

CareSalute (HMO-POS)
H1019-143

2023



SUMMARY OF BENEFITS

ATLANTIC COAST:

Brevard
Indian River

CarePlus
HEALTH PLANS

Snapshot of Benefits

CareSalute (HMO-POS) H1019-143



Monthly Plan Premium

\$0



Medicare Part B Premium Reduction

Up to \$144 back every month



Primary Care Physician Office Visit

\$0 copay



Specialist Office Visit

\$40 copay (in-network)

\$50 copay (out-of-network)



OTC Allowance

\$20 monthly



Routine Dental, Vision and Hearing Coverage

\$0 copay



Inpatient Hospital Care

\$225 copay per day for days 1-8 (in-network)

\$275 copay per day for days 1-8 (out-of-network)

Emergency Care

\$90 copay (in-network and out-of-network)

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

Licensed CarePlus Sales Agent Name: _____

Licensed CarePlus Sales Agent Phone Number: _____

Great news



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

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

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

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

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

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

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

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

Pre-Enrollment Checklist



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

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

Understanding the Benefits

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

Understanding Important Rules

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

2023 Summary of Benefits



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



Tips for comparing your Medicare choices

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



Who can join CareSalute (HMO-POS)?

To join **CareSalute (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 and hospitals can you use?

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

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

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



What does this plan cover?

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

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

This plan does not include coverage for Part D prescription drugs. If you do not have prescription drug coverage through the Veteran's Administration, for example, you may want to consider a Medicare Advantage plan that includes prescription drug coverage.

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.** 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,
call Member Services:
1-800-794-5907 (TTY: 711).

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

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

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

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

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Out-of-network coverage available in Brevard and Indian River counties only

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

Monthly Plan Premium

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

Part B Premium Reduction

- This plan will reduce your monthly Medicare Part B premium by up to **\$144**. Your social security check will increase by this amount.

Deductible

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

Maximum Out-of-Pocket Limit (combined in-network and out-of-network)

- **\$4,900** per year.
- This amount is the most you will pay during the plan year for approved medical services under our plan. Once you (or others on your behalf) pay this amount, we pay 100% of your covered services for the rest of the plan year. Excludes costs for services abroad, and supplemental benefits.

COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital Care

	<u>In-network</u>	<u>Out-of-network</u>
• Days 1 - 8 .	\$225 copay per day	\$275 copay per day
• Days 9 - 90 .	\$0 copay	\$0 copay
• Days 91 and beyond.	\$0 copay	\$0 copay
• Our plan covers an unlimited number of days for an inpatient hospital stay.		
• See Evidence of Coverage for benefit period information.		

Outpatient Hospital Care

	<u>In-network</u>	<u>Out-of-network</u>
• Pulmonary rehabilitation services.	\$20 copay	\$50 copay
• Mental health care group and individual therapy visits.	\$30 copay	\$50 copay
• Supervised Exercise Therapy (SET) services.		
• Physical, occupational, and speech therapy.	\$40 copay	\$50 copay
• Cardiac rehabilitation services.		
• Diagnostic procedures and tests. See diagnostic services for additional details.	\$175 copay	\$250 copay
• Surgery services.		
• Chemotherapy drugs.	20% coinsurance	20% coinsurance
• Renal dialysis.		

Ambulatory Surgery Center

	<u>In-network</u>	<u>Out-of-network</u>
• Physician and professional services.		
• Diagnostic colonoscopy services.	\$0 copay	\$0 copay
• Colorectal cancer screening.		
• Surgery services.	\$125 copay	\$200 copay

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Out-of-network coverage available in Brevard and Indian River counties only

Doctor Visits

	<u>In-network</u>	<u>Out-of-network</u>
<ul style="list-style-type: none"> Primary care physician (PCP) visits. <ul style="list-style-type: none"> – Must select a PCP from our network. 	\$0 copay	Not covered
<ul style="list-style-type: none"> Specialist visits. 	\$40 copay	\$50 copay

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

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

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

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

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

- \$0** copay at your in-network primary care physician’s office.
- \$40** copay at a specialist’s office.
- \$40** copay at an urgent care center.
- Coverage for urgently needed services is the same worldwide.

