

- **Cost*:**
  - Copayment/Coinsurance: There are different levels or "tiers" of medications, with different costs in the CarePlus formulary. Also, in some plans your share of the cost can increase when your prescription drug costs reach a certain limit. This limit is known as the coverage gap.

**If you are in a program that helps pay for your prescription drugs, please review the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the "Low Income Subsidy Rider" or "LIS Rider") for detailed information about your prescription drug coverage.*

Can I have my prescription drugs shipped to my home?

Yes, for certain kinds of drugs, you can use a mail-order pharmacy. Generally, the drugs available through mail-order are drugs you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our network mail-order pharmacies are marked as "mail-order" drugs in our formulary.

You can get your prescription drugs shipped to your home through Humana-owned PrescribeIT Rx*, the preferred cost sharing mail-order pharmacy in our network. We also have other mail-order pharmacies available in our network that offer standard cost-sharing. You may use either, but your portion of the cost may be lower with a mail-order pharmacy that offers preferred cost-sharing. Remember, if you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

To begin using PrescribeIT Rx, ask your PCP to fax your prescription drug to PrescribeIT Rx at 1-800-526-1491. You can order at least a 30-day supply of the drug and no more than a 90-day supply. You also have the choice to sign up for automated mail-order of new prescriptions initiated by your provider.

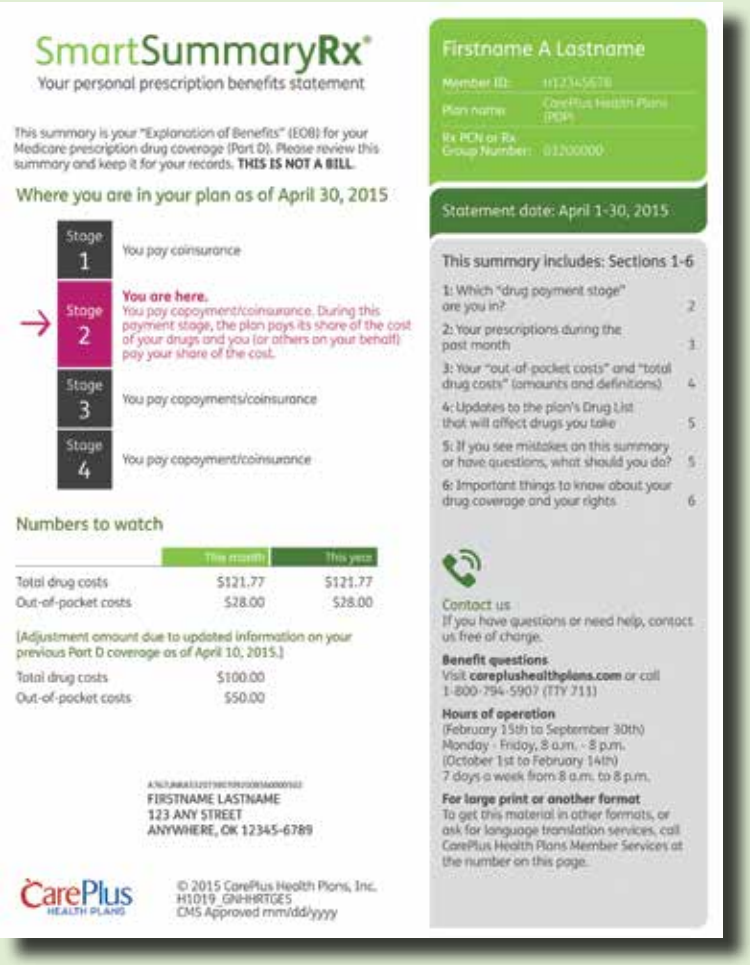
Typically, you should expect to receive your prescription drugs within 10 calendar days from the time that the mail-order pharmacy receives the order. If you would like to speak to a representative, would like more information about how to place an order, or if you do not receive your prescription drug(s) within the estimated time mentioned above, please call PrescribeIT Rx at 1-800-526-1490, Monday through Friday, from 8 a.m. to 5 p.m. TTY users should call 711. A registered pharmacist checks every order for accuracy and is available to speak with you during regular business hours.

