CareOne PLATINUM (HMO-POS)
H1019-110

2021

SUMMARY OF BENEFITS

SPACE COAST:

Brevard
Indian River

CarePlus HEALTH PLANS

H1019_MKSB1102021_M

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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor.
  Visit **CarePlusHealthPlans.com/medicare-plans/2021** 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 pharmacy 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.

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 your State Medicaid Program.

- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2022.

- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

2021 Summary of Benefits

This Summary of Benefits booklet gives you a summary of what **CareOne PLATINUM (HMO-POS)** covers and what you pay. It does not list every service covered by this plan or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage (EOC) on our website, CarePlusHealthPlans.com/medicare-plans/2021, or call us and we will send you a copy. An EOC is automatically mailed to you after you enroll in our plan.

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 also 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. If out-of-network coverage is not indicated in the chart, the service is only covered when received from a provider within the CarePlus network.

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

You must generally use network pharmacies to fill your prescriptions for Medicare-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/pharmacy directory on our website: 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 covering medical services, we cover certain Part D drugs and Part B drugs such as chemotherapy and some drugs administered by your physician. For more information on covered drugs, refer to the Evidence of Coverage (EOC).

You can see our complete Drug Guide (approved list of prescription drugs/formulary) and any restrictions on our website, CarePlusHealthPlans.com/medicare-plans/2021-prescription-drug-guides.

You can also call us and we will send you a copy of our Drug Guide.

How to determine your drug costs

The plan groups medications into one of five tiers. You will need to use your formulary to locate what tier your drug is in to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the drug coverage you have reached.

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and Florida's Medicaid program, **you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too**. Please contact us to learn more about how this plan works for dual-eligible members.

Need more information or have questions?

Visit us at **CarePlusHealthPlans.com**, or call us at one of the phone numbers listed below.

If you are a member
of this plan, reach out to
a Member Services representative
by calling toll-free
1-800-794-5907 (TTY: **711**).

If you are not a member
of this plan, reach out to
a licensed sales agent
by calling toll-free
1-800-794-4105 (TTY: **711**).

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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.

CareOne PLATINUM (HMO-POS) H1019-110
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MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUM OUT-OF-POCKET LIMIT

Monthly Plan Premium

- **$0**
- You must continue to pay your Medicare Part B premium. If you qualify for Medicaid, the Part B premium may be covered through your State Medicaid Program.

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 have paid this amount, we pay 100% of your covered services for the rest of the year, excluding any prescription drug costs, health expenses incurred during foreign travel, or supplemental benefit costs.

COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital Care

	In-network	Out-of-network
• Days **1 - 7.**	**$150** copay	**$170** copay
• 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.
- A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient hospital care or skilled care in a Skilled Nursing Facility (SNF) for 60 days in a row. If you go into a hospital or SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Outpatient Hospital Care

	In-network	Out-of-network
• Lab services	**$0** copay	**$0** copay
• Mental health care group and individual therapy visits. • Physical therapy, occupational therapy, speech and language therapy. • Cardiac and pulmonary rehabilitation services. • Supervised Exercise Therapy (SET) services.	**$20** copay	**$25** copay
• Therapeutic radiology (radiation therapy) services.	**$55** copay	**$55** copay
• Diagnostic procedures and tests. • Basic radiology (X-ray) services. • Diagnostic radiology services (including advanced imaging services such as MRI, MRA and CT scans). • Diagnostic mammography services. • Nuclear medicine services. • Diagnostic colonoscopy services. • Surgery services.	**$110** copay	**$135** copay
• Chemotherapy drugs. • Renal dialysis.	**20%** coinsurance	**20%** coinsurance

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Doctor Visits

	In-network	Out-of-network
• Primary care physician (PCP) visits. – You must select an in-network physician as your PCP. The PCP that you choose will focus on your needs and coordinate your care with other network providers.	**$0** copay	Not covered
• Specialist visits.	**$20** copay	**$25** copay

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

- **$0** copay
- Our plan covers many 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
  - – "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 world-wide. If you receive emergency care (in-area or out-of-area) and pay for covered services, we will reimburse you for our share of the cost up to the Medicare allowable charge.
- 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.
- **$20** copay at a specialist's office.
- **$20** copay at an urgent care center.
- Coverage for urgently needed services is the same world-wide. If you receive urgently needed care (in-area, out-of-area, or after-hours) and pay for covered services, we will reimburse you for our share of the cost up to the Medicare allowable charge.

