# SUMMARY of BENEFITS

2016

## TAMPA AREA

Hillsborough
Pasco
Pinellas
Polk

## CareFree (HMO)

## H1019-060

CarePlus HEALTH PLANS

Keeping the **HEALTH** in health care.

H1019_MKSBCo0602016 Accepted

CarePlus HEALTH PLANS

**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. Someone who speaks English/Language 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. 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。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。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. 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. 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 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. 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 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-794-5907 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. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:**
إننا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الإتصال بنا على 1-800-794-5907 . سيقوم شخص ما يتحدث اللغة العربية بمساعدتك. هذه الخدمة 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 पर फोन करें. कोई व्यक्ति जो हिन्दी 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. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** 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. 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. 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. 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 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。

# SUMMARY OF BENEFITS

January 1, 2016 - December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

## You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **CareFree (HMO)**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **CareFree (HMO)** covers and what you pay.

- If you want 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 http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Sections in this booklet

- Things to Know About **CareFree (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-800-794-5907 (TTY 711).

*Este documento está disponible en otros formatos como Braille y letra grande.*

*Este documento puede estar disponible en idiomas distintos al inglés. Para obtener información adicional, llámenos al 1-800-794-5907 (TTY 711).*

## THINGS TO KNOW ABOUT CAREFREE (HMO)

### Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time.

### CareFree (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-794-5907 (TTY 711).
- If you are not a member of this plan, call toll-free 1-800-794-4105 (TTY 711).
- Our website: http://www.careplushealthplans.com

### Who can join?

To join **CareFree (HMO)**, 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: Hillsborough, Pasco, Pinellas, and Polk.

### Which doctors, hospitals, and pharmacies can I use?

**CareFree (HMO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider and pharmacy directory at our website (www.careplushealthplans.com/members/pharmacy-directories).

Or, call us and we will send you a copy of the provider and pharmacy directories.

### What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.careplushealthplans.com/medicare-plans/2016-prescription-drug-guides.
- Or, call us and we will send you a copy of the formulary.

### How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

## SUMMARY OF BENEFITS
January 1, 2016 - December 31, 2016

## MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

| | CareFree (HMO) |
|---|---|
| **How much is the monthly premium?** | **$0** per month. In addition, you must keep paying your Medicare Part B premium.<br>CarePlus Health Plans, Inc. will reduce your Medicare Part B premium by up to **$80**. |
| **How much is the deductible?** | This plan does not have a deductible. |
| **Is there any limit on how much I will pay for my covered services?** | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br>Your yearly limit(s) in this plan:<br>• **$6,700** for services you receive from in-network providers.<br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |
| **Is there a limit on how much the plan will pay?** | Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply. |

## COVERED MEDICAL AND HOSPITAL BENEFITS

**NOTE:**

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

### OUTPATIENT CARE AND SERVICES

| | |
|---|---|
| **Acupuncture** | Not covered |
| **Ambulance[1]** | **$250** copay |
| **Chiropractic Care** | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **$20** copay<br>Routine chiropractic visit (for up to **12** every year): **$20** copay |
| **Dental Services[1,2]** | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **$35** copay |
| **Diabetes Supplies and Services[1,2]** | Diabetes monitoring supplies: **0-20%** of the cost, depending on the supply<br>Diabetes self-management training: You pay nothing<br>Therapeutic shoes or inserts: **$10** copay |

| | CareFree (HMO) |
|---|---|
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays** *(Costs for these services may vary based on place of service)*[1,2] | Diagnostic radiology services (such as MRIs, CT scans): **$25-150** copay, depending on the service<br>Diagnostic tests and procedures: **$0-150** copay, depending on the service<br>Lab services: You pay nothing<br>Outpatient x-rays: **$0-150** copay, depending on the service<br>Therapeutic radiology services (such as radiation treatment for cancer): **$25-35** copay or **20%** of the cost, depending on the service |
| **Doctor's Office Visits**[1,2] | Primary care physician visit: You pay nothing<br>Specialist visit: **$35** copay |
| **Durable Medical Equipment** *(wheelchairs, oxygen, etc.)*[1] | **0-20%** of the cost, depending on the equipment<br>If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors. |
| **Emergency Care** | **$75** copay<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| **Foot Care** *(Podiatry Services)* | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$35** copay<br>Routine foot care: **$35** copay |
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues: **$35** copay<br>Routine hearing exam (for up to **1** every year): You pay nothing<br>Hearing aid fitting/evaluation (for up to **1** every year): You pay nothing<br>Hearing aid: **$0** copay<br>Our plan pays up to **$1,000** every year for hearing aids.<br>Our plan pays the cost of a hearing exam and hearing aid fitting/evaluation. If total cost does not exceed **$500** per ear, per year, you pay nothing. |
| **Home Health Care**[1,2] | You pay nothing |