**Other pharmacies are available in our network.*

How can I keep track of my prescription drug expenses?

You may track your prescription drug expenses through the CarePlus SmartSummary Rx®. The SmartSummary Rx® is a document that provides a personalized and easy-to-follow description of the prescription drugs you've filled or refilled using your CarePlus benefits the previous month.

It is more than just an itemized list of your prescription drugs. The SmartSummary Rx® includes a complete "accounting" of your prescription drug costs, along with the amount your plan has paid for each prescription filled.


SmartSummaryRx®
Your personal prescription benefits statement

This summary is your "Explanation of Benefits" (EOB) for your Medicare prescription drug coverage (Part D). Please review this summary and keep it for your records. **THIS IS NOT A BILL.**

Where you are in your plan as of April 30, 2015

Stage 1 — You pay coinsurance

Stage 2 — **You are here.** You pay copayment/coinsurance. During this payment stage, the plan pays its share of the cost of your drugs and you (or others on your behalf) pay your share of the cost.

Stage 3 — You pay copayments/coinsurance

Stage 4 — You pay copayment/coinsurance

Numbers to watch

	This month	This year
Total drug costs	$121.77	$121.77
Out-of-pocket costs	$28.00	$28.00

[Adjustment amount due to updated information on your previous Part D coverage as of April 10, 2015.]

Total drug costs	$100.00
Out-of-pocket costs	$50.00

FIRSTNAME LASTNAME
123 ANY STREET
ANYWHERE, OK 12345-6789

CarePlus HEALTH PLANS

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H1019_GNHHRTGES
CMS Approved mm/dd/yyyy

Firstname A Lastname
Member ID: H12345678
Plan name: CarePlus Health Plans (PDP)
Rx PCN or Rx Group Number: 01200000

Statement date: April 1-30, 2015

This summary includes: Sections 1-6

1: Which "drug payment stage" are you in? 2
2: Your prescriptions during the past month 3
3: Your "out-of-pocket costs" and "total drug costs" (amounts and definitions) 4
4: Updates to the plan's Drug List that will affect drugs you take 5
5: If you see mistakes on this summary or have questions, what should you do? 5
6: Important things to know about your drug coverage and your rights 6

Contact us
If you have questions or need help, contact us free of charge.

Benefit questions
Visit **careplushealthplans.com** or call 1-800-794-5907 (TTY 711)

Hours of operation
(February 15th to September 30th)
Monday - Friday, 8 a.m. - 8 p.m.
(October 1st to February 14th)
7 days a week from 8 a.m. to 8 p.m.

For large print or another format
To get this material in other formats, or ask for language translation services, call CarePlus Health Plans Member Services at the number on this page.

What additional information does the SmartSummary Rx® have?

The SmartSummary Rx® provides you with other useful information such as:

- Your prescription drug benefit;
- Your monthly prescription claims;
- Your total drug cost for the month and year-to-date plus how much of those costs your plan paid and how much you paid – so you can see the value of your prescription drug benefit;
- Suggestions for cost savings on your prescription drugs; and,
- Educational articles about relevant chronic conditions.

Medicare Savings Programs/Extra Help

Can I receive "Extra Help" with my prescription drug costs and how would I benefit from applying for "Extra Help"?

People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay for up to 75% or more of your drug costs, including monthly prescription drug premiums, annual deductible, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or the Part D late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this "Extra Help", contact our Social Services department, your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for "Extra Help" online at www.socialsecurity.gov/prescriptionhelp.

Who do I call for assistance?

