2027
Evidence of Coverage

CareNeeds Platinum (HMO D-SNP)
H1019-023

South Florida
Broward, Miami-Dade, & Palm Beach Counties

CarePlus HEALTH PLANS™

We care about your well-being

Thanks for being a CareNeeds Platinum (HMO D-SNP) member. We value your membership, and we're dedicated to helping you be the best you want to be.

This Evidence of Coverage contains important information about your plan. This book is a very detailed document with the full, legal description of your benefits and costs. You should keep this document for reference throughout the plan year.

We look forward to being your partner in health for many years to come. If you have any questions, we're here to help.

January 1 - December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of CareNeeds Platinum (HMO D-SNP)

This document gives the details of your Medicare health and drug coverage from January 1 - December 31, 2027. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Your plan premium and cost sharing
- Your medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 800-794-5907 (TTY users call 711). Hours are 8 a.m. to 8 p.m., seven days a week. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at CarePlusHealthPlans.com. This call is free.

This plan, CareNeeds Platinum (HMO D-SNP), is offered by CarePlus Health Plans, Inc. (When this Evidence of Coverage says "we," "us," or "our," it means CarePlus Health Plans, Inc. When it says "plan" or "our plan," it means CareNeeds Platinum (HMO D-SNP).)

Sponsored by CarePlus Health Plans, Inc. and the State of Florida, Agency for Health Care Administration.

This document is available for free in Creole and Spanish.

This information is available in a different format, including Braille, large print, and audio. Please call Member Services at the number listed above if you need plan information in another format.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2028.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

CareNeeds Platinum (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2029 based on a review of CareNeeds Platinum (HMO D-SNP)'s Model of Care.

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OMB Approval 0938-1051 (Expires: July 31, 2029)

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Lists the names, addresses, phone numbers, and other contact information for a variety of helpful resources in your state.

CHAPTER 1: Get started as a member

SECTION 1 You're a member of CareNeeds Platinum (HMO D-SNP)

Section 1.1 You're enrolled in CareNeeds Platinum (HMO D-SNP), which is a Medicare Special Needs Plan

You're covered by both Medicare and Medicaid:

- **Medicare** is the federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that aren't covered by Medicare.

You've chosen to get your Medicare health care and your drug coverage through our plan, CareNeeds Platinum (HMO D-SNP). Our plan covers all Part A and Part B services. However, cost sharing and provider access in our plan differ from Original Medicare.

CareNeeds Platinum (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means benefits are designed for people with special health care needs. CareNeeds Platinum (HMO D-SNP) is designed for people who have Medicare and are entitled to help from Florida Medicaid.

If you get help from Florida Medicaid with Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare services. Florida Medicaid may also provide other benefits by covering health care services and prescription drugs that aren't usually covered under Medicare. You may also get Extra Help from Medicare to pay for the costs of your Medicare drugs. CareNeeds Platinum (HMO D-SNP) will help you manage all these benefits, so you get the health services and payment help that you're entitled to.

CareNeeds Platinum (HMO D-SNP) is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. We're pleased to provide your Medicare coverage, including drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This Evidence of Coverage is part of our contract with you about how CareNeeds Platinum (HMO D-SNP) covers your care. Other parts of this contract include your enrollment form, the Prescription Drug Guide (formulary), and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for the months you're enrolled in CareNeeds Platinum (HMO D-SNP) between January 1, 2027 and December 31, 2027.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of CareNeeds Platinum (HMO D-SNP) after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) and Florida Medicaid must approve CareNeeds Platinum (HMO D-SNP). You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare and Florida Medicaid renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and Medicaid Categories: QDWI,QI,QMB,SLMB.

Note: If you lose your Florida Medicaid eligibility but can reasonably be expected to regain eligibility within six-month(s), then you're still eligible for membership. Chapter 4, Section 2.1 tells you about coverage and cost sharing during this period.

Section 2.2 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

In addition, Medicaid offers programs to help people pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums.

- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled and Working Individual (QDWI):** Helps pay Part A premiums

Section 2.3 Plan service area for CareNeeds Platinum (HMO D-SNP)

CareNeeds Platinum (HMO D-SNP) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes the following county/counties in Florida: Broward, Miami-Dade, Palm Beach Counties, FL.

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 800-794-5907 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.4 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify CareNeeds Platinum (HMO D-SNP) if you're not eligible to stay a member of our plan on this basis. CareNeeds Platinum (HMO D-SNP) must disenroll you if you don't meet this requirement.

SECTION 3 What to expect when you first join our plan

Section 3.1 Health risk assessment

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. The HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

Section 3.2 Care team and care plan

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, specialists you see, or other health professionals that you choose.

You work with a care team to make a care plan based on your preferences. A care plan tells you and your doctors and other health providers what services you need and how to get them. It includes your medical, behavioral health, and other services if applicable.

Your care plan includes:

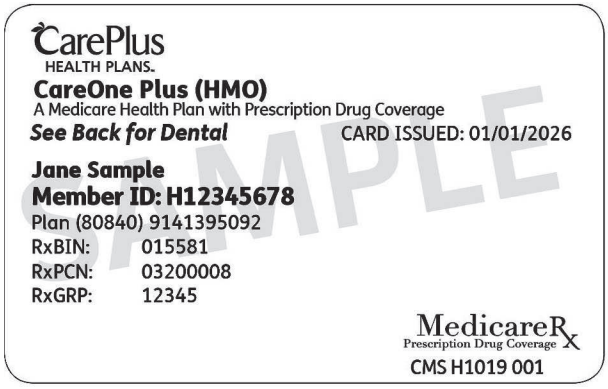
- your health care goals as prioritized by you, and
- a timeline for getting the services you need.

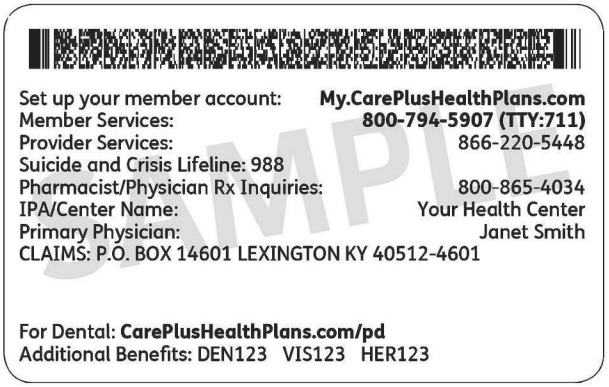
Your care team meets with you after your HRA. They ask about the services you need. They also tell you about services you may want to think about getting. Your care team works with you to update your care plan at least every year or as needed if you have any changes in your health status.