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Out-of-network coverage available in Brevard and Indian River counties only

Diagnostic Services

	<u>In-network</u>	<u>Out-of-network</u>
<ul style="list-style-type: none"> • Diagnostic procedures and tests: <ul style="list-style-type: none"> – At your in-network primary care physician's office – At a specialist's office – At an urgent care center – At a hospital facility as an outpatient 	\$0 copay \$40 copay \$40 copay \$175 copay	Not covered \$50 copay \$50 copay \$250 copay
<ul style="list-style-type: none"> • Basic radiology (X-rays): <ul style="list-style-type: none"> – At your in-network primary care physician's office – At a specialist's office – At an urgent care center – At a freestanding radiological facility – At a hospital facility as an outpatient 	\$0 copay \$40 copay \$40 copay \$40 copay \$125 copay	Not covered \$50 copay \$50 copay \$50 copay \$175 copay
<ul style="list-style-type: none"> • Diagnostic radiology (e.g., MRI, MRA, CT Scans): <ul style="list-style-type: none"> – At your in-network primary care physician's office – At a specialist's office – At a freestanding radiological facility – At a hospital facility as an outpatient 	\$125 copay \$125 copay \$125 copay \$175 copay	Not covered \$200 copay \$200 copay \$250 copay
<ul style="list-style-type: none"> • Radiation therapy: <ul style="list-style-type: none"> – At a specialist's office – At a freestanding radiological facility – At a hospital facility as an outpatient 	\$40 copay \$40 copay 20% coinsurance	\$50 copay \$40 copay 20% coinsurance
<ul style="list-style-type: none"> • Lab tests 	\$0 copay	\$0 copay
<ul style="list-style-type: none"> • Diagnostic mammograms: <ul style="list-style-type: none"> – At a specialist's office – At a freestanding radiological facility – At a hospital facility as an outpatient 	\$0 copay	\$0 copay
<ul style="list-style-type: none"> • Diagnostic colonoscopies: <ul style="list-style-type: none"> – At a specialist's office – At an ambulatory surgical center – At a hospital facility as an outpatient 	\$0 copay	\$0 copay
<ul style="list-style-type: none"> • Nuclear medicine: <ul style="list-style-type: none"> – At a freestanding radiological facility – At a hospital facility as an outpatient 	\$125 copay \$175 copay	\$200 copay \$250 copay

Hearing Services

	<u>In-network</u>	<u>Out-of-network</u>
<ul style="list-style-type: none"> • Medicare-covered exam to diagnose and treat hearing and balance issues. 	\$40 copay	\$50 copay
<ul style="list-style-type: none"> • Supplemental routine hearing services: <ul style="list-style-type: none"> – Routine hearing exam, 1 per calendar year. – Hearing aid fitting/evaluation, 1 per calendar year. – \$500 allowance per ear for hearing aids, per calendar year. – 1-month battery supply and 2-year warranty included. 	\$0 copay	Not covered

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Dental Services

	<u>In-network</u>	<u>Out-of-network</u>
<ul style="list-style-type: none"> Medicare-covered services. Excludes preventive, restoration, removal and replacement services. 	\$40 copay	\$50 copay
<ul style="list-style-type: none"> Supplemental routine dental services: <ul style="list-style-type: none"> Periodic oral evaluations, up to 2 per calendar year Comprehensive oral evaluation, 1 every 3 calendar years Emergency diagnostic exam, up to 2 per calendar year Fluoride treatment, up to 2 per calendar year Periodontal maintenance, up to 4 per calendar year Prophylaxis cleanings, up to 2 per calendar year Bitewing X-rays, 1 set per calendar year Panoramic X-ray film, 1 per calendar year Amalgam and/or composite fillings, up to 2 per calendar year Scaling and root planing (deep cleaning), 1 per quadrant per calendar year Simple or surgical extractions, up to 3 per calendar year Denture reline, 1 per calendar year Complete or partial dentures (upper and/or lower), 1 set every 5 calendar years Root canal, 1 per calendar year Anesthesia Extractions, unlimited for dentures. All other extractions are limited. Total periodic and comprehensive oral evaluations limited to 2 per calendar year. 	\$0 copay	Not covered

Vision Services

	<u>In-network</u>	<u>Out-of-network</u>
<ul style="list-style-type: none"> Medicare-covered eye exams to diagnose and treat diseases and conditions of the eye. 	\$40 copay	\$50 copay
<ul style="list-style-type: none"> Diabetic eye exam. 	\$0 copay	\$0 copay
<ul style="list-style-type: none"> 1 pair of eyeglasses or contact lenses after cataract surgery. 	\$0 copay	\$0 copay
<ul style="list-style-type: none"> Supplemental routine vision services: <ul style="list-style-type: none"> Routine eye exams with refraction, 1 per calendar year. \$200 yearly allowance for contact lenses or eyeglasses of your choice; OR, you may choose 2 free pairs of select eyeglasses (1 pair may be prescription sunglasses). Ultraviolet protection, scratch resistant coating, and fitting included with eyeglasses. You are responsible for any eyewear costs above the yearly allowance amount or the costs of any upgrades when a free pair is selected. 	\$0 copay	Not covered