To see if you qualify for "Extra Help," you may call:

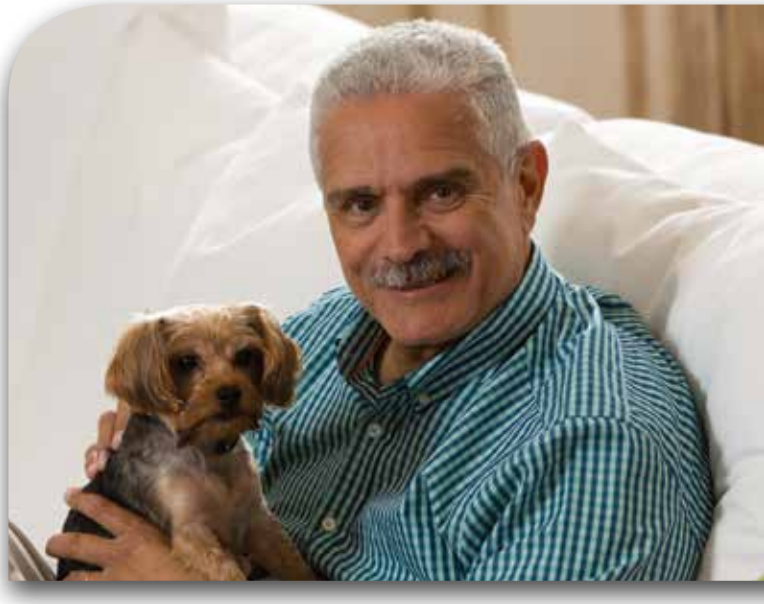
- CarePlus Social Services department at 1-855-392-3900, Monday through Friday, from 8 a.m. to 5 p.m. TTY users should call 711
- 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or
- Your state Medicaid office

Florida Department of Children and Families
Office of Economic Self-Sufficiency
MyFLFamilies.com
Community Partner

Would CarePlus assist me with the application process for Federal and State Assistance Programs?

Yes, CarePlus has a Social Services department that helps beneficiaries apply and/or re-apply for State and Federal Assistance Programs such as the Medicare Savings Program and the "Extra Help" prescription drug assistance program. They have been assisting beneficiaries since 2002 and are an approved community partner with the Automated Community Connection to Economic Self Sufficiency (ACCESS) Program, Florida Department of Children and Families. Using this program service is completely voluntary and at no cost to you. If you choose not to use this service, your enrollment with CarePlus will not be affected.

The specific agency that offers the options for assistance will be the one responsible to determine final eligibility. You are always free to apply for public assistance directly with the sponsoring agency. However, if you would like our Social Services department's assistance, you may call 1-855-392-3900 to speak to a CarePlus Social Services representative. TTY users should call 711.



Preventive Services

Why are Preventive Services important?

Preventive services may help find health problems early, when treatment works best, and may keep you from getting certain diseases or illnesses. Preventive services include certain exams, lab tests, vaccinations, and screenings.

CarePlus offers all Medicare-covered preventive services at no cost to you. However, if you are also treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment may apply for the care received for the existing medical condition.

Please refer to your Evidence of Coverage (EOC) to view the full listing of preventive services, and detailed information regarding coverage and limitations.

What is the CarePlus Rewards Program*? How does it work?

CarePlus Rewards is a program that rewards you for your healthy activities at no extra cost!

You will receive a brochure in the mail explaining the program and how you can earn the rewards. You can earn gift cards for completing preventive care activities such as the "Welcome to Medicare" preventive visit, cardiovascular disease screening, diabetes screening or flu shot, among others.

***In accordance with the federal requirements of the Centers for Medicare & Medicaid Services (CMS), no amount on this card can be redeemed for cash and no amount on this card may be applied toward the purchase of any prescription drug under your CarePlus Medicare plan. All rewards (gift cards) must be ordered from CarePlus within 60 days after the plan year ends. Please contact Member Services at the phone number listed on the back cover of this booklet for further details about this program.**

Behavioral/Mental Health Services

Does my plan offer behavioral/mental health services?