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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	**$20** copay	**$25** copay
– At an urgent care center	**$25** copay	**$25** copay
– At a hospital facility as an outpatient	**$110** copay	**$135** copay
• **Basic radiology (X-ray) services:**		
– At your in-network primary care physician's office	**$0** copay	Not covered
– At a specialist's office	**$20** copay	**$25** copay
– At an urgent care center	**$25** copay	**$25** copay
– At a freestanding radiological facility	**$25** copay	**$25** copay
– At a hospital facility as an outpatient	**$110** copay	**$135** copay
• **Diagnostic radiology services** (includes advanced imaging services such as MRI, MRA and CT Scans)**:**		
– At your in-network primary care physician's office	**$95** copay	Not covered
– At a specialist's office	**$95** copay	**$95** copay
– At a freestanding radiological facility	**$95** copay	**$95** copay
– At a hospital facility as an outpatient	**$110** copay	**$135** copay
• **Therapeutic radiology (radiation therapy) services:**		
– At a specialist's office	**$20** copay	**$25** copay
– At a freestanding radiological facility	**20%** coinsurance	**20%** coinsurance
– At a hospital facility as an outpatient	**$55** copay	**$55** copay
• **Lab services**	**$0** copay	**$0** copay
• **Diagnostic mammography services:**		
– At a specialist's office	**$0** copay	**$0** copay
– At a freestanding radiological facility	**$0** copay	**$0** copay
– At a hospital facility as an outpatient	**$110** copay	**$135** copay
• **Diagnostic colonoscopy services:**		
– At a specialist's office	**$20** copay	**$25** copay
– At an ambulatory surgical center	**$95** copay	**$95** copay
– At a hospital facility as an outpatient	**$110** copay	**$135** copay
• **Nuclear medicine services:**		
– At a freestanding radiological facility	**$60** copay	**$60** copay
– At a hospital facility as an outpatient	**$110** copay	**$135** copay

Ambulatory Surgery Center (in-network and out-of-network)

- **$0** copay for physician and professional services.
- **$95** copay for diagnostic colonoscopy services.
- **$95** copay for surgery services.
- **$0** copay for colorectal cancer screening.

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Hearing Services

	In-network	Out-of-network
• Medicare-covered exam to diagnose and treat hearing and balance issues.	**$20** copay	**$25** copay
• Supplemental routine hearing services: – Routine hearing exam (up to **1** per calendar year). – Hearing aid fitting/evaluation (up to **1** per calendar year). – Our plan covers up to **$500** per ear, per calendar year for hearing aids. – **1** month battery supply and **2**-year warranty included.	**$0** copay	Not covered

Dental Services

	In-network	Out-of-network
• Limited Medicare-covered dental services. Excludes preventive, restoration, removal and replacement services.	**$20** copay	**$25** copay
• Supplemental routine dental services: – Periodic oral evaluation(s), up to **2** per calendar year – Comprehensive oral evaluation, up to **1** every **3** calendar years – Prophylaxis cleaning(s), up to **2** per calendar year – Bitewing X-rays, up to **1** set per calendar year – Panoramic X-ray film, up to **1** per calendar year – Amalgam and/or resin filling(s), up to **2** per calendar year – Scaling and root planing (deep cleaning), up to **1** per quadrant per calendar year – Simple or surgical extractions, up to **3** per calendar year – Anesthesia • 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.	**$20** copay	**$25** copay
• Diabetic eye exam.	**$0** copay	**$0** copay
• **1** pair of eyeglasses (frames and lenses) or contact lenses after cataract surgery.	**$0** copay	**$0** copay
• Supplemental routine vision services: – Supplemental routine eye exams with refraction, up to **1** per calendar year. – Our plan also pays up to **$180** per calendar year for contact lenses or eyeglasses (frames and lenses) of your choice. – Ultraviolet protection and scratch resistant coating included on eyeglasses. – No charge for eyeglass fitting. – You are responsible for any eyewear costs above the yearly allowance amount.	**$0** copay	Not covered