CareSalute (HMO-POS) H1019-143**Out-of-network coverage available in Brevard and Indian River counties only****Mental Health Services**

	<u>In-network</u>	<u>Out-of-network</u>
<ul style="list-style-type: none"> • Inpatient visit - general hospital: <ul style="list-style-type: none"> – Days 1 - 8. – Days 9 - 90. – See Evidence of Coverage for maximum stays and lifetime reserve days. 	\$225 daily copay \$0 daily copay	\$275 daily copay \$0 daily copay
<ul style="list-style-type: none"> • Inpatient visit - psychiatric facility: <ul style="list-style-type: none"> – Days 1 - 8. – Days 9 - 90. – Covers up to 190 days in a lifetime. 	\$225 daily copay \$0 daily copay	\$275 daily copay \$0 daily copay
<ul style="list-style-type: none"> • Outpatient visit: <ul style="list-style-type: none"> – Group and individual therapy visits. – Partial hospitalization. – Includes treatment for mental illness and substance abuse. 	\$30 copay	\$50 copay

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

- **\$0** copay per day for days **1 - 20**.
- **\$188** copay per day for days **21 - 100**.
- No prior hospital stay required.
- Covers up to **100** days per benefit period.
- See Evidence of Coverage for benefit period details.

Physical Therapy**In-network:**

- **\$40** copay per visit.

Out-of-network:

- **\$50** copay per visit.

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

- **\$240** copay per trip for emergencies.
- **\$0** copay per trip for medically necessary non-emergencies.

Routine Transportation (in-network only)

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

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

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

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Out-of-network coverage available in Brevard and Indian River counties only

ADDITIONAL COVERED MEDICAL BENEFITS

Outpatient Surgery

	<u>In-network</u>	<u>Out-of-network</u>
• At your primary care physician's office.	\$0 copay	Not covered
• At a specialist's office.	\$40 copay	\$50 copay
• At an ambulatory surgical center.	\$125 copay	\$200 copay
• At a hospital facility as an outpatient.	\$175 copay	\$250 copay

Additional Rehabilitation Services

	<u>In-network</u>	<u>Out-of-network</u>
• Pulmonary (lungs) rehabilitation services.	\$20 copay	\$50 copay
• Supervised Exercise Therapy (SET) services.	\$30 copay	\$50 copay
• Occupational therapy (daily living activities), speech and language therapy.	\$40 copay	\$50 copay
• Cardiac (heart) rehabilitation services.		

Foot Care (Podiatry Services)

	<u>In-network</u>	<u>Out-of-network</u>
• Medicare-covered exams and treatment.	\$40 copay	\$50 copay
• Unlimited visits to participating podiatrists for supplemental routine foot care to treat flat feet or misalignment; corn, wart or callus removal; and hygienic care. No referral required.	\$40 copay	Not covered

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

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

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

- \$0 copay for primary care physician virtual visit.
- \$40 copay for specialist virtual visit.
- \$0 copay for behavioral health and substance abuse virtual visit.
- \$0 copay for urgent care virtual visit.
- This service may not be offered by all in-network plan providers. Check directly with your provider about the availability of telehealth services, or you can also visit our website at [CarePlusHealthPlans.com/physician-finder](https://www.CarePlusHealthPlans.com/physician-finder) to access our online, searchable directory.

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Out-of-network coverage available in Brevard and Indian River counties only

Wellness Programs (in-network only)

- **Deliver Fresh Meals Program:**
 - \$0 copay for up to **14** home delivered meals after an overnight hospital or skilled nursing facility stay. Up to 4 times per year.
- **SilverSneakers® Fitness Program:**
 - \$0 copay for access to participating gyms, classes, videos, and more.
- **Over-the-Counter (OTC) Items:**
 - \$20 monthly allowance toward select OTC items such as vitamins and pain relievers.
 - Please visit our plan website to see our list of covered OTC items.
- **CarePlus Rewards:**
 - Earn a \$50 gift card for completing preventive screenings and other healthy activities.

Acupuncture

	<u>In-network</u>	<u>Out-of-network</u>
• Up to 20 Medicare-covered treatments for chronic low back pain when ordered by a physician.	\$40 copay	\$50 copay
• Up to 25 routine visits per year.	\$0 copay	Not covered

Chiropractic Care

	<u>In-network</u>	<u>Out-of-network</u>
• 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	\$50 copay
• Routine chiropractic services: <ul style="list-style-type: none">– Up to 12 routine visits in-network every year, no referral required.	\$20 copay	Not covered

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

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

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

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

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

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

IMPORTANT

At CarePlus, it is important you are treated fairly.

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

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

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

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



Multi-Language Insert

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Japanese: 当社の健康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。通訳をご用命になるには、1-800-794-5907 (TTY: 711) にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。



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