| | CareFree (HMO) |
|---|---|
| **Mental Health Care**[1,2] | Inpatient visit:<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>Our plan covers 90 days for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>• **$195** copay per day for days **1** through **5**<br>• You pay nothing per day for days **6** through **90**<br>Outpatient group therapy visit: **$35** copay<br>Outpatient individual therapy visit: **$35** copay |
| **Outpatient Rehabilitation**[1,2] | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to **36** sessions up to **36** weeks): **$35** copay<br>Occupational therapy visit: **$35** copay<br>Physical therapy and speech and language therapy visit: **$35** copay |
| **Outpatient Substance Abuse**[1,2] | Group therapy visit: **$35** copay<br>Individual therapy visit: **$35** copay |
| **Outpatient Surgery**[1,2] | Ambulatory surgical center: **$125** copay<br>Outpatient hospital: **$150** copay |
| **Over-the-Counter Items** | Please visit our website to see our list of covered over-the-counter items.<br>You are eligible to receive a **$10** monthly benefit toward the purchase of selected over-the-counter items when you use the participating mail-order service. |
| **Prosthetic Devices** *(braces, artificial limbs, etc.)*[1] | Prosthetic devices: **20%** of the cost<br>Related medical supplies: **20%** of the cost |
| **Renal Dialysis**[1,2] | **0-20%** of the cost, depending on the service |
| **Transportation**[1] | You pay nothing<br>Van transportation provided by contracted vendor to plan-approved locations for up to **4** one-way trip(s) per calendar year. |
| **Urgently Needed Services** | **$0-35** copay, depending on the service |

| | CareFree (HMO) |
|---|---|
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$0-35** copay, depending on the service<br>Routine eye exam (for up to **1** every year): You pay nothing<br>Contact lenses (for up to **1** every year): **$0** copay<br>Eyeglasses (frames and lenses) (for up to **1** every year): **$0** copay<br>Eyeglasses or contact lenses after cataract surgery: You pay nothing<br>Our plan pays up to **$115** every year for contact lenses and eyeglasses (frames and lenses).<br>Our plan pays the cost of a routine eye exam and prescribed eye wear. If total cost does not exceed **$115** per year for contact lenses or glasses and frames, you pay nothing. |
| **PREVENTIVE CARE** | You pay nothing<br>Our plan covers many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Yearly "Wellness" visit<br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **HOSPICE** | You pay nothing for hospice care from a Medicare-certified hospice.<br>You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. |

| | CareFree (HMO) | |
|---|---|---|
| **INPATIENT CARE** | | |
| **Inpatient Hospital Care**[1,2] | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>• **$195** copay per day for days **1** through **5**<br>• You pay nothing per day for days **6** through **90**<br>• You pay nothing per day for days **91** and beyond | |
| **Inpatient Mental Health Care** | For inpatient mental health care, see the "Mental Health Care" section of this booklet. | |
| **Skilled Nursing Facility (SNF)**[1,2] | Our plan covers up to 100 days in a SNF.<br>• You pay nothing per day for days **1** through **20**<br>• **$150** copay per day for days **21** through **100** | |
| **PRESCRIPTION DRUG BENEFITS** | | |
| **How much do I pay?** | For Part B drugs such as chemotherapy drugs[1]: **20%** of the cost<br>Other Part B drugs[1]: **20%** of the cost | |
| **INITIAL COVERAGE** | You pay the following until your total yearly drug costs reach **$3,310**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br>You may get your drugs at network retail pharmacies and mail order pharmacies. | |
| | **Standard Retail Cost-Sharing** | |
| **Tier** | **One-Month Supply** | **Three-Month Supply** |
| **Tier 1** (Preferred Generic) | **$0** | **$0** |
| **Tier 2** (Generic) | **$5** copay | **$15** copay |
| **Tier 3** (Preferred Brand) | **$35** copay | **$105** copay |
| **Tier 4** (Non-Preferred Brand) | **$60** copay | **$180** copay |
| **Tier 5** (Specialty Tier) | **33%** of the cost | Not Offered |
| | **Standard Mail Order Cost-Sharing** | |
| **Tier** | **One-Month Supply** | **Three-Month Supply** |
| **Tier 1** (Preferred Generic) | **$0** | **$0** |
| **Tier 2** (Generic) | **$5** copay | **$15** copay |
| **Tier 3** (Preferred Brand) | **$35** copay | **$105** copay |
| **Tier 4** (Non-Preferred Brand) | **$60** copay | **$180** copay |
| **Tier 5** (Specialty Tier) | **33%** of the cost | Not Offered |