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Mental Health Care

	In-network	Out-of-network
• **Inpatient visit - general hospital:** – Days **1 - 7**. – Days **8 - 90**. – Our plan covers up to 90 days per stay in a general hospital. – 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. Once you have used up these extra 60 days, your coverage for a current stay ends and coverage for each future hospital stay ends after 90 days.	**$150** copay per day **$0** copay per day	**$170** copay per day **$0** copay per day
• **Inpatient visit - psychiatric facility:** – Days **1 - 7**. – Days **8 - 90**. – Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**$150** copay per day **$0** copay per day	**$170** copay per day **$0** copay per day
• **Outpatient visit:** – Outpatient group and individual therapy visits. – Partial hospitalization. – Includes outpatient treatment for mental illness and/or substance abuse.	**$20** copay	**$25** copay

Skilled Nursing Facility (SNF) Care (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 is required.
- Our plan covers up to **100** days in a SNF per benefit period.
- A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Physical Therapy

In-network:

- **$20** copay per visit

Out-of-network:

- **$25** copay per visit

Ambulance Services

- **$150** copay per trip for in-network emergency ambulance services by ground transportation.
- **$180** copay per trip for out-of-network emergency ambulance services by ground transportation.
- **$0** copay per trip for medically necessary non-emergency ambulance services by ground transportation.

Routine Transportation (in-network only)

- **$0** copay for up to **50** one-way trips per calendar year.
- Transportation provided by contracted vendor to plan-approved locations.

CareOne PLATINUM (HMO-POS) H1019-110
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Medicare Part B Drugs (in-network and out-of-network)

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

PART D PRESCRIPTION DRUG BENEFITS (IN-NETWORK ONLY)

- This plan uses a formulary. Quantity limitations and other drug restrictions/authorizations may apply.
- CarePlus offers a nationwide network of pharmacies.
- Your cost for prescription drugs depends on the pharmacy where the prescription is filled (retail, mail-order, or long term care facility). Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. Your cost may be less at pharmacies with preferred cost-sharing.
- Your cost also depends on where the drug is administered (at home, pharmacy or provider's office), the supply needed (30 days or a long-term supply), which phase of the Part D benefit you are in, and if you qualify for Extra Help.
- If you get drugs from an out-of-network pharmacy, you may pay more than you pay at an in-network pharmacy. The cost-sharing information provided in this booklet is for in-network pharmacies.
- Total yearly drug costs are the total drug costs paid by both you and the plan.
- For more information on prescription drug benefit cost-sharing and phases, please call us or access our Evidence of Coverage online at CarePlusHealthPlans.com/medicare-plans/2021.
- You can also call us to find out if a particular drug is covered or look for the drug in our Drug Guide (formulary) at: CarePlusHealthPlans.com/medicare-plans/2021-prescription-drug-guides.
- **With Extra Help from Medicare, you pay whichever is less for your prescription drugs, your cost-share under the plan or the Low Income Subsidy (LIS) cost-share.**

Deductible

- **$0** - This plan does not have an annual deductible.

Insulin Savings Program

- You will pay the following amounts for select insulin drugs through the initial coverage and coverage gap stages.

