2027

Summary of Benefits

CareOne Plus (HMO) H1019-113

Daytona and Jacksonville

North Florida

Our service area includes the following county/counties in Florida: Clay, Duval, Flagler, St. Johns, Volusia.

H1019_SB_MAPD_HMO_113000_2027_M

CarePlus HEALTH PLANS™

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 **888-685-8607 (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 **888-685-8607 (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 (Drug Guide) 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, 2028.
- [ ] **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.
- [ ] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

H1019113000

Let's talk about CareOne Plus (HMO)

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

CareOne Plus (HMO) is a Medicare Advantage HMO 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), 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)

How to reach us

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

If you're **not** a member of this plan, call toll free: **888-685-8607 (TTY: 711)**.

You can call us seven days a week from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays.

Or visit our website:
CarePlusHealthPlans.com/ContactUs

More about CareOne Plus (HMO)

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 booklet to act as your Primary Care Provider (PCP). CareOne Plus (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.

A healthy partnership

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

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Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium.
Part B premium reduction[1]	Your plan will reduce your Monthly Part B premium by up to **$2** but by no more than Original Medicare's Part B Premium for 2027.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** deductible for Tier 1, Tier 2 and Tier 3 **$700** deductible for Tier 4 and Tier 5
Medical Maximum out-of-pocket responsibility	**$3,000** in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

[1]It could take up to 120 days for the Social Security Administration to complete their processing. This means you may not see the increase in your Social Security check for up to 120 days after the effective date of this plan. Any missed increases will be added to your next check after processing is complete.

Medical Benefits

INPATIENT HOSPITAL COVERAGE	
This plan covers an unlimited number of days for an inpatient stay	**$200** copay per day for days 1-5 **$0** copay per day for days 6-90
OUTPATIENT HOSPITAL COVERAGE	
Diagnostic colonoscopy	**$0** copay
Diagnostic mammography	**$0** copay
Surgery services	**$175** copay
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**$0** copay
Surgery services	**$100** copay
DOCTOR VISITS	
Primary Care Provider (PCP)	• PCP's office: **$0** copay • Telehealth: **$0** copay
Specialist	• Specialist's office: **$10** copay • Telehealth: **$10** copay

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." This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***CarePlusHealthPlans.com/PAL****.*

Medical Benefits (cont.)

PREVENTIVE CARE

This plan covers all Medicare preventive services including:

Cancer Screenings
- Breast cancer screening (mammogram)
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Lung cancer screening
- Prostate cancer screening

Cardiovascular (heart) Care
- Abdominal aortic aneurysm screening
- Cardiovascular disease risk reduction visit
- Cardiovascular disease screenings

Diabetes Care
- Diabetes screenings
- Diabetes self-management training
- Medicare Diabetes Prevention Program (MDPP)

Dietary Guidance and Support
- Medical nutrition therapy
- Obesity screening and therapy

Any additional preventive services approved by Medicare during the contract year will be covered.

$0 copay

Routine Screenings and Immunizations
- Annual Wellness Visit (AWV)
- Immunizations
- Routine physical exam
- "Welcome to Medicare" preventive visit

Screenings and Counseling Services
- Bone mass measurement
- Depression screening
- Glaucoma screening
- HIV screening
- Screening & counseling to reduce alcohol misuse
- Sexually transmitted infections (STIs) screening and counseling
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

EMERGENCY CARE

Emergency services at emergency room
If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received.

$150 copay

URGENTLY NEEDED SERVICES

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

- Telehealth: **$10** copay
- Urgent care center: **$10** copay

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Medical Benefits (cont.)

WORLDWIDE COVERAGE	
If you have an emergency or urgently needed service outside of the U.S and its territories, you will be responsible to pay for the rendered services upfront and can request reimbursement. If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received.	• Emergency ambulance: **$250** copay per trip • Emergency room - Hospital: **$150** copay • Urgent care center: **$10** copay