SECTION 4 Important membership materials

Section 4.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card. Sample membership card:





DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your CareNeeds Platinum (HMO D-SNP) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

The back of the identification card indicates your dental benefits with a six-character code, DEN000, for example. Medicare Advantage dental benefits use a PPO dental network with in-network only coverage. The front of the card refers only to the plan's medical benefits. For information about dental benefits, see the Mandatory Supplemental Dental Benefit description in Chapter 4 of this document.

If our plan membership card is damaged, lost, or stolen, call Member Services at 800-794-5907 (TTY users call 711) right away and we'll send you a new card.

Be sure to show your Florida Medicaid ID card in addition to your CareNeeds Platinum (HMO D-SNP) membership card to make your provider aware that you may have additional coverage.

Section 4.2 *Provider Directory*

The Provider Directory **(CarePlusHealthPlans.com/Directories)** lists our current network providers, durable medical equipment suppliers and pharmacies. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is situations where it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when CareNeeds Platinum (HMO D-SNP) authorizes use of out-of-network providers.

Many of the plan's network providers are also Medicaid certified. Refer to your Provider Directory to identify which plan network providers are also participating with Florida Medicaid. You are not restricted to Medicaid certified providers for your Medicare plan services.

The Provider Directory **(CarePlusHealthPlans.com/Directories)** lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the Provider Directory to find the network pharmacy you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that aren't in the plan's network.

The Provider Directory will also tell you which of the pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have a Provider Directory, you can ask for a copy (electronically or in paper form) by visiting our website at **CarePlusHealthPlans.com/Directories**. The website can give you the most up-to-date information about changes in our network providers and pharmacies. You can also request this information by calling Member Services at 800-794-5907 (TTY users call 711). Requested paper Provider Directories will be mailed to you within 3 business days.

Section 4.3 Drug Guide *(formulary)*

Our plan has a List of Covered Drugs (also called the Drug Guide or formulary). It tells which prescription drugs are covered under the Part D benefit in CareNeeds Platinum (HMO D-SNP). The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug Guide meets all Medicare requirements. Drugs included in the Medicare Drug Price Negotiation Program will be included on your Drug Guide unless they have been removed or replaced as described in Chapter 5, Section 6. Medicare approved the CareNeeds Platinum (HMO D-SNP) Drug Guide.

The Drug Guide also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug Guide. The Drug Guide includes information for the covered drugs most commonly used by our members. However, we also cover additional drugs that aren't included in the Drug Guide. If one of your drugs isn't listed in the Drug Guide, visit our website or call Member Services at 800-794-5907 (TTY users call 711) to find out if we cover it. To get the most complete and current information about which drugs are covered, visit **https://www.careplushealthplans.com/medicare/medicare-advantage-plans/prescription-drugs-list** or call Member Services at 800-794-5907 (TTY users call 711).

SECTION 5 Summary of Important Costs for 2027

Your Costs in 2027	
	In-Network
Monthly plan premium*	**$0**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1.2 for details.)	**$3,400** If you are eligible for Medicare cost-sharing assistance under Medicaid, you most likely are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	**$0** copayment per visit
Specialist office visits	**$0** copayment per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**$0** copayment per stay
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage and Catastrophic Coverage Stages.) Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.	**Part D drug coverage deductible** If you receive Extra Help, your deductible is **$0**. Refer to your LIS Rider insert for your cost sharing amounts. If you **do not** receive Extra Help, the deductible is **$700**. **$0** for Tier 1, Tier 2, and Tier 3 **$700** for Tier 4 and Tier 5; except for covered insulin products and most adult Part D vaccines
	Copayment/Coinsurance during the Initial Coverage Stage:

Your Costs in 2027	
	In-Network
	For a 30-day supply from a **retail pharmacy**: • **Drug Tier 1: $0** You pay no more than **$0** per month supply of each covered insulin product on this tier. • **Drug Tier 2: $0** You pay no more than **$0** per month supply of each covered insulin product on this tier. • **Drug Tier 3: 17%** You pay no more than **17%** up to **$35** per month supply of each covered insulin product on this tier. • **Drug Tier 4: 41%** You pay no more than **25%** up to **$35** per month supply of each covered insulin product on this tier. • **Drug Tier 5: 25%** You pay no more than **25%** up to **$35** per month supply of each covered insulin product on this tier.
	For a 100-day supply from a **mail-order pharmacy** with preferred cost-sharing: • **Drug Tier 1: $0** You pay no more than **$0** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 2: $0** You pay no more than **$0** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 3: 17%** You pay no more than **17%** up to **$105** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 4: 41%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 5:** Not available

Your Costs in 2027	
	In-Network
	For a 100-day supply from a **mail-order pharmacy** with standard cost-sharing: • **Drug Tier 1: $30** You pay no more than **25%** up to **$30** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 2: $60** You pay no more than **16%** up to **$60** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 3: 17%** You pay no more than **17%** up to **$105** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 4: 41%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 5:** Not available
	Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs.

Your costs may include the following:

- Plan Premium (Section 5.1)
- Monthly Medicare Part B Premium (Section 5.2)
- Part D Late Enrollment Penalty (Section 5.3)
- Income Related Monthly Adjusted Amount (Section 5.4)
- Medicare Prescription Payment Plan Amount (Section 5.5)

Section 5.1 Plan premium

You don't pay a separate monthly plan premium for CareNeeds Platinum (HMO D-SNP).

Section 5.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above to be eligible for our plan, you must maintain your eligibility for Florida Medicaid as well as have both Medicare Part A and Medicare Part

B. For most CareNeeds Platinum (HMO D-SNP) members, Florida Medicaid pays for your Part A premium (if you don't qualify for it automatically) and Part B premium.

If Florida Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 5.3 Part D Late Enrollment Penalty (LEP)

Because you're dually-eligible, the LEP doesn't apply as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll generally have to pay this penalty for as long as you have Part D coverage.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay for your drug costs.
- You went less than 63 days in a row without Part D or other creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or a newsletter from that plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
  - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty.
Here's how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable drug coverage, if the break in coverage was 63 days or more.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2027, this average premium amount is **$41.33**.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times **$41.33**, which equals **$5.79**. This rounds to **$5.80**. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year,** because the national base beneficiary premium can change each year.
- **You'll generally continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're under 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a reconsideration of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 5.4 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes to your income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 5.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 6 More information about your monthly plan premium

Section 6.1 Your monthly plan premium won't change during the year

We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year, we'll tell you in September, and the new premium will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty.

- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you disenroll from your plan and go 63 days or more in a row without Part D or other creditable drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 7 Keep your plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 800-794-5907 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 8 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 800-794-5907 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer") pays up to the limits of its coverage. The insurance that pays second, (the "secondary payer"), only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

CHAPTER 2:
Phone numbers and resources

SECTION 1 CareNeeds Platinum (HMO D-SNP) contacts

For help with claims, billing, or member card questions, call or write to CareNeeds Platinum (HMO D-SNP) Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	800-794-5907 Calls to this number are free. You can call us seven days a week, from 8 am to 8 pm. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**. Member Services 800-794-5907 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
Fax	888-556-2128
Write	CarePlus Health Plans, Inc. P.O. Box 14168 Lexington, KY 40512-4168
Website	**CarePlusHealthPlans.com/ContactUs**

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	800-794-5907 Calls to this number are free. You can call us seven days a week, from 8 am to 8 pm. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**.

Coverage Decisions for Medical Care – Contact Information	
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
Fax	888-790-9999
Write	CarePlus Health Plans, Inc. P.O. Box 14165 Lexington, KY 40512-4165
Website	**CarePlusHealthPlans.com/Decisions**

Coverage Decisions for Part D Drugs – Contact Information	
Call	800-555-2546 Calls to this number are free. You can call us seven days a week, from 8 am to 8 pm. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
Fax	877-486-2621
Write	CarePlus Health Plans, Inc. Attention: CarePlus Clinical Pharmacy Review P.O. Box 14601 Lexington, KY 40512-4601
Website	**CarePlusHealthPlans.com/RxDecisions**

Appeals For Medical Care – Contact Information	
Call	800-794-5907 Calls to this number are free. You can call us seven days a week, from 8 am to 8 pm. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours of operation are the same as above.

Appeals For Medical Care – Contact Information	
Fax	888-556-2128 Medical Care and Dental Services
Write	**Appeals For Medical Care** CarePlus Grievances & Appeals Department P.O. Box 14165 Lexington, KY 40512-4165 **Appeals for Dental Services** HumanaDental for CarePlus P.O. Box 14165 Lexington, KY 40512-4165
Website	**CarePlusHealthPlans.com/Appeal** - Medical Care **CarePlusHealthPlans.com/Dental** - Dental Services

Appeals For Part D drugs – Contact Information	
Call	800-451-4651 Calls to this number are free. We are open Monday - Friday, from 8 am to 8 pm. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
Fax	877-556-7005
Write	CarePlus Health Plans, Inc. Attention: Grievance & Appeals Department P.O. Box 14165 Lexington, KY 40512-4165
Website	**CarePlusHealthPlans.com/Resources**

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care or Part D drugs – Contact Information	
Call	800-794-5907 Calls to this number are free. You can call us seven days a week, from 8 am to 8 pm. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**.

Complaints about Medical Care or Part D drugs – Contact Information	
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
Fax	888-556-2128 Medical Care, Part D drugs and Dental Services
Write	**Complaints About Medical Care or Part D drugs** CarePlus Grievances & Appeals Department P.O. Box 14165 Lexington, KY 40512-4165 **Complaints About Dental Services** HumanaDental for CarePlus P.O. Box 14165 Lexington, KY 40512-4165
Medicare Website	To submit a complaint about CareNeeds Platinum (HMO D-SNP) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests – Contact Information	
Call	800-794-5907 Calls to this number are free. You can call us seven days a week, from 8 am to 8 pm. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours of operation are the same as above.

Payment Requests – Contact Information	
Write	**Request for payment - Medical Care** CarePlus Health Plans, Inc. P.O. Box 14601 Lexington, KY 40512-4601 **Request for payment - Part D drugs** CarePlus Health Plans, Inc. P.O. Box 14140 Lexington, KY 40512-4140 **Requests for payment - Dental Services** HumanaDental for CarePlus P.O. Box 14611 Lexington KY 40512-4611
Website	**CarePlusHealthPlans.com/Resources** - Medical Care or Part D drugs **CarePlusHealthPlans.com/Dental** - Dental Services

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE, (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044

Medicare – Contact Information	
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about CareNeeds Platinum (HMO D-SNP). **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Contact information for your State Health Insurance Assistance Program (SHIP) can be found in "Exhibit A" in the back of this document.

The State Health Insurance Assistance Program (SHIP) is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Health Insurance Assistance Program counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. State Health Insurance Assistance Program counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. Contact information for your state Quality Improvement Organization (QIO) can be found in "Exhibit A" in the back of this document.

The Quality Improvement Organization (QIO) has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. The QIO is an independent organization. It's not connected with our plan.

Contact your Quality Improvement Organization (QIO) in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount, or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, contact Social Security to let them know.

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

To be enrolled in this Dual Eligible Special Needs Plan, you must be enrolled in Medicare and also must receive certain levels of assistance from Florida Medicaid. (See Chapter 1, Section 2.1 "Special eligibility requirements for our plan" for the specific requirements for this plan.)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums.
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled and Working Individual (QDWI):** Helps pay Part A premiums.

If you have questions about the help you get from Medicaid, contact Florida Medicaid. Contact information for Florida Medicaid can be found in "Exhibit A" in the back of this document.

The Florida Department of Financial Services - Division of Consumer Services helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

	Florida Department of Financial Services - Division of Consumer Services - Contact Information
Call	877-693-5236 or 850-413-3089 8 a.m. – 5 p.m., Monday - Friday
TTY	TTY: 711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Florida Department of Financial Services – Division of Consumer Services 200 East Gaines St, Tallahassee, FL 32399-0322
Website	http://www.myfloridacfo.com/division/consumers/

The Department of Elder Affairs State Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

	Department of Elder Affairs State Long-Term Care Ombudsman - Contact Information
Call	850-414-2323 or 888-831-0404
TTY	TTY: 711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.

	Department of Elder Affairs State Long-Term Care Ombudsman - Contact Information
Write	Department of Elder Affairs State Long-Term Care Ombudsman 4040 Esplanade Way, Suite 380 Tallahassee, FL 32399 Email: LTCOPInformer@elderaffairs.org
Website	https://ombudsman.elderaffairs.org/

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (**Medicare.gov/basics/costs/help/drug-costs**) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Most of our members qualify for and are already getting Extra Help from Medicare to pay for their prescription drug plan costs.

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048,
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Florida Medicaid. Contact information for Florida Medicaid can be found in "Exhibit A" in the back of this document.

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of your proper copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- If you already have a document that proves you have qualified for Extra Help, you can also show it the next time you go to a pharmacy to have a prescription filled. You can use any one of the following documents to provide evidence to us, or to show as proof at the pharmacy.

Proof that you already have Extra Help status

- A letter from the Social Security Administration showing your Extra Help status. This letter could be called Important Information, Award Letter, Notice of Change, or Notice of Action.
- A letter from the Social Security Administration showing that you receive Supplemental Security Income. If that's the case, you also qualify for Extra Help.

