2025

# Summary of Benefits

## CareOne Plus (HMO-POS)

Treasure Coast

Brevard and Indian River Counties

Our service area includes the following county/counties in Florida: Brevard, Indian River.

## 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 customer service representative at **1-800-794-4105 (TTY: 711)**.

### 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/Plans** 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2026.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ This 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 may pay a higher copay/coinsurance for services received by non-contracted providers.

# Let's talk about CareOne Plus (HMO-POS)

Find out more about the CareOne Plus (HMO-POS) plan – including the health and drug services it covers – in this easy-to-use guide.

CareOne Plus (HMO-POS) is a Medicare Advantage HMO-POS plan with a Medicare contract. Enrollment in this CarePlus plan depends on contract renewal.

The benefit information provided is 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. For a complete list of services we cover, please refer to the plan's Evidence of Coverage on our website, **CarePlusHealthPlans.com/Plans**.

## To be eligible

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

## Plan name

CareOne Plus (HMO-POS)

## How to reach us

If you're a member of this plan, call toll-free: **1-800-794-5907 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-794-4105 (TTY: 711)**.

**October 1 - March 31:**
Call 7 days a week from 8 a.m. – 8 p.m.

**April 1 - September 30:**
Call Monday - Friday, 8 a.m. – 8 p.m.

Or visit our website:

**CarePlusHealthPlans.com/ContactUs**

## More about CareOne Plus (HMO-POS)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and your state Medicaid program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs may be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your CarePlus membership card to make your provider aware that you may have additional coverage. Your services are paid first by CarePlus and then by Medicaid.

As a member you must select an in-network doctor within the service area listed in this document to act as your Primary Care Provider (PCP). CareOne Plus (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 within the plan's service area. If you use providers who aren't in our network, you may be subject to higher out-of-pocket costs.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by CarePlus to the provider.

## A healthy partnership

Get more from this plan — with extra services and resources provided by CarePlus!

CarePlus HEALTH PLANS

## Monthly Premium, Deductible and Limits

| PLAN COSTS | |
|---|---|
| **Monthly plan premium** | **$0**<br>You must keep paying your Medicare Part B premium. |
| **Medical deductible** | This plan does not have a deductible. |
| **Pharmacy (Part D) deductible** | **$0** deductible. |
| **Maximum out-of-pocket responsibility** | **$3,500** in-network<br>**$3,500** combined in- and out-of-network<br>The most you pay for copays, coinsurance and other costs for covered medical services for the year. |

## Medical Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **INPATIENT HOSPITAL COVERAGE** | | |
| This plan covers an unlimited number of days for an inpatient stay. | **$200** copay per day for days 1-7<br>**$0** copay per day for days 8-90 | **$250** copay per day for days 1-7<br>**$0** copay per day for days 8-90 |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Diagnostic colonoscopy** | **$0** copay | **$0** copay |
| **Diagnostic mammography** | **$0** copay | **$0** copay |
| **Surgery services** | **$200** copay | **$250** copay |
| **AMBULATORY SURGERY CENTER** | | |
| **Diagnostic colonoscopy** | **$0** copay | **$0** copay |
| **Surgery services** | **$90** copay | **$125** copay |
| **DOCTOR VISITS** | | |
| **Primary care provider (PCP)** | | |
| • PCP's office | **$0** copay | **Not Covered** |
| • Telehealth | **$0** copay | **Not Covered** |
| **Specialist** | | |
| • Specialist's office | **$15** copay | **$25** copay |
| • Telehealth | **$15** copay | **Not Covered** |

*Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require a referral or preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **CarePlusHealthPlans.com/PAL**.*

## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PREVENTIVE CARE** | | |
| This plan covers all Medicare preventive services including:<br>• **Abdominal aortic aneurysm screening**<br>• **Alcohol misuse screening & counseling**<br>• **Annual Wellness Visit (AWV)**<br>• **Bone mass measurement**<br>• **Breast cancer screening (mammogram)**<br>• **Cardiovascular disease risk reduction visit**<br>• **Cardiovascular disease screenings**<br>• **Cervical and vaginal cancer screening**<br>• **Colorectal cancer screening**<br>• **Depression screening**<br>• **Diabetes screenings**<br>• **Diabetes self-management training**<br>• **Glaucoma screening**<br>• **HIV screening**<br>• **Immunizations**<br>• **Lung cancer Screening**<br>• **Medical nutrition therapy**<br>• **Medicare Diabetes Prevention Program (MDPP)**<br>• **Obesity screening and therapy**<br>• **Prostate cancer screening**<br>• **Routine physical exam**<br>• **Sexually transmitted infections (STIs) screening and counseling**<br>• **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br>• **"Welcome to Medicare" preventive visit** | **$0** copay<br>Certain preventive services are covered only when received from your PCP. | **$0** copay or **50%** of the cost, depending on the service and where service is provided<br>Certain preventive services are covered only when received from your PCP. |