DIAGNOSTIC SERVICES, LABS & IMAGING	
Advanced imaging services (MRI, MRA, PET and CT scans)	• Freestanding radiological facility: **$150** copay • Outpatient hospital: **$200** copay • PCP's office: **$150** copay • Specialist's office: **$150** copay
Basic radiological services (X-rays)	• Freestanding radiological facility: **$40** copay • Outpatient hospital: **$75** copay • PCP's office: **$0** copay • Specialist's office: **$10** copay • Urgent care center: **$10** copay
Diagnostic mammography	• Freestanding radiological facility: **$0** copay • Specialist's office: **$0** copay
Diagnostic procedures and tests	• Outpatient hospital: **$75** copay • PCP's office: **$0** copay • Specialist's office: **$10** copay • Urgent care center: **$10** copay
Lab services	• Freestanding laboratory: **$0** copay • Outpatient hospital: **$0** copay • PCP's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **$0** copay
Nuclear medicine and services	• Freestanding radiological facility: **$150** copay • Outpatient hospital: **$200** copay
Sleep study	• Member's home: **$0** copay • Outpatient hospital: **$75** copay • Specialist's office: **$10** copay
Therapeutic radiology (Radiation therapy)	• Freestanding radiological facility: **$50** copay • Outpatient hospital: **20%** of the cost • Specialist's office: **$10** copay

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Medical Benefits (cont.)

HEARING SERVICES

Medicare-covered hearing	**$10** copay
Mandatory supplemental hearing benefit	In-Network: **HER106** • **$0** copay for fitting, routine hearing exams up to 1 per year. • **$0** copay for follow-up provider visits up to 3 per year. • **$399** copay for each Level 1 prescription hearing aid up to 1 per ear per year. • **$675** copay for each Level 2 prescription hearing aid up to 1 per ear per year. • Note: Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty. • One fitting and three follow-up provider visits during first year following hearing aid purchase, with the original provider.

DENTAL SERVICES

Medicare-covered dental	**$10** copay
Mandatory supplemental dental benefit **In-network providers:** • All services must be received in-office from a participating, in-network, general dentist or dental specialist (e.g., oral surgeon, endodontist, periodontist, etc.). • 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). **Benefit limits:** • The dentist may suggest and help arrange for additional services not listed in this benefit schedule; however, any procedures received that	In-Network: **DEN202** • **$0** copay for comprehensive oral exam up to 1 every 3 years. • **$0** copay for bridge recementation, bridges-pontic, complete or partial dentures up to 1 every 5 years. • **$0** copay for bridges-crown up to 2 every 5 years. • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant per year. • **$0** copay for denture adjustments, rebase, reline, panoramic film, root canal, scaling for moderate inflammation up to 1 per year. • **$0** copay for bitewing x-rays, emergency diagnostic exam, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for amalgam and/or composite filling, periodontal maintenance up to 4 per year. • **$0** copay for simple or surgical extraction up to 5 per year.

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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 contracted discount.
- Submitted claims are subject to a review process, which may include a clinical review and dental history to approve coverage.
- Limitations and exclusions may apply. Benefits are offered on a calendar year basis.

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 our Member Services department at 800-794-5907. If you use a TTY, call 711. You can call us seven days a week, from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays.

No out-of-network coverage on this plan. To find a dentist or to check to see if your dentist is in our network, go to **CarePlusHealthPlans.com/FindCare**.

- **$0** copay for necessary anesthesia with covered service up to as needed with covered codes per year.
- **$0** copay for extractions for dentures up to unlimited per year.
- Unlimited extractions are covered only for the purpose of member receiving dentures, all other extractions are limited to 5 per year.

VISION SERVICES

Eyewear (post cataract surgery)	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services	**$10** copay
Mandatory supplemental vision benefit See a network vision provider, for more information on your no-cost eyeglass option. To find a routine vision care provider or to check to see if your provider is in our network, go to **CarePlusHealthPlans.com/FindCare**. Copayments, coinsurance and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.	In-Network: **VIS029** • **$0** copay for refraction and dilation (if necessary) with routine exam up to 1 per year. • **$400** 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. • May choose prescription sunglasses as 1 pair. • Eyeglasses include ultraviolet protection and scratch-resistant coating.

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Medical Benefits (cont.)

These benefits are offered on a calendar year basis. Any amount unused by the end of the year will expire.

MENTAL HEALTH SERVICES	
Inpatient 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 1-5 **$0** copay per day for days 6-90
Mental health therapy visits	• Outpatient hospital: **$10** copay • Specialist's office: **$10** copay • Telehealth: **$10** copay
Outpatient substance abuse services	• Outpatient hospital: **$10** copay • Specialist's office: **$10** copay • Telehealth: **$10** copay
SKILLED NURSING FACILITY (SNF)	
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$218** copay per day for days 21-100
AMBULANCE	
Air	**20%** of the cost
Ground	**$250** copay per trip
TRANSPORTATION	
Mandatory supplemental transportation benefit The member ***must*** contact transportation vendor at least 3 business days in advance of their appointment to arrange transportation.	**$0** copay for plan approved location up to 26 one-way trip(s) per year. This benefit offers unlimited miles per one-way trip. Any one-way trip longer than 35 miles requires prior approval.
Uniformity flexibility non-emergency medical transportation benefit The member ***must*** contact transportation vendor at least 3 business days in advance of their appointment to arrange transportation.	**$0** copayment for plan approved location up to unlimited one-way trip(s) per year for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit offers unlimited miles per one-way trip. Any one-way trip longer than 35 miles requires prior approval.