Proof that you have active Florida Medicaid status that qualifies for Extra Help

- A copy of any state document or any printout from the state showing your active Medicaid status that qualifies for Extra Help. The active date shown must be in the month of July or later of last year.

Proof of a Medicaid payment for a stay at a medical facility

Your stay at the medical facility must be at least one full month long and must be in the month of July or later of last year.

- A billing statement from the facility showing the Medicaid payment
- A copy of any state document or any printout from the state system showing the Medicaid payment for you

If you first show one of the documents listed above as proof at the pharmacy, please also send us a copy. Mail the document to:

CarePlus Health Plans, Inc.
P.O. Box 14168
Lexington, KY 40512-4168

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at 800-794-5907 (TTY users call 711) if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the ADAP operating in your State.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the ADAP operating in your State. Contact information for your AIDS Drug Assistance Program (ADAP) can be found in "Exhibit A" in the back of this document.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** Extra Help from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call Member Services at 800-794-5907 (TTY users call 711) or visit Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	800-794-5907 Calls to this number are free. You can call us seven days a week, from 8 am to 8 pm. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**. Member Services 800-794-5907 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
Write	CarePlus Health Plans, Inc. P.O. Box 14168 Lexington, KY 40512-4168
Website	To learn more about this payment option, please visit **CarePlusHealthPlans.com/RxCostHelp** or visit Medicare.gov

SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are not free.
Website	https://RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 800-794-5907 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the inside back cover.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator.** The benefits administrator can help you understand how your current drug coverage will work with our plan.

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care and other services our plan covers, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing or only your share of the cost for covered services.

  If you are cost-share protected by Florida Medicaid, see Chapter 4 Section 1.1 for more information on Medicare cost-share protection from Medicaid.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, CareNeeds Platinum (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare in the Medical Benefits Chart in Chapter 4.

CareNeeds Platinum (HMO D-SNP) will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).

- In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information go to Section 2.3.

- You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.

- **You must get your care from a network provider** (see Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means that you have to pay the provider in full for services you get. Here are 3 exceptions:

  - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.

  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. You must obtain authorization from the plan prior to seeking care from an out-of-network provider. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.

  - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care

What is a PCP and what does the PCP do for you?

A "PCP" is your Primary Care Provider. When you become a member of the plan, you must choose a network doctor to be your PCP. Your PCP is a provider who meets state license requirements and is trained to give you basic medical care.

Having a PCP is an important step in managing your overall well-being. As the doctor who gets to know your medical history best, your PCP can provide you with routine healthcare and ongoing preventive care to keep you as healthy as possible. Your PCP can coordinate all your care, by checking with other network providers, when you need to see specialists or get other services such as:

- Care from specialists
- Follow-up care
- Hospital admissions
- Lab Tests

- Physical Therapy
- X-Rays

Your plan requires you to have a PCP, but you don't need a referral from your PCP to see other network doctors or receive the covered services listed in Chapter 3, Section 2.2 below. In some cases, your PCP will need to ask for prior authorization (prior approval). Chapter 4 has more information on which services require prior authorization.

Just call your PCP to make an appointment when you need one. To help your PCP understand your medical history and oversee all your care, you may want to have your previous doctors send your past medical records to your new PCP.

How to choose a PCP?
When you enrolled, you received a Provider Directory with a list of many PCPs in your area. If you need help finding or choosing one, call Member Services or you can always see the most up-to-date list online at **CarePlusHealthPlans.com/FindCare**.

To choose a PCP that's a good fit for you, call them to ask how long it usually takes to get an appointment and be sure the office hours are convenient for you. If there are particular network hospitals that you think you might want to use, you should also ask if the PCP uses them.

If you would prefer to have a PCP that has the same cultural, ethnic or racial background as you, call Member Services to ask if someone's in the network.

How to change your PCP
You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. You'll need to ask which hospitals and specialists your PCP uses for referrals.

To change your PCP call Member Services. We'll make sure your new PCP is accepting new patients. The change usually goes into effect on the first day of the month after you call.

Be sure to tell Member Services if you're currently seeing specialists or any other providers that required a referral from your old PCP. We'll make sure you can continue with any services that had already been approved.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically

necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 800-794-5907 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- All covered preventive services from network providers. These services are indicated in the Chapter 4 Medical Benefits Chart with an
- Dermatology services from a network provider
- Chiropractic services from a network provider
- Podiatry services from a network provider
- Supplemental Benefits covered by the plan. These services are indicated in the Chapter 4 Medical Benefits Chart with an asterisk (*).

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

When your PCP thinks that you need specialized treatment, he/she can give you a referral to see a specialist or certain other providers in the plan's network. If you are seeing a network specialist for your care, you may need to return to your PCP for a referral for additional services.

For some types of services, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization"). See Chapter 4, Section 2.1 for information about which services require prior authorization.

It is very important to get a referral (approval in advance) from your PCP before you see a specialist or certain other providers in the plan's network (there are a few exceptions, including women's health care that we explained earlier in this section). If you don't have a referral (approval in advance) before you get services from a network specialist, you may have to pay for these services yourself. If the network specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits.

If there are specific specialists in the plan's network you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain network specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a network specialist that your current PCP can't refer you to. Earlier in this section, under "Changing your PCP," we explained how to change your PCP.

If you need hospital care, we will cover these services for you. Covered services are listed in the Medical Benefits Chart in Chapter 4 under the heading "Inpatient hospital care." We use "hospital" to mean a facility that is certified

by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living. Except in an emergency, your PCP or specialist will arrange your admission to the hospital.

For a list of network hospitals, please refer to the Provider Directory. Your doctor may not admit to all network hospitals. Please ask your doctor to find out the hospitals with which he/she has privileges. If there are specific hospitals you want to use, you must first find out whether your PCP, or the doctors you will be seeing, use these hospitals.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization is required for service to be covered.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

Section 2.4 How to get care from out-of-network providers

Your network PCP must give you approval in advance before you can use providers not in the plan's network. This is called giving you a "referral." For more information about this and situations when you can see an out-of-network provider without a referral (such as an emergency), see Sections 2.2 and 2.3 of this chapter. If you don't have a

referral (approval in advance) before you get services from an out-of-network provider, you may have to pay for these services yourself.

For some types of services, your doctor may need to get approval in advance from our plan (this is called getting "prior authorization"). See Chapter 4, Section 2.1 for more information about which services require prior authorization.

Note: You are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for End-Stage Renal Disease (ESRD) members who have traveled outside the plans service area and are not able to access contracted ESRD providers.

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call Member Services using the phone number printed on the inside back cover.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care–thinking that your health is in serious danger–and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care only if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

What if you are in the plan's service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care, we will cover urgently needed services that you get from an out-of-network provider.