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CarePlus HEALTH PLANS

## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Any additional preventive services approved by Medicare during the contract year will be covered. | | |
| **EMERGENCY CARE** | | |
| **Emergency services at emergency room**<br>If you are admitted to the same hospital within 24 hours, you do not have to pay your share of the cost for the emergency care. | **$140** copay | **$140** copay |
| **Physician and professional services at emergency room** | **$0** copay | **$0** copay |
| **URGENTLY NEEDED SERVICES** | | |
| • **Telehealth**<br>• **Urgent care center**<br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention. | **$15** copay<br>**$15** copay | **Not Covered**<br>**$15** copay |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Advanced imaging services (MRI, MRA, PET and CT scan)** | | |
| • Freestanding radiological facility | **$150** copay | **$200** copay |
| • Outpatient hospital | **$200** copay | **$250** copay |
| • PCP's office | **$150** copay | **Not Covered** |
| • Specialist's office | **$150** copay | **$200** copay |
| **Basic radiological services (X-rays)** | | |
| • Freestanding radiological facility | **$15** copay | **$25** copay |
| • Outpatient hospital | **$90** copay | **$90** copay |
| • PCP's office | **$0** copay | **Not Covered** |
| • Specialist's office | **$15** copay | **$25** copay |
| • Urgent care center | **$15** copay | **$25** copay |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Diagnostic mammography** | | |
| • Freestanding radiological facility | **$0** copay | **$0** copay |
| • Specialist's office | **$0** copay | **$0** copay |
| **Diagnostic procedures and tests** | | |
| • Outpatient hospital | **$25** copay | **$25** copay |
| • PCP's office | **$0** copay | **Not Covered** |
| • Specialist's office | **$15** copay | **$25** copay |
| • Urgent care center | **$15** copay | **$25** copay |
| **Lab services** | | |
| • Freestanding laboratory | **$0** copay | **$25** copay |
| • Outpatient hospital | **$0** copay | **$25** copay |
| • PCP's office | **$0** copay | **Not Covered** |
| • Specialist's office | **$0** copay | **$0** copay |
| • Urgent care center | **$0** copay | **$0** copay |
| **Nuclear medicine and services** | | |
| • Freestanding radiological facility | **$150** copay | **$200** copay |
| • Outpatient hospital | **$200** copay | **$250** copay |
| **Sleep study** | | |
| • Member's home | **$0** copay | **$0** copay |
| • Outpatient hospital | **$25** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |
| **Therapeutic radiology (Radiation therapy)** | | |
| • Freestanding radiological facility | **$15** copay | **$25** copay |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| • Specialist's office | **$15** copay | **$25** copay |
| **HEARING SERVICES** | | |
| **Medicare-covered hearing** | **$15** copay | **$25** copay |

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CarePlus HEALTH PLANS

## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Mandatory supplemental hearing benefit**<br>To find a routine hearing care provider or to check to see if your provider is in our network, go to **CarePlusHealthPlans.com/Doctor** > Medical > Enter Zip Code > Type Audiologist in box under "Name, specialty, condition*" > Search | **HER751**<br>• **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year.<br>• **$500** maximum benefit coverage amount for each prescription hearing aids (all types) up to 1 per ear per year.<br>• Note: Includes 1 month battery supply and 2 year warranty. | **Not Covered** |
| **DENTAL SERVICES** | | |
| **Medicare-covered dental** | **$15** copay | **$25** copay |
| **Mandatory supplemental dental benefit**<br>All services must be received in-office from a participating, in-network, general dentist or dental specialist (e.g., oral surgeon, endodontist, periodontist, etc.). Limitations and exclusions may apply. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire.<br><br>The dentist may suggest and help arrange for additional services not listed in this benefit schedule; however, any procedures received that either are not listed in this benefit schedule or exceed the benefit limitations listed in this schedule are not covered by this benefit. The member may be responsible for the costs of these additional services and may be charged the dental provider's usual and customary fees, less any | **DEN103**<br>• **$0** copay for comprehensive oral exam up to 1 every 3 years.<br>• **$0** copay for partial or complete dentures up to 1 set(s) every 5 years.<br>• **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant per year.<br>• **$0** copay for denture reline, panoramic film, root canal up to 1 per year.<br>• **$0** copay for bitewing x-rays up to 2 set(s) per year.<br>• **$0** copay for emergency diagnostic exam, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.<br>• **$0** copay for amalgam and/or composite filling, periodontal maintenance up to 4 per year.<br>• **$0** copay for simple or surgical extraction up to 5 per year.<br>• **$0** copay for extractions for dentures, necessary anesthesia with covered service up to unlimited per year. | **Not Covered** |