Tier	Supply	Retail: Preferred Cost-Sharing	Retail: Standard Cost-Sharing	Mail-Order: Preferred Cost-Sharing	Mail-Order: Standard Cost-Sharing
Tier 2 Generic	30-day	**$10** copay	**$20** copay	**$10** copay	**$20** copay
	90-day	**$30** copay	**$60** copay	**$0** copay	**$60** copay
Tier 3 Preferred Brand	30-day	**$30** copay	**$35** copay	**$30** copay	**$35** copay
	90-day	**$90** copay	**$105** copay	**$80** copay	**$105** copay

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Initial Coverage

- The following chart shows what you pay for your drugs (except for select insulin), until your total yearly drug costs reach **$4,130**.

Tier	Supply	Retail: Preferred Cost-Sharing	Retail: Standard Cost-Sharing	Mail-Order: Preferred Cost-Sharing	Mail-Order: Standard Cost-Sharing
Tier 1 Preferred Generic	30-day	**$0** copay	**$10** copay	**$0** copay	**$10** copay
	90-day	**$0** copay	**$30** copay	**$0** copay	**$30** copay
Tier 2 Generic	30-day	**$10** copay	**$20** copay	**$10** copay	**$20** copay
	90-day	**$30** copay	**$60** copay	**$0** copay	**$60** copay
Tier 3 Preferred Brand	30-day	**$30** copay	**$47** copay	**$30** copay	**$47** copay
	90-day	**$90** copay	**$141** copay	**$80** copay	**$141** copay
Tier 4 Non-Preferred Drug	30-day	**$95** copay	**$100** copay	**$95** copay	**$100** copay
	90-day	**$285** copay	**$300** copay	**$275** copay	**$300** copay
Tier 5 Specialty Tier	30-day	**33%** coinsurance	**33%** coinsurance	**33%** coinsurance	**33%** coinsurance
	90-day	Not offered	Not offered	Not offered	Not offered

Coverage Gap

- After your total yearly drug costs (what you and the plan pay) reach **$4,130**, you enter the coverage gap.
- The plan covers the following drugs through the coverage gap:
  – Tier 1 Preferred Generic - All drugs
  – Tier 2 Generic - All drugs
- Your cost for these medications is the same before and during the coverage gap.
- All other medication is **100%** member responsibility during the coverage gap, less any applicable Part D coverage gap discounts.
- While you are in the coverage gap, you pay no more than **25%** of the cost for all generic and brand-name drugs based on the plan's contracted rates through retail and mail-order pharmacies.

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Catastrophic Coverage

- After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay the greater of:
  – **5%** of the cost, or
  – **$3.70** copay for generic (including brand drugs treated as generic) and a **$9.20** copay for all other drugs.
- Your yearly out-of-pocket drug costs is the total of any Part D-covered drug payments made during the calendar year by you, on your behalf, or under another Medicare prescription drug plan before you joined our plan, and determines when you enter the catastrophic coverage phase.

Excluded Part D Drugs Covered by Our Plan

- This plan covers certain erectile dysfunction drugs.
- Your cost for these drugs is the same as your cost for Tier 1 drugs during the Initial Coverage phase, regardless of the drug phase you are in when your prescription is filled.
- Refer to this plan's Evidence of Coverage for specific coverage information including costs.
- These drugs are covered at an in-network retail or mail-order pharmacy and do not apply towards your total annual drug cost.

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.	**$20** copay	**$25** copay
• At an ambulatory surgical center.	**$95** copay	**$95** copay
• At a hospital facility as an outpatient.	**$110** copay	**$135** copay

Other Rehabilitation Services

	In-network	Out-of-network
• Occupational therapy (daily living activities), speech and language therapy. • Cardiac (heart) and pulmonary (lungs) rehabilitation services. – Cardiac rehab services include a maximum of 2 one-hour sessions per day for a maximum of 36 sessions within – 36 weeks. • Supervised Exercise Therapy (SET) services.	**$20** copay	**$25** copay