Yes, as a CarePlus member you are able to receive behavioral and substance abuse services through our network provider Beacon Health Options. You may contact Beacon Health Options directly by calling 1-800-221-5487; Monday through Friday, from 8:30 a.m. to 6:00 p.m. TTY users should call 711. A Beacon Health Options representative will be able to assist you in finding a healthcare provider that meets your needs.

Authorization rules may apply. Please refer to your Evidence of Coverage (EOC) for coverage details.

Diabetes Supplies

Are diabetes supplies such as lancets, blood glucose test strips and/or glucometers covered?

Yes, these diabetes supplies are covered by CarePlus and are available through our retail and mail-order network pharmacies, including Humana-owned PrescribeIT Rx*, the preferred cost-sharing mail-order pharmacy.

Diabetes supplies ordered through PrescribeIT Rx are conveniently shipped to your home and should arrive within 10 calendar days from the time that the mail-order pharmacy receives the order. To place your order, or if you do not receive your diabetes supplies within the estimated time mentioned above, please contact PrescribeIT Rx directly at 1-800-526-1490; Monday through Friday, from 8 a.m. to 5 p.m. TTY users should call 711. Your PCP can also fax your prescription to PrescribeIT Rx's toll-free fax number at 1-800-526-1491.

**Other pharmacies are available in our network.*

Preferred Brands for Diabetes Monitoring Supplies include:

- Your choice of an Accu-Chek® or Nipro (e.g., TrueResult®, TrueTestTM, TrueTrack®) glucometer starter kit;
- Refills of lancets and test strips for up to a 90-day supply, based on your PCP's recommendations.

If I use a retail network pharmacy to obtain my diabetes monitoring supplies rather than mail-order, will my out-of-pocket costs be higher?

Diabetes monitoring supplies are only covered at network retail pharmacies and network mail-order pharmacies. Your costs are the same at any participating pharmacy as long as you select the preferred brand-name supplies; however, by using PrescribeIT Rx* you add the convenience of having these supplies shipped to your home at no additional cost.

Certain CarePlus plans have a 20% coinsurance for non-preferred brands obtained at durable medical equipment (DME) providers, retail or mail-order pharmacies, including PrescribeIT Rx*. To maximize your benefits, it is always best to obtain preferred diabetes monitoring supplies from network providers and pharmacies.

**Other pharmacies are available in our network. Authorization Rules may apply. Please refer to your Evidence of Coverage (EOC) for coverage details.*

Do diabetes monitoring supplies count towards my prescription drug benefit?

Certain diabetes monitoring supplies are considered DME items and are generally covered as a medical benefit. However, your prescription drug benefit covers diabetes supplies used for injecting insulin, such as:

- Insulin syringes;
- Needles;
- Alcohol swabs; and
- Gauze.

Authorization rules may apply. Please refer to your Evidence of Coverage (EOC) for coverage details.

Cost for these items count toward your prescription drug benefit.

Over-the-Counter (OTC) Products

How do I use my Over-the-Counter (OTC) mail-order benefit?

As a member of CarePlus you are eligible for a monthly allowance to be used toward the purchase of over-the-counter health and wellness products, such as cough medicine, pain relievers, and first aid items - available through our OTC mail-order service. Your order will be conveniently shipped to your home.

What is the process for obtaining my OTC mail-order products?

Please take the following steps to order your OTC items:

1. Complete the OTC mail-order form included in your pre-enrollment package. If you are a current member, you may request an OTC mail-order form from Member Services by calling the phone number listed on the back cover of this booklet.
2. Select the products that you would like to receive from the OTC mail-order form, up to your plan's allowable benefit amount. If you order from the mail-order pharmacy PrescribeIT Rx*, you may also purchase items above your allowable monthly amount by completing the additional payment information on your order form. Failure to submit payment in full will lead to items being cancelled to bring your order total at or below your monthly benefit allowance.
3. Follow the mailing instructions on your OTC mail-order form.