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| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| contracted discount. Submitted claims are subject to a review process, which may include a clinical review and dental history to approve coverage.<br><br>For more information about your dental benefits, go to **CarePlusHealthPlans.com/Dental** to view the Dental Benefit Schedule for your dental plan. You may also call Member Services at 1-800-794-5907 (TTY: 711). Hours of operation: October 1 – March 31, daily 8 a.m. – 8 p.m. and April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.<br><br>In-network dental providers have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dental provider, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment will still apply).<br><br>No out-of-network coverage on this plan.<br><br>To find a dentist or check to see if your dentist is in our network, go to **CarePlusHealthPlans.com/Dental-Finder** > enter Zip Code > Select | • Unlimited extractions are covered only for the purpose of member receiving dentures, all other extractions are limited to 5 per year. | |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Search category >Type dentist name or specialty or select "all dental providers". | | |
| **VISION SERVICES** | | |
| **Eyewear (post cataract surgery)** | **$0** copay | **$0** copay |
| **Medicare-covered diabetic eye exam** | **$0** copay | **50%** of the cost |
| **Medicare-covered vision services** | **$15** copay | **$25** copay |
| **Mandatory supplemental vision benefit**<br>To find a routine vision care provider or to check to see if your provider is in our network, go to **CarePlusHealthPlans.com/Doctor** > Medical > Enter Zip Code > Type Optometrist in box under "Name, specialty, condition*" > Search. | **VIS179**<br>• **$0** copay for refraction and dilation (if necessary) with routine exam up to 1 per year.<br>• **$350** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames plus fitting; or 3 pairs of select eyeglasses per year at no cost.<br>• May choose prescription sunglasses as 1 pair.<br>• Eyeglasses include ultraviolet protection, scratch-resistant coating, standard no-line bifocals, and transition lenses. | **Not Covered** |
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<br>This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital | **$200** copay per day for days 1-7<br>**$0** copay per day for days 8-90 | **$250** copay per day for days 1-7<br>**$0** copay per day for days 8-90 |
| **Mental health therapy visits** | | |
| • Outpatient hospital | **$15** copay | **$25** copay |
| • Partial hospitalization | **$15** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |

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## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Outpatient substance abuse services** | | |
| • Outpatient hospital | **$15** copay | **$25** copay |
| • Partial hospitalization | **$15** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |
| • Telehealth | **$15** copay | **Not Covered** |
| **SKILLED NURSING FACILITY (SNF)** | | |
| This plan covers up to 100 days in a SNF | **$20** copay per day for days 1-20<br>**$203** copay per day for days 21-100 | **$20** copay per day for days 1-20<br>**$203** copay per day for days 21-100 |
| **AMBULANCE** | | |
| **Air** | **20%** of the cost | **20%** of the cost |
| **Ground** | **$250** copay per trip | **$250** copay per trip |
| **TRANSPORTATION** | | |
| The member ***must*** contact transportation vendor to arrange transportation. | **$0** copay for plan approved location up to 20 one-way trip(s) per year.<br>This benefit offers unlimited miles per trip. | |