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Medical Benefits (cont.)

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

Prescription Drug Benefits

PLAN HIGHLIGHTS	
$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below.
Deductible	**$0** deductible for Tier 1, Tier 2 and Tier 3
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: Erectile dysfunction (ED) drugs Prescription vitamins
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

$0 deductible for Tier 1, Tier 2 and Tier 3. This plan has a **$700** deductible for Tier 4 and Tier 5 drugs. You pay the full cost of these drugs until you reach **$700**. Then, you only pay your cost-share, entering into the Initial Coverage Stage.

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INITIAL COVERAGE

You pay the following until your total out-of-pocket costs reach **$2,400**. 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	15%	15%	15%	15%	15%	13%
Tier 4: Non-Preferred Drug	50%	50%	50%	50%	50%	50%
Tier 5: Specialty Tier	25%	N/A	25%	N/A	25%	N/A

You can fill your prescriptions in several ways, including through retail and mail-order pharmacies. For CarePlus plans, CenterWell Pharmacy® is the preferred mail-order pharmacy with cost-sharing benefits. To learn more, visit **CenterWellPharmacy.com**.

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

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

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 1: Preferred Generic	$0	$0	25% up to $10	25% up to $30	$0	$0
Tier 2: Generic	$0	$0	14% up to $20	14% up to $60	$0	$0
Tier 3: Preferred Brand	15% up to $35	15% up to $105	15% up to $35	15% up to $105	15% up to $35	13% up to $105
Tier 4: Non-Preferred Drug	25% up to $35	25% up to $105	25% up to $35	25% up to $105	25% up to $35	25% up to $105
Tier 5: Specialty Tier	25% up to $35	N/A	25% up to $35	N/A	25% up to $35	N/A

*Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

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, even if you haven't paid your deductible.

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

*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 **$2,400** you pay **$0** for plan-covered Part D and Excluded drugs.

EXCLUDED DRUG COVERAGE

Erectile dysfunction (ED) drugs	Select drugs covered at Tier 1 cost-share amount.
Prescription vitamins	Select drugs covered at Tier 1 cost-share amount.

*Refer to your Evidence of Coverage for more information on Excluded Drug coverage.

EXTRA HELP

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

Prior to reaching your annual **$2,400** out-of-pocket limit, you will pay one of the following depending on your level of Extra Help:

- **$5.80** for generic/preferred multi-source drug or biosimilar; **$14.40** for any other drug; OR
- **$1.65** for generic/preferred multi-source drug or biosimilar; **$5.00** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,400** 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 800-772-1213 (TTY: 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

Acupuncture services (Medicare-covered)	**$10** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
Chiropractic services (Medicare-covered)	**$15** copay
Podiatry services (Medicare-covered)	**$10** copay
MEDICAL EQUIPMENT/SUPPLIES	
Continuous glucose monitor (CGM)	• DME provider: **20%** of the cost • Pharmacy: **20%** of the cost • Preferred pharmacy: **$0** copay
Diabetic monitoring supplies	• Diabetic supplier: **$0** copay • Network retail pharmacy: **$0** copay
Durable medical equipment (DME) – High Cost	• DME provider: **20%** of the cost
Durable medical equipment (DME) – All Other	• DME provider: **20%** of the cost
Medical supplies	• Medical supplier: **20%** of the cost
Prosthetic devices and related supplies	• Prosthetics provider: **20%** of the cost
REHABILITATION SERVICES	
Cardiac rehabilitation services	• Outpatient hospital: **$10** copay • Specialist's office: **$10** copay

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Additional Benefits (cont.)

Occupational therapy	• Comprehensive outpatient rehab facility: **$10** copay • Outpatient hospital: **$10** copay • Specialist's office: **$10** copay
Physical therapy	• Comprehensive outpatient rehab facility: **$10** copay • Outpatient hospital: **$10** copay • Specialist's office: **$10** copay
Pulmonary rehabilitation services	• Outpatient hospital: **$10** copay • Specialist's office: **$10** copay
Speech therapy	• Comprehensive outpatient rehab facility: **$10** copay • Outpatient hospital: **$10** copay • Specialist's office: **$10** copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	• Outpatient hospital: **$10** copay • Specialist's office: **$10** copay

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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 **888-685-8607**.