** Other pharmacies are available in our network.*

What happens if I submit my OTC mail-order form too early?

If you are a new member and you submit your order form before your enrollment becomes effective, the order will be processed; however, your order will not be mailed until the beginning of the month your enrollment becomes effective.

OTC benefit may vary depending on your plan. Please refer to your Evidence of Coverage (EOC) for detailed information.

Vision Services

What are my covered services?

CarePlus provides coverage for vision care. Vision services must be obtained from one of our network providers. Depending on your benefit plan, vision services may include coverage for a routine eye exam and standard eyeglasses (from a select collection) or contact lenses.

Vision benefits vary depending on your plan and authorization rules may apply. Please refer to your Evidence of Coverage (EOC) for detailed information.

Why do I need to see an optometrist before seeing an ophthalmologist?

For routine services, you may want to visit an optometrist first, before going to see an ophthalmologist. An optometrist can conduct a routine eye exam and prescribe eyeglasses or contact lenses.

If you have a serious eye condition or disease, an optometrist will refer you to an ophthalmologist. Your PCP may also refer you directly to an ophthalmologist. Always remember that the common theme to eye health is prevention - early diagnosis and treatment.

Dental Services

What is the name of the CarePlus dental benefit provider?

If you are enrolled in a CarePlus plan that offers dental benefit coverage, you may obtain dental services by utilizing our dental network provider, Argus Dental. You can contact Argus Dental at 1-844-520-2041. Monday through Friday, from 8 a.m. to 8 p.m. TTY users should call 711.

Dental benefits are not available in all areas and vary depending on your plan. Authorization rules may apply. Please refer to your Evidence of Coverage (EOC) for detailed information.

Can I still receive dental services even if my plan does not offer dental benefits?

If the plan you are enrolled in does not offer dental benefits, you may receive dental discounts for certain dental services with a participating CarePlus dentist or specialist. This dental discount is available through our Valued-Added Items and Services program.* Contact Member Services at the number listed on the back cover of this booklet to find a participating dentist or specialist near you.

**The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the CarePlus grievance process. Valued-Added Items and Services (VAIS) are not plan benefits. Plan's members who choose to obtain VAIS items or services are responsible for all costs.*

Hearing Services

What is the name of the CarePlus hearing benefit provider?

If you enrolled in a CarePlus plan that offers hearing benefits, you can obtain these services through our hearing network provider HearUSA, Inc. You may contact HearUSA, Inc. at 1-800-442-8231; Monday through Friday, from 8 a.m. to 8 pm. TTY users should call 1-888-300-3277. You may also visit their website at www.hearusa.com.

Hearing benefits are not available in all areas and vary depending on your plan. Authorization rules may apply. Please refer to your Evidence of Coverage (EOC) for detailed information.

Can I still receive hearing services even if my plan does not offer hearing benefits?

If the plan you are enrolled in does not offer hearing benefits, you can still receive discounts for certain hearing services through our Valued-Added Items and Services program*. For a list of HearUSA, Inc. providers in your area, visit www.hearusa.com or call HearUSA, Inc. toll-free at 1-800-442-8231; Monday through Friday from 8 a.m. to 8 p.m. TTY users should call 1-888-300-3277. You can call the same phone numbers if you have questions or need to verify fees for a particular service. Please refer to your Valued-Added Items and Services brochure for details, or contact Member Services at the phone number listed on the back cover of this booklet.

**The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the CarePlus grievance process. Valued-Added Items and Services (VAIS) are not plan benefits. Plan's members who choose to obtain VAIS items or services are responsible for all costs.*

Home Delivery Meal Program

What is the Well Dine℠ Inpatient Meal Program?