The plan's Provider Directory will tell you which urgent care facilities in your area are in-network. This information can also be found online at **CarePlusHealthPlans.com/FindCare**. For any other questions regarding urgently needed services, please contact Member Services (phone numbers are printed on the inside back cover).

What if you are <u>outside</u> the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers worldwide emergency and urgent care services outside of the United States under the following circumstances. If you have an emergency or an urgent need for care outside of the U.S. and its territories;

- You will be responsible to pay for those services upfront and request reimbursement from us.
- We will reimburse you for covered out-of-network emergency and urgent care services outside of the U.S. and its territories. However, the reimbursement rates will be no greater than the rates at which Original Medicare would pay for such services had the services been performed in the United States in the locality where you reside.
- The amount we pay you, if any, will be reduced by any applicable cost-sharing. Because we will reimburse at rates no greater than the rates at which Original Medicare would reimburse, and because foreign providers

might charge more for services than the rates at which Original Medicare would pay, the total of our reimbursement plus the applicable cost-sharing may be less than the amounts you pay the foreign provider.

This is a supplemental benefit not generally covered by Medicare. You must submit proof of payment to CarePlus for reimbursement. See Chapter 4 (Medical Benefits Chart, what is covered and what you pay) for more information. If you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. You can send the bill with medical records to us for payment consideration. See Chapter 7 (Asking us to pay our share of a bill you have received for covered medical services or drugs) for information about what to do if you receive a bill or if you need to ask for reimbursement. Transportation back to the United States from another country is NOT covered. Pre-scheduled, pre-planned treatments (including treatment for an ongoing condition) and/or elective procedures are NOT covered.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit **CarePlusHealthPlans.com/Alert** for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan

CareNeeds Platinum (HMO D-SNP) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will **not** count toward your out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you've used.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us that you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials

If you participate in a study not approved by Medicare or our plan, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit

documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies, available at: Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that's **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's voluntary and not required by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:

- You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
- – and – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Medicare Inpatient Hospital coverage limits apply (please refer to the Medical Benefits Chart in Chapter 4).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of CareNeeds Platinum (HMO D-SNP), you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Member Services at 800-794-5907 (TTY users call 711) for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage CareNeeds Platinum (HMO D-SNP) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents

- Maintenance and repairs of oxygen equipment

If you leave CareNeeds Platinum (HMO D-SNP) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave your plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you with services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of CareNeeds Platinum (HMO D-SNP). This section also gives information about medical services that aren't covered. See Section 4, "Services that aren't covered by our plan" for various plan and benefit exclusions and limitations.

Section 1.1 Out-of-pocket costs you may pay for covered services

If you get Medicare cost-share help from Florida Medicaid, you pay nothing for your covered services as long as you follow our plan's rules for getting your care. Go to Chapter 3 for more information about our plan's rules for getting your care. Additionally, CareNeeds Platinum (HMO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments - even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law.

If you are billed or asked to pay a provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services, tell your provider you are cost-share protected and can't be charged. If you have already made payment, you have the right to a refund. If your provider will not stop billing, you can call Member Services or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Member Services or Medicare can ask your provider to stop billing you and refund any payment you have made.

Members who do not receive Medicare cost-sharing assistance from Florida Medicaid are responsible for the copayments/coinsurance listed in the Medical Benefits Chart.

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get help from Florida Medicaid, very few members ever reach this out-of-pocket maximum. If you're eligible for Medicare cost-sharing help under Medicaid, you're most likely not responsible for

paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services from in-network providers.

Medicare Advantage Plans have limits on the amount you have to pay out of pocket each year for medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the amount is $3,400 (In-Network).**

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **$3,400**, you won't have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Florida Medicaid or another third party).

Section 1.3 Providers aren’t allowed to balance bill you

As a member of CareNeeds Platinum (HMO D-SNP), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can’t bill you for additional separate charges called **balance billing.** This protection applies even if we pay the provider less than the provider charges for a service and even if there’s a dispute and we don’t pay certain provider charges.

Here’s how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan.)
  - If you get covered services from an out-of-network provider who participates in Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
  - If you get the covered services from an out-of-network provider who doesn’t participate in Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 800-794-5907 (TTY users call 711).

If you are cost share protected by Florida Medicaid, we don't allow in-network providers to bill you for covered services. We pay our in-network providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. If you get a bill from a provider that you feel you should not pay, call Member Services at 800-794-5907 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services CareNeeds Platinum (HMO D-SNP) covers and what you pay out-of-pocket for each service (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) must be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means that you pay the provider in full for the out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart by a footnote. The Medical Benefits Chart does not list all services that require prior authorization.
    - > The preauthorization list can be found here: **CarePlusHealthPlans.com/PAL**
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid may cover your cost-sharing for Medicare services, including plan medical deductibles and cost shares as well as Medicare Part A & Part B premiums, depending on your level of assistance from the Florida Medicaid. Florida Medicaid may also cover services Medicare does not cover.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your Medicare & You 2027 handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you receive the preventive service, plan cost-sharing will apply for the care you got for the existing medical condition.

- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

- If you lose your Florida Medicaid eligibility but can be expected to regain it within six-months, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, you may be subject to Part D premiums and Part D cost-shares based on your level of Extra Help. Additionally, based on your level of Florida Medicaid eligibility, you may also be responsible for Medicare Part A and/or Part B premiums. Plan cost-sharing amounts for Medicare basic and supplemental benefits don't change during this period.

Important Benefit Information for People Who Qualify for Uniformity Flexibility

If you are diagnosed with one or more of the health conditions identified below, you may be eligible for one or more Uniformity Flexibility supplemental benefits.
- Heart Failure (including Heart Failure with Reduced Ejection Fraction (HFrEF) and non-HFrEF with qualifying additional conditions)
- Coronary Artery Disease (CAD)
- Hypertension
- Chronic Kidney Disease (CKD)
- Chronic respiratory conditions
- Congestive Heart Failure (CHF)

You may be eligible for the following Uniformity Flexibility benefits if you meet the applicable criteria:
- Virtual Cardiac Recovery Program - for members with recent heart failure-related hospitalization
  - **Other important things to know about our coverage:** For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from. If you get covered services from a network provider, you pay based on the plan's reimbursement rate. If you get covered services from an out-of-network provider who participates with Medicare, you pay based on the Medicare payment rate for participating providers. If you get covered services from an out-of-network provider who does not participate with Medicare, you pay based on the Medicare payment rate for non-participating providers. Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you may pay more than you would in Original Medicare. For others, you may pay less. For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you are treated or monitored for an existing condition during the same visit, cost-sharing may apply. If Medicare adds coverage for any services during the plan year, either Medicare or our plan will cover those services.