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CarePlus HEALTH PLANS

## Medical Benefits (cont.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MEDICARE PART B DRUGS**<br>Some rebatable Part B drugs may be subject to a lower coinsurance. | | |
| **Allergy shots and serum** | | |
| • PCP's office | **$0** copay | **Not Covered** |
| • Specialist's office | **$0** copay | **$0** copay |
| **Chemotherapy drugs** | | |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| • Specialist's office | **20%** of the cost | **20%** of the cost |
| **Other Part B drugs** | | |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| • PCP's office | **20%** of the cost | **Not Covered** |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| • Specialist's office | **20%** of the cost | **20%** of the cost |
| **Part B Insulin** | | |
| • Outpatient hospital | **20%** of the cost | **20%** of the cost |
| • PCP's office | **20%** of the cost | **Not Covered** |
| • Pharmacy | **20%** of the cost | **20%** of the cost |
| • Specialist's office | **20%** of the cost | **20%** of the cost |
| You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan. | | |

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# Prescription Drug Benefits

## PLAN HIGHLIGHTS

| | |
|---|---|
| **$0 copays** | **$0** copays at select pharmacy locations and tiers. Additional details below. |
| **Deductible** | **$0** deductible |
| **Insulin costs** | You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan. |
| **100-day supply** | Up to 100-day supply on eligible drugs |
| **Excluded drug coverage** | Additional drug coverage for the following:<br>Erectile dysfunction (ED) drugs<br>Prescription vitamins |
| **$0 vaccines** | **$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) |

## DEDUCTIBLE

This plan has a **$0** deductible.

## INITIAL COVERAGE

You pay the following until your total yearly out-of-pocket drug costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

| Pharmacy Cost-Sharing | | | | | | |
|---|---|---|---|---|---|---|
| | **Retail Cost-Sharing** Includes all in-network retail pharmacies | | **Standard Mail-Order Cost-Sharing** | | **Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™ | |
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| **Tier 1:** Preferred Generic | $0 | $0 | $10 | $30 | $0 | $0 |
| **Tier 2:** Generic | $0 | $0 | $20 | $60 | $0 | $0 |
| **Tier 3:** Preferred Brand | $25 | $75 | $47 | $141 | $25 | $65 |
| **Tier 4:** Non-Preferred Drug | 35% | 35% | 48% | 48% | 35% | 35% |
| **Tier 5:** Specialty Tier | 33% | N/A | 33% | N/A | 33% | N/A |

You have several options for filling your prescriptions, including retail and mail-order pharmacies. CenterWell Pharmacy® is the preferred mail-order, cost-sharing pharmacy for many CarePlus plans, which means you may pay as little as **$0** for certain Tier 1 and Tier 2 generics. Learn more at **CenterWellPharmacy.com**.

Other pharmacies are available in our network. To find which pharmacies are available in our network, go to **CarePlusHealthPlans.com/PharmacyFinder**.
*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier.

| Insulin Cost-Sharing | | | | | | |
|---|---|---|---|---|---|---|
| | **Retail Cost-Sharing** Includes all in-network retail pharmacies | | **Standard Mail-Order Cost-Sharing** | | **Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™ | |
| **Day supply** | **30-day** | **100-day*** | **30-day** | **100-day*** | **30-day** | **100-day*** |
| **Tier 2:** Generic | $0 | $0 | $20 | $60 | $0 | $0 |
| **Tier 3:** Preferred Brand | $25 | $75 | $35 | $105 | $25 | $65 |
| **Tier 5:** Specialty Tier | $35 | N/A | $35 | N/A | $35 | N/A |

Other pharmacies are available in our network. To find which pharmacies are available in our network, go to **CarePlusHealthPlans.com/PharmacyFinder**.

*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-day supply.

**CATASTROPHIC COVERAGE**

After your total out-of-pocket costs reach **$2,000** you pay **$0** for plan-covered Part D and Excluded drugs.

| EXCLUDED DRUG COVERAGE | |
|---|---|
| **Erectile dysfunction (ED) drugs** | Covered at Tier 1 cost-share amount. |
| **Prescription vitamins** | Covered at Tier 1 cost-share amount. |

**EXTRA HELP**

If you receive "Extra Help" for your drugs you will have a **$0** deductible.