Your plan may include the Well Dine℠ Inpatient Meal Program benefit. This is a CarePlus benefit that allows you to receive nutritious, precooked frozen meals delivered to your home at no cost after an inpatient stay in a hospital or nursing facility. If your plan offers this benefit, you may arrange to receive this service. Please contact Well Dine℠ at 1-866-96MEALS (1-866-966-3257); Monday through Friday, from 8 a.m. to 9 p.m., and Saturday, 9 a.m. to 5 p.m. TTY users should call 711, for further details or to take advantage of this benefit after your discharge. You will be asked to provide your CarePlus member ID number and other basic information.

The Well Dine℠ Inpatient Meal Program is not available in all areas and may vary depending on your plan. Please refer to your Evidence of Coverage (EOC) for detailed information.

What is the Independent Living Systems (ILS) Meal Discount Services Program*?

As a CarePlus member, you may enjoy the benefits of a meal discount service program offered through the Independent Living Systems (ILS) Meal Discount Services Program*. The ILS program offers healthy meals delivered to you for less. For information, visit the ILS website at www.ilsmeals.com. You can order your meals online. You may also call ILS directly at 1-866-412-6102, Monday through Friday from 8 a.m. to 9 p.m. and Saturday from 9 a.m. to 5 p.m. TTY users should call 711.

**The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the CarePlus grievance process. Valued-Added Items and Services (VAIS) are not plan benefits. Plan's members who choose to obtain VAIS items or services are responsible for all costs.*

Healthways SilverSneakers® Fitness Program

What is the SilverSneakers® Fitness Program* about?

SilverSneakers is a fitness program that offers an innovative blend of physical activity, healthy lifestyle and socially-oriented programming that allows you the opportunity to take greater control of your health. In addition to a basic membership at participating fitness centers, you can:

- Participate in classes designed exclusively for older adults to improve your body's strength and flexibility.
- Have access to on-site advisors for information and specialized service.

**Any nonstandard fitness center services that usually have an extra fee are not included in your membership.*

Should I consult with my doctor before participating?

Yes, it is highly recommend that you consult with your doctor before participating in any fitness program.

Where can I get more information regarding participating SilverSneakers centers in my area?

For information on participating centers in your area, please refer to the Provider Directory or call SilverSneakers at 1-888-423-4632; Monday through Friday, from 8 a.m. to 8 p.m., TTY users should call 711. Or visit their website at www.silversneakers.com.

SilverSneakers® is a registered trademark of Healthways, Inc.

Please refer to your Evidence of Coverage (EOC) for detailed information.

Laboratory Services

Does CarePlus have a preferred laboratory provider?

Yes, LabCorp is the CarePlus contracted provider for laboratory testing services. It is important that you utilize LabCorp in order to avoid any possible out-of-pocket expenses. Your PCP should also be using the services of LabCorp.

Benefits vary depending on your plan and authorization rules may apply. Please refer to your Evidence of Coverage (EOC) for detailed information.

How do I locate a participating LabCorp location?

To locate a participating LabCorp location, you can call LabCorp Customer Service directly at 1-800-877-5227, 24 hours a day, 7 days a week. TTY users should call 711. Or visit their website at www.labcorp.com/wps/portal/findalab.

May I have my lab work done at my doctor's office?

You may be able to have your lab work done at the time of your office visit without the need to leave the office. Some providers may offer this service; however, they may charge an additional fee. We recommend that you ask about coverage prior to obtaining lab services directly at your doctor's office.

Transportation Services

What is considered transportation services?

Transportation includes non-emergency trips to plan approved locations within the plan service area for access to medical care or as requested by your PCP.

What do I do if I need to schedule transportation services?

CarePlus members enrolled in plans that offer transportation services may contact Access2Care (A2C) at 1-866-956-5635, Monday through Saturday, from 7 a.m. to 7 p.m., to schedule transportation services. TTY users should call 711.

If you attend a CAC-Florida Medical Center, you may call your selected center to schedule your transportation services.