Foot Care/Podiatry Services

	In-network	Out-of-network
• Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	**$20** copay	**$25** copay
• Supplemental routine podiatry services: – Routine foot care. – You may self-refer to a network podiatrist for **unlimited** routine visits for treatment of flat feet or other structural misalignments of the feet, removal of corns, removal of warts, removal of calluses, and hygienic care.	**$20** copay	Not covered

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

- **Durable medical equipment:**
  – **20%** coinsurance
- **Prosthetic devices *(braces, artificial limbs, etc.)* and other medical supplies:**
  – **20%** coinsurance
- **Diabetic supplies:**
  – **$10** copay for therapeutic shoes and inserts.
- **Diabetic monitoring supplies:**
  – **$0** copay

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

- **$0** copay for primary care physician virtual visit.
- **$20** copay for specialist virtual visit
- **$0** copay for behavioral health and substance abuse virtual visit.
- **$0** copay for urgent care virtual visit.
- This benefit 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
  – Once you are released to go home from an overnight stay in the hospital or skilled nursing facility, you're eligible for up to **10** freshly prepared nutritious meals delivered to your door at no cost to you. Limited to 4 times per year.
- **SilverSneakers® Fitness Program:**
  – **$0** copay
  – The fitness program includes access to 17,000+ participating locations and signature group exercise classes led by certified instructors. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.
  – Consult your doctor before beginning any new diet or exercise regimen.
- **Over-the-Counter (OTC) Items:**
  – You are eligible to receive a **$30** monthly allowance toward the purchase of select OTC items such as pain relievers, cough and cold medicines, allergy medications, and first aid/medical supplies when you use the participating mail-order service.
  – Please visit our plan website to see our list of covered OTC items.
- **CarePlus Rewards:**
  – CarePlus rewards offers members a gift card of their choice from participating retailers for completing preventive screenings and certain other healthcare activities. Some limitations and exclusions apply.
  – In accordance with the federal requirements of the Centers for Medicare & Medicaid Services, no amounts on the gift cards shall be redeemable for cash or be used to purchase Medicare-covered items or services. All rewards (gift cards) must be earned and redeemed prior to the end of the plan year. Rewards not redeemed by 12/31 will be forfeited.

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Acupuncture

	In-network	Out-of-network
• Up to **20** Medicare-covered acupuncture treatments for chronic low back pain when ordered by a physician.	**$20** copay	**$25** copay
• Supplemental routine acupuncture services: – Up to **25** visits every 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.)	**$20** copay	**$25** copay
• Supplemental routine chiropractic services: – Up to **12** self-referred, routine visits to a network chiropractor every year.	**$20** copay	Not covered

COVID-19 Testing and Treatment (in-network only)

- **$0** copay for testing and treatment services for COVID-19 in-network and out-of-network.
- Members receive **14** days of meals (**28** meals) after a COVID-19 diagnosis.

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

- **$0** copay for limited skilled nursing care and certain other health services you get in your home for the treatment of an illness or injury.
- 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 hospice care from a Medicare-certified hospice.
- 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.

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

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

Wigs Related to Chemotherapy Treatment (in-network only)

- **$0** copay
- With physician authorization, eligible members may receive up to **$500** reimbursement per calendar year toward the purchase of a wig for medical hair loss related to chemotherapy treatment. Must use network provider(s).

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, marital status, or religion. 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: Member Services Department.
  11430 NW 20th Street, Suite 300. Miami, FL 33172.
  If you need help filing a grievance, call **1-800-794-5907 (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 1 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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone 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.

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

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
ગુજરાતી (Gujarati): નઃશૂલ્ક ભાષા સહાય સેવાઓ પ્રાપ્ત કરવા માટે ઉપરોક્ત નંબર પર કૉલ કરો.
ภาษาไทย (Thai): โทรติดต่อที่หมายเลขด้านบนนี้เพื่อรับบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic): الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

CP REV: 6.25.20

CarePlus
HEALTH PLANS

CarePlusHealthPlans.com

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