Prior to reaching your annual **$2,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.90** for generic/preferred multi-source drug or biosimilar; **$12.15** for any other drug; OR
- **$1.60** for generic/preferred multi-source drug or biosimilar; **$4.80** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,000** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 (TTY: 1-800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

## Additional Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Acupuncture services (Medicare-covered)** | **$15** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. | **$15** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **Chiropractic services (Medicare-covered)** | **$15** copay | **$25** copay |
| **Podiatry services (Medicare-covered)** | **$15** copay | **$25** copay |

## Additional Benefits (cont.)

| | | |
|---|---|---|
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Continuous glucose monitor (CGM)** | | |
| • DME provider | **20%** of the cost | **50%** of the cost |
| • Pharmacy | **20%** of the cost | **50%** of the cost |
| **Diabetic monitoring supplies** | | |
| • Diabetic supplier | **$0** copay | **$0** copay |
| • Network retail pharmacy | **$0** copay | **$0** copay |
| **Durable medical equipment (DME) – High Cost** | **20%** of the cost | **50%** of the cost |
| **Durable medical equipment (DME) – All Other** | **20%** of the cost | **50%** of the cost |
| **Medical supplies at medical supplier** | **20%** of the cost | **20%** of the cost |
| **Prosthetics devices and related supplies at prosthetics provider** | **20%** of the cost | **20%** of the cost |
| **REHABILITATION SERVICES** | | |
| **Cardiac rehabilitation services** | | |
| • Outpatient hospital | **$15** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |
| **Occupational therapy** | | |
| • Comprehensive outpatient rehab facility | **$15** copay | **$25** copay |
| • Outpatient hospital | **$15** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |
| **Physical therapy** | | |
| • Comprehensive outpatient rehab facility | **$15** copay | **$25** copay |
| • Outpatient hospital | **$15** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |
| **Pulmonary rehabilitation** | | |
| • Outpatient hospital | **$15** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |
| **Speech therapy** | | |
| • Comprehensive outpatient rehab facility | **$15** copay | **$25** copay |
| • Outpatient hospital | **$15** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |

## Additional Benefits (cont.)

| | | |
|---|---|---|
| **Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)** | | |
| • Outpatient hospital | **$15** copay | **$25** copay |
| • Specialist's office | **$15** copay | **$25** copay |

# More benefits with **this plan**

Enjoy some of these extra benefits included in this plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **CarePlusHealthPlans.com/Plans** to view a copy of the EOC or call **1-800-794-4105** .

**Routine Acupuncture**
**$0** copay for acupuncture visits up to 25 visit(s) per year.
Authorization rules may apply.

**Routine Chiropractic services**
**$15** copay for routine chiropractic visits up to 12 visit(s) per year.

**Routine foot care**
**$15** copay for routine podiatry visits up to unlimited visit(s) per year.

**CarePlus Well Dine™ Meal Program**
**$0** copayment for CarePlus Well Dine™ meal program.

After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals).

Meals must be requested within 30 days of discharge from your inpatient stay.

Limited to 4 times per year.

**Over-the-Counter (OTC) mail order**
**$50** quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.

Unused amount expires at the end of the quarter.

- Quarterly allowance amounts are available to use at the beginning of January, April, July, and October.
- Limitations and restrictions may apply.

**Rewards and Incentives**
Members earn rewards by completing CMS defined preventive screenings and healthcare activities.

Members can choose gift cards to specific retailers for their rewards.

**Wigs (related to chemotherapy treatment)**
Up to a **$500** maximum benefit per year.

**SilverSneakers® fitness program**
Live a healthier, more active life through fitness and social connection at participating locations and online.

# Notes

# Notes

# Notice of Non-Discrimination

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. CarePlus Health Plans, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **1-800-794-5907 (TTY: 711)**. If you believe that CarePlus Health Plans, Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with CarePlus Health Plans, Inc.'s Non-Discrimination Coordinator at P.O. Box 277810, Miramar, FL 33027, **1-800-794-5907 (TTY: 711)**, or **Accessibility1@CarePlus-HP.com**. If you need help filing a grievance, CarePlus Health Plans, Inc.'s Non-Discrimination Coordinator can help you.

You can also file a 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

This notice is available at **CarePlusHealthPlans.com/Multi-Language-Insert**.

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CarePlus HEALTH PLANS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Form CMS-10802 (Expires 12/31/25)

# Find out **more**

Need help finding a doctor or pharmacy? You can see this plan's **Provider and Pharmacy Directory** at our website at **CarePlusHealthPlans.com/Directories** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see this plan's **Drug Guide** at our website at **CarePlusHealthPlans.com/PrescriptionDrugGuides** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the 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, seven days a week. TTY users should call 1-877-486-2048.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth. 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/Doctor** to access our online, searchable directory. Please refer to your Evidence of Coverage for additional details on what this plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.



CarePlus HEALTH PLANS®

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Brevard and Indian River Counties

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