| | CareFree (HMO) | |
|---|---|---|
| | Preferred Mail Order Cost-Sharing | |
| **Tier** | **One-Month Supply** | **Three-Month Supply** |
| **Tier 1** (Preferred Generic) | **$0** | **$0** |
| **Tier 2** (Generic) | **$5** copay | **$0** |
| **Tier 3** (Preferred Brand) | **$35** copay | **$95** copay |
| **Tier 4** (Non-Preferred Brand) | **$60** copay | **$170** copay |
| **Tier 5** (Specialty Tier) | **33%** of the cost | Not Offered |
| If you reside in a long-term care facility, you pay the same as at a retail pharmacy.<br>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. | | |
| **COVERAGE GAP** | Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,310**.<br>After you enter the coverage gap, you pay **45%** of the plan's cost for covered brand name drugs and **58%** of the plan's cost for covered generic drugs until your costs total **$4,850**, which is the end of the coverage gap. Not everyone will enter the coverage gap.<br>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. | |

| | CareFree (HMO) | | |
|---|---|---|---|
| | **Standard Retail Cost-Sharing** | | |
| **Tier** | **Drugs Covered** | **One-Month Supply** | **Three-Month Supply** |
| **Tier 1** (Preferred Generic) | Some | **$0** | **$0** |
| **Tier 2** (Generic) | Some | **$5** copay | **$15** copay |
| **Tier 3** (Preferred Brand) | Some | **$35** copay | **$105** copay |
| **Tier 4** (Non-Preferred Brand) | Some | **$60** copay | **$180** copay |
| **Tier 5** (Specialty Tier) | Some | **33%** of the cost | Not Offered |
| | **Standard Mail Order Cost-Sharing** | | |
| **Tier** | **Drugs Covered** | **One-Month Supply** | **Three-Month Supply** |
| **Tier 1** (Preferred Generic) | Some | **$0** | **$0** |
| **Tier 2** (Generic) | Some | **$5** copay | **$15** copay |
| **Tier 3** (Preferred Brand) | Some | **$35** copay | **$105** copay |
| **Tier 4** (Non-Preferred Brand) | Some | **$60** copay | **$180** copay |
| **Tier 5** (Specialty Tier) | Some | **33%** of the cost | Not Offered |
| | **Preferred Mail Order Cost-Sharing** | | |
| **Tier** | **Drugs Covered** | **One-Month Supply** | **Three-Month Supply** |
| **Tier 1** (Preferred Generic) | Some | **$0** | **$0** |
| **Tier 2** (Generic) | Some | **$5** copay | **$0** |
| **Tier 3** (Preferred Brand) | Some | **$35** copay | **$95** copay |
| **Tier 4** (Non-Preferred Brand) | Some | **$60** copay | **$170** copay |
| **Tier 5** (Specialty Tier) | Some | **33%** of the cost | Not Offered |
| **CATASTROPHIC COVERAGE** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,850**, you pay the greater of:<br>• **5%** of the cost, or<br>• **$2.95** copay for generic (including brand drugs treated as generic) and a **$7.40** copayment for all other drugs. | | |


**www.careplushealthplans.com**

CarePlus is an HMO plan with a Medicare contract. Enrollment in CarePlus depends on contract renewal.