Please refer to the applicable benefit rows in the Medical Benefits Chart for detailed information about coverage, limitations, and cost-sharing.

If you're eligible for Medicare cost-sharing help under Medicaid, you don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

Important Benefit Information for Enrollees with Chronic Conditions

- If you're diagnosed with any of the chronic condition(s) listed below, and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.

  - This plan offers the CarePlus CareEssentials Allowance® which is a Special Supplemental Benefits for the Chronically Ill (SSBCI).

- To be eligible for SSBCI, you must meet **ALL** of the following requirements:
  - Be diagnosed with one or more of the Eligible Chronic Conditions listed below.
  - Have a high risk of hospitalization or other significant adverse health outcomes.
  - Require intensive care coordination.
- Eligible Chronic Conditions for the CarePlus CareEssentials Allowance®:
  - Autoimmune disorders
  - Cancer
  - Cardiovascular disorders
  - Chronic alcohol use and other substance use disorders
  - Chronic and disabling mental health conditions
  - Chronic gastrointestinal disease
  - Chronic heart failure
  - Chronic hyperlipidemia
  - Chronic hypertension
  - Chronic kidney disease
  - Chronic lung disorder
  - Conditions associated with cognitive impairment
  - Conditions with functional challenges
  - Dementia
  - Diabetes mellitus
  - HIV/AIDS
  - Neurologic disorders
  - Post-organ transplant
  - Severe hematologic disorders
  - Stroke
- CarePlus may determine whether you have an eligible chronic condition in one or more of the following ways:
  - **Medical Claim:** CarePlus has a medical claim on file that includes a diagnosis for one or more of the Eligible Chronic Conditions. The medical claim must have a date of service on or after 1/1/2022.

  OR
  - **Health Risk Assessment (HRA):** Indication on a Health Risk Assessment (HRA), that you have been diagnosed with at least one of the Eligible Chronic Conditions. The HRA must be completed on or after 1/1/2022. The HRA can be found by setting up and logging into your account at CarePlusHealthPlans.com/HRA.
- Once CarePlus confirms that you have met the chronic condition requirement through one of the methods above, CarePlus will review your member file to determine whether you meet the remaining eligibility requirements.
- This review will determine whether you are eligible to receive additional benefits through CarePlus CareEssentials Allowance®
- You may contact Member Services for additional information and assistance.
- For more details, go to the Special Supplemental Benefits for the Chronically Ill row in the Medical Benefits Chart below.

* This spending allowance is a 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. 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.

This apple shows the preventive services in the Medical Benefits Chart.

*** This asterisk shows the supplemental benefits in the Medical Benefits Chart.**

See Section 1.1 of this chapter for information on Florida Medicaid cost-share protection.

For a full list of Medicaid benefits offered through your state Medicaid program and cost-sharing requirements, if any, please see the Medicaid Benefit Comparison section of your Summary of Benefits. Please contact your Medicaid Agency for benefit eligibility and determining your level of cost-sharing responsibility. Note: Cost sharing is based on your level of Medicaid eligibility. For this plan, the following Medicaid levels are cost-share protected: QMB.

Medical Benefits Chart

Covered Service	What you pay
Note: You may owe amounts for each service when receiving multiple related services.	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 20 visits per calendar year under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements. Our 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**.	**In-Network:** **$0** copayment – Specialist's Office

Covered Service	What you pay
*** Acupuncture for routine services** Acupuncture is the procedure of inserting and manipulating needles into various points on the body to relieve pain or for therapeutic purposes which are medically necessary. You are covered for up to 25 visits per calendar year. Our 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**.	**In-Network:** Routine acupuncture **$0** copayment – Specialist's Office
Allergy shots and serum You are covered for allergy shots and serum when medically necessary.	**In-Network:** Allergy Shots and Serum **$0** copayment – PCP's Office – Specialist's Office
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. You are covered for emergency ambulance transportation world-wide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit proof of payment to CarePlus for reimbursement. For more information please see Chapter 7. We may not reimburse you for all out of pocket expenses. This is because our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share. Our 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**.	Depending on your level of Medicaid eligibility, you may not be responsible for the copayments, coinsurances, or deductibles for the services listed in this section. **In-Network:** Emergency Ambulance **$0 or $200** copayment per trip regardless of the number of trips – Ground Ambulance **$0 or 20%** coinsurance regardless of the number of trips – Air Ambulance Non-Emergency Ambulance **$0** copayment per trip regardless of the number of trips – Ground Ambulance **$0 or 20%** coinsurance regardless of the number of trips – Air Ambulance **Out-of-Network:** Worldwide Coverage **$0 or $200** copayment per trip regardless of the number of trips – Emergency Ambulance
Annual wellness visit	**In-Network:**

Covered Service	What you pay
If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	**In-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period. Our plan requires prior authorization for certain items and services. The	**In-Network:** **$0** copayment – Specialist's Office – Outpatient Hospital

Covered Service	What you pay
following link will take you to a list of items and services that may be subject to prior authorization: **CarePlusHealthPlans.com/PAL**.	
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
*** 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. For additional information, please contact the number on the back of your CarePlus Member ID card.	**In-Network:** There is no coinsurance, copayment, or deductible to participate.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct a vertebral subluxation (one or more of the bones of your spine move out of position) *In addition to the Medicare Covered Benefit listed above, you may self-refer to a network chiropractor for 12 visits per calendar year for care. Our 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**.	**In-Network:** Medicare Covered Chiropractic Services **$0** copayment – Specialist's Office **In-Network:** Chiropractic Services (Routine) **$0** copayment – Specialist's Office
Colorectal cancer screening	**In-Network:** There is no coinsurance,

Covered Service	What you pay
The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover **Mandatory Supplemental Dental Benefits** which include preventive and diagnostic services.	**In-Network:** Medicare Covered Dental Services **$0** copayment – Specialist's Office **Mandatory Supplemental Dental Benefits** *You are covered for Mandatory Supplemental Dental Benefit. See the **Mandatory Supplemental Dental Benefit** description at the end of this chart for details.