How long before my medical appointment should I call to schedule the transportation services?

You **must** call 72 hours prior to your medical appointment to schedule transportation services.

May I bring a companion to my medical appointment?

Yes. You will need to alert the transportation provider at the time you are making your transportation arrangements that you will be travelling with a companion.

I use a wheelchair, would the transportation provider be able to accommodate my needs?

Yes. You will need to advise the transportation provider of any special needs you may have at the time you call to schedule your transportation arrangement.

Transportation services are not available in all areas and benefits vary depending on your plan. Some locations may be excluded. Please refer to your Evidence of Coverage (EOC) for detailed information.

CarePlus Nursing Hotline

Does CarePlus offer a nurse hotline*?

Yes! CarePlus offers you access to a registered nurse 24 hours a day, 7 days a week, 365 days a year. Just call 1-800-819-8467. TTY users should call 711. By contacting our nurse hotline, you have a direct line for answers to many health-related questions. In addition, our nurses work with your PCP to ensure you get the best care possible.

The CarePlus Nursing Hotline can assist you with:

- Tips for healthy living;
- Advice on minor illnesses or injuries;
- Answering condition-specific questions or questions about upcoming surgeries, procedures, or preventive care such as immunizations; and
- Coordinating the scheduling of an appointment with your PCP.

**The advice provided by the nurse hotline is not intended to replace the care of a physician. You should follow-up with your PCP as soon as possible and seek appropriate care in an emergency.*

Claims

Why do I receive an Explanation of Benefits (EOB) notice for my claims that states "this is not a bill" but there is member responsibility?

An Explanation of Benefits (EOB) gives you important information about health benefits that have been provided to you and billed to CarePlus. Please note that an EOB is not a bill. It shows how your claims were processed, what CarePlus paid and what your cost-share, if any, is for that service. Cost-share is your "out-of-pocket" for your deductible, copayments and coinsurance. In many cases, you would have paid your cost-share, if any; at the time the services were provided. If you were not charged applicable cost sharing at the time of service, your provider may send you a bill.

What should I do if I receive an Explanation of Benefits (EOB) from CarePlus confirming payment for services that were never received?

If after careful review of your EOB, you notice any discrepancies or errors in the name of billing provider(s), the type(s) of service(s) rendered or the date(s) that the service(s) were provided, please call Member Services at the phone number listed on the back cover of this booklet. A Member Services representative will review the EOB with you and verify if the billed service(s) were actually rendered. The Member Services representative will also be able to advise you as to how and why the charges were processed.

What should I do if I have other coverage?

In order to ensure that your benefits are maximized, you should notify us immediately of any other health insurance coverage you may have. Similarly, if you are involved in a motor vehicle accident, or a slip and fall, please contact Member Services and inform them of the occurrence to ensure full payment of your medical claims.

Member Services department

Our Member Services representatives are available to assist you with any questions or concerns you may have with regards to your plan. You may call Member Services at 1-800-794-5907; from 8 a.m. to 8 p.m., 7 days a week. From February 15th to September 30th, we are open Monday – Friday from 8 a.m. to 8 p.m. TTY users should call 711.

At the time of your call, please remember to have your CarePlus member ID card available. The Member Services representative will ask you to identify yourself with information printed on your card.

Our goal is to provide you with the information needed and excellent service.

CarePlus
HEALTH PLANS

www.careplushealthplans.com

CarePlus is an HMO plan with a Medicare contract. Enrollment in CarePlus depends on contract renewal. This information is not a complete description of benefits. In addition, not all benefits listed may be available on all plans or in a single plan benefit package. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year.

This information is available for free in other languages. Please call our Member Services number at 1-800-794-5907. TTY users should call 711.

Esta información está disponible de forma gratuita en otros idiomas. Por favor llame a nuestro número de Servicios para Afiliados al 1-800-794-5907. Los usuarios de TTY deben llamar al 711.