CarePlus CareEssentials® Allowance*
$45 monthly allowance on a prepaid spending card.

All plan members receive this amount to buy approved over the counter (OTC) health and wellness products at participating retailers or through the plan's approved OTC mail order vendor.

Plus, members may also use this money for eligible groceries, utilities, rent, and more if they have certain qualifying chronic condition(s) and meet other program criteria.

Any unused amount rolls over each month and expires at the end of the plan year or upon disenrollment, whichever occurs first.

- Allowance is available to use at the beginning of every month.
- Limitations and restrictions may apply.

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

Routine foot care
$10 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.

Rewards and Incentives - Go365®
Complete eligible healthy activities, like preventive screenings and exams, and get rewarded with Go365 Primary.

SilverSneakers® fitness program
$0 copayment for SilverSneakers®.

The fitness program includes access to participating locations and signature group exercise classes led by certified instructors.

This benefit also connects you to a support network and virtual resources through live

* CarePlus CareEssentials Allowance and Chronic Condition Care Assistance are Special supplemental benefit(s) for members with specific chronic conditions who require intensive care coordination and are at a high risk for hospitalization or other adverse health outcomes. Qualifying conditions may include diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, or chronic heart failure, among others. Some plans require at least two conditions. See the plan's Evidence of Coverage for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income. Contact your local HUD office with questions.

CarePlus HEALTH PLANS™

classes, on-demand videos and through a mobile app.

Go to SilverSneakers.com to learn more about your benefit.

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/FindCare** 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.

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

The Part B Premium Reduction benefit pays part or all of your Part B premium and the amount may change based on the amount you pay for Part B premium.

CarePlus HEALTH PLANS™

Activate your secure MyCarePlus account.

Your online MyCarePlus account is an important part of your CarePlus membership. Use it to view this plan's details anytime and access important plan documents online, all in one place. It's easy to use and tailored to you.

Already have an account?

Go to **CarePlusHealthPlans.com/Logon** and log in.

Don't have an account yet?

Create one using the same link above in just minutes.

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 **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 14618, Lexington KY 40512-4618, **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/NDN**.

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Notice of Availability - Auxiliary Aids and Services Notice

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English: Free language, auxiliary aid, and alternate format services are available. Call **1-800-794-5907 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسِّيق البديل مجاناً. اتصل على الرقم **1-800-794-5907 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարեք **1-800-794-5907 (TTY` 711)** հեռախոսահամարով:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **1-800-794-5907 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **1-800-794-5907**（听障专线：**711**）。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **1-800-794-5907**（聽障專線：**711**）。

Kreyòl Ayisyen [Haitian Creole]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòma sèvis ki disponib. Rele **1-800-794-5907 (TTY: 711)**.

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **1-800-794-5907 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1-800-794-5907 (TTY: 711)** تماس بگیرید.

Français [French] : Des services gratuits d’assistance linguistiques, d’aide auxiliaire et de format alternatif sont disponibles. Appelez le **1-800-794-5907 (ATS : 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **1-800-794-5907 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **1-800-794-5907 (TTY: 711)**.

ગુજરાતી [Gujarati]: મફત ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **1-800-794-5907 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **1-800-794-5907 (TTY: 711)**

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **1-800-794-5907 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare il numero **1-800-794-5907 (TTY: 711)**.

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日本語 [Japanese]: 言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**1-800-794-5907 (TTY: 711)** までお電話ください。

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ภาษาไทย [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **1-800-794-5907 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **1-800-794-5907 (TTY: 711)** 번으로 문의하십시오.

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajiłii'ígíí bee ak'e'elyaaígíí t'áá jiik'eh hólǫ́. **1-800-794-5907 (TTY: 711)** bich'į' hodíílnih.

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **1-800-794-5907 (TTY: 711)**.

Português [Brazilian Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **1-800-794-5907 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **1-800-794-5907 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **1-800-794-5907 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **1-800-794-5907 (TTY: 711)**.

Tagalog [Tagalog]: May available na mga libreng serbisyo sa wika, mga gamit na pantulong, at alternatibong format. Tumawag sa **1-800-794-5907 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **1-800-794-5907 (TTY: 711)** எண்ணை அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **1-800-794-5907 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **1-800-794-5907 (TTY: 711)**۔

Tiếng Việt [Vietnamese]: Có sẵn miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **1-800-794-5907 (TTY: 711)**.

This notice is available at **CarePlusHealthPlans.com/MLI**

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