Covered Service	What you pay
Our 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**.	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors – These are the only covered (preferred) brands of blood glucose monitors and test strips: ACCU-CHEK® manufactured by Roche, or Trividia products sometimes packaged under your pharmacy's name. – CarePlus covers any blood glucose monitors and test strips specified within the preferred brand list above. In general, alternate non-preferred brand products are not covered unless your doctor provides adequate information that the use of an alternate brand is medically necessary in your specific situation. If you are new to CarePlus and are using a brand of blood glucose monitor and test strips that are not on the preferred brand list, you may contact us within the first 90 days of enrollment into the plan to request a temporary supply of the alternate non-preferred brand. During this time, you should talk with your doctor to decide whether any of the preferred product brands listed above are medically appropriate for you. Non-preferred brand products will not be covered following the initial 90 days of coverage without an approved prior authorization for a coverage exception. – For both existing and new members, if it is medically necessary for you to use or continue to use an alternate non-preferred brand product, you or your provider may request a coverage exception to have CarePlus cover a non-preferred brand product through the end	**In-Network:** Diabetes self-management training **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital Diabetic Monitoring Supplies **$0** copayment – Diabetic Supplier – Network Retail Pharmacy Diabetic Shoes and Inserts **$0** copayment – Durable Medical Equipment Provider – Prosthetics Provider

Covered Service	What you pay
of the benefit year. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. For more information on making an appeal, see Chapter 9 (If you have a problem or complaint (coverage decisions, appeals, complaints)). • For people with diabetes who have severe diabetic foot disease, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting. • Diabetes self-management training under certain conditions • For Continuous Glucose Monitors, see Durable medical equipment (DME) and related supplies. The (preventive service) only applies to Diabetes self-management training. Our 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**.	
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, continuous glucose monitors**, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website **CarePlusHealthPlans.com/FindCare**. Our 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**. **Preferred Continuous Glucose Monitors (CGMs) are covered at pharmacies. Preferred CGMs are Dexcom & Freestyle Libre. Non-preferred CGMs are not covered through a pharmacy unless your doctor provides adequate information that the use of an alternate brand is medically necessary. All CGMs will continue to be covered through durable medical equipment providers (DME).	**In-Network:** Durable Medical Equipment **$0** copayment – Durable Medical Equipment Provider Continuous Glucose Monitor **$0** copayment – Preferred Pharmacy – Durable Medical Equipment Provider – Pharmacy

Covered Service	What you pay
EKG screening The screening EKG, when done as a referral from the Welcome to Medicare preventive visit, is only covered once during a beneficiary's lifetime.	**In-Network:** There is no coinsurance, copayment, or deductible for an EKG screening visit.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. You are covered for emergency care world-wide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit proof of payment to CarePlus for reimbursement. For more information please see Chapter 7. We may not reimburse you for all out of pocket expenses. This is because our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share.	Depending on your level of Medicaid eligibility, you may not be responsible for the copayments, coinsurances, or deductibles for the services listed in this section. **In-Network:** Emergency Services **$0 or $150** copayment – Emergency Room **Out-of-Network:** Worldwide Coverage **$0 or $150** copayment – Emergency Room **In-Network:** Provider and Professional Services **$0** copayment – Emergency Room You do not pay the emergency room visit cost share if you are admitted to the same hospital within 24 hours for the same condition. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.
Hearing services	**In-Network:** Medicare Covered Hearing Services **$0** copayment

Covered Service	What you pay
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. In addition, we cover **Mandatory Supplemental Hearing Benefits** which include a routine hearing exam and hearing aid coverage. Our 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**.	– Specialist's Office **Mandatory Supplemental Hearing Benefits** *You are covered for Mandatory Supplemental Hearing Benefit. See the **Mandatory Supplemental Hearing Benefit** description at the end of this chart for details.
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies Our 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**.	**In-Network:** Home Health Care **$0** copayment – Member's Home Durable Medical Equipment **$0** copayment – Durable Medical Equipment Provider
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for	**In-Network:** Medical Supplies **$0** copayment – Medical Supply Provider Other Medicare Part B Drugs **$0** copayment

Covered Service	What you pay
example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Our 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**.	– PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy Provider and Professional Services **$0** copayment – PCP's Office
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not CareNeeds Platinum (HMO D-SNP). Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. Provider cost sharing may apply for outpatient consultations.

Covered Service	What you pay
rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services that are covered by CareNeeds Platinum (HMO D-SNP) but not covered by Medicare Part A or B:** CareNeeds Platinum (HMO D-SNP) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information.	**In-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. You are covered for an unlimited number of medically necessary inpatient hospital days. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units)	**In-Network:** Inpatient Care **$0** copayment per admission – Inpatient Hospital If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd pay at a network hospital.

Covered Service	What you pay
• Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If CareNeeds Platinum (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Travel and lodging reimbursement requires a minimum of 100 miles one way to transplant center and is limited to **$10,000** per transplant. • If you are in need of a solid organ or bone marrow/stem cell transplant, please contact Member Services at 800-794-5907, TTY 711 to be directed to our Transplant Team for important information about your transplant care. Additional details on transplant travel and lodging can be found at **CarePlusHealthPlans.com/Transplant.** • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet Medicare Hospital Benefits available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Prior authorization is required for inpatient hospital care and transplant services. The following link will take you to a list of items and services that may be subject to prior authorization: **CarePlusHealthPlans.com/PAL**.	**In-Network:** Provider and Professional Services **$0** copayment – Inpatient Hospital
Inpatient services in a psychiatric hospital	**In-Network:**

Covered Service	What you pay
Covered services include mental health care services that require a hospital stay. • 190-day lifetime limit for inpatient services in a psychiatric hospital • The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital • The benefit days used under the Original Medicare program will count toward the 190-day lifetime reserve days when enrolling in a Medicare Advantage plan Prior authorization is required for inpatient mental health care. The following link will take you to a list of items and services that may be subject to prior authorization: **CarePlusHealthPlans.com/PAL**.	Inpatient Mental Health Care **$0** copayment per admission – Inpatient Hospital – Inpatient Psychiatric Facility **In-Network:** Provider and Professional Services **$0** copayment – Inpatient Hospital – Inpatient Psychiatric Facility
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	When your inpatient stay is not covered, you will pay the cost of the services received as described throughout this benefit chart.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered Service	What you pay
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle.	**In-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug	**In-Network:** Chemotherapy Drugs **$0** copayment – Specialist's Office – Outpatient Hospital Medicare Part B Insulin Drugs **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy Other Medicare Part B Drugs **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy Your cost-share for covered Medicare Part B drugs is the same at all participating providers. Some rebatable Part B drugs may be subject to a lower coinsurance. There may be a cost for the administration of a Part B drug, in addition to the cost for the drug itself. You may have to try a different drug first before we will agree to cover the drug you are requesting. This is called "step therapy." You will pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a

Covered Service	What you pay
• Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **CarePlusHealthPlans.com/PAL** We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6. Our 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**.	deductible it does not apply to the Part B insulin.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities	**In-Network:** **$0** copayment – Specialist's Office – Outpatient Hospital

Covered Service	What you pay
• Periodic assessments Our 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**.	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests Our 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**.	**In-Network:** Provider and Professional Services **$0** copayment – PCP's Office – Specialist's Office Diagnostic Procedures and Tests **$0** copayment – PCP's Office – Specialist's Office – Urgent Care Center – Outpatient Hospital Advanced Imaging Services **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital – Freestanding Radiological Facility Basic Radiological Services **$0** copayment – PCP's Office – Specialist's Office – Urgent Care Center – Outpatient Hospital – Freestanding Radiological Facility Diagnostic Mammography **$0** copayment – Specialist's Office – Outpatient Hospital – Freestanding Radiological Facility Radiation Therapy **$0** copayment – Specialist's Office – Outpatient Hospital – Freestanding Radiological Facility

Covered Service	What you pay
	Nuclear Medicine Services **$0** copayment – Outpatient Hospital – Freestanding Radiological Facility Facility Based Sleep Study **$0** copayment – Specialist's Office – Outpatient Hospital Home Based Sleep Study **$0** copayment – Member's Home Medical Supplies **$0** copayment – Medical Supply Provider Diagnostic Colonoscopy **$0** copayment – Ambulatory Surgical Center – Outpatient Hospital Lab Services **$0** copayment – PCP's Office – Specialist's Office – Urgent Care Center – Outpatient Hospital – Freestanding Laboratory
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	**In-Network:** **$0** copayment – Outpatient Hospital

Covered Service	What you pay
Get more information from the Medicare fact sheet Medicare Hospital Benefits available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you go to the Emergency Room and are asked to stay for further observation, you will only pay the ER copay. Please refer to the "Emergency Care" section of this chart for what you pay for an ER visit. Additional costs may apply for any procedures or tests performed while under observation. See **Outpatient Hospital Services** section. Our 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**.	
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Our 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**.	Depending on your level of Medicaid eligibility, you may not be responsible for the copayments, coinsurances, or deductibles for the services listed in this section. **In-Network:** Diagnostic Procedures and Tests **$0** copayment – Outpatient Hospital Advanced Imaging Services **$0** copayment – Outpatient Hospital Nuclear Medicine Services **$0** copayment – Outpatient Hospital Basic Radiological Services **$0** copayment – Outpatient Hospital Diagnostic Mammography **$0** copayment – Outpatient Hospital Radiation Therapy **$0** copayment – Outpatient Hospital Lab Services **$0** copayment

Covered Service	What you pay
	– Outpatient Hospital Surgery Services **$0** copayment – Outpatient Hospital Mental Health Services **$0** copayment – Outpatient Hospital Hyperbaric Oxygen **$0** copayment – Outpatient Hospital Wound Care **$0** copayment – Outpatient Hospital Facility Based Sleep Study **$0** copayment – Outpatient Hospital Emergency Services **$0 or $150** copayment – Emergency Room Diagnostic Colonoscopy **$0** copayment – Outpatient Hospital Intensive Outpatient Services **$0** copayment – Outpatient Hospital Partial Hospitalization **$0** copayment – Outpatient Hospital
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-Network:** Mental Health Services **$0** copayment – Specialist's Office – Outpatient Hospital

Covered Service	What you pay
Our 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**.	
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Our 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**.	**In-Network:** Physical Therapy **$0** copayment – Specialist's Office – Outpatient Hospital – Comprehensive Outpatient Rehab Facility Speech Therapy **$0** copayment – Specialist's Office – Outpatient Hospital – Comprehensive Outpatient Rehab Facility Occupational Therapy **$0** copayment – Specialist's Office – Outpatient Hospital – Comprehensive Outpatient Rehab Facility
Outpatient substance use disorder services You are covered for treatment of substance abuse, as covered by Original Medicare. Our 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**.	**In-Network:** Outpatient Substance Use Disorder Services **$0** copayment – Specialist's Office – Outpatient Hospital
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. Our 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**.	**In-Network:** Surgery Services **$0** copayment – Outpatient Hospital – Ambulatory Surgical Center Diagnostic Colonoscopy **$0** copayment – Ambulatory Surgical Center – Outpatient Hospital
Partial hospitalization services and Intensive outpatient services	**In-Network:**

Covered Service	What you pay
Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. Our 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**.	Partial Hospitalization **$0** copayment – Outpatient Hospital Intensive Outpatient Services **$0** copayment – Outpatient Hospital
*** Personal Home Care (PHC)** $0 copayment for a minimum of 3 hours per day, up to a maximum of 42 hours per calendar year for certain in-home support services to assist individuals in performing activities of daily living (ADLs) within the home by a qualified aide. Support includes assistance with: • Bathing or showering • Dressing and undressing • Grooming • Toileting • Continence care • Transferring • Ambulation or mobility, including walking or using mobility aids • Eating or feeding assistance Authorization is required. Please contact Member Services to take advantage of this benefit or to receive more information.	**In-Network:** **$0** copayment
*** Physical exam (Routine)** In addition to the Annual Wellness Visit or the Welcome to Medicare physical exam, you are covered for the following exam once per calendar year: • Comprehensive preventive medicine evaluation and management, including an age and gender appropriate history, examination, and counseling/anticipatory guidance/risk factor reduction interventions	**In-Network:** Routine Physical Exams **$0** copayment – PCP's Office

Covered Service	What you pay
Note: Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately.	
Physician/practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including services by primary care providers (PCPs) and specialists; mental health specialty services and psychiatric services; outpatient substance abuse services; and urgently needed services – You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth – You may use a phone, computer, tablet, or other video technology • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: – You're not a new patient **and** – The check-in isn't related to an office visit in the past 7 days **and** – The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: – You're not a new patient **and** – The evaluation isn't related to an office visit in the past 7 days **and** – The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	**In-Network:** Provider and Professional Services **$0** copayment – PCP's Office – Specialist's Office Telehealth Services **$0** copayment – PCP Virtual – Specialist Virtual – Mental Health Care and Substance Abuse Treatment Virtual – Urgent Care Virtual Advanced Imaging Services **$0** copayment – PCP's Office – Specialist's Office Surgery Services **$0** copayment – PCP's Office – Specialist's Office Radiation Therapy **$0** copayment – Specialist's Office Urgently Needed Services **$0** copayment – PCP's Office – Specialist's Office

Covered Service	What you pay
• Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Physician/practitioner urgently needed services furnished in an office setting Our 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**.	

Podiatry services
 	
Covered services include:
• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)
• Routine foot care for members with certain medical conditions affecting the lower limbs
 	
*You are also covered for supplemental routine foot care benefits:
• You may self-refer for unlimited visits per calendar year to a network specialist. Covered supplemental services include:
  • Paring or cutting of benign hyperkeratotic lesions (e.g., corn, wart, callus)
  • Trimming or debridement of nails
 	
Our 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**.
	In-Network:
	Medicare Covered Podiatry Services
	$0 copayment
	– Specialist's Office
	
	In-Network:
	Podiatry Services (Routine)
	$0 copayment
	– Specialist's Office

Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening	**In-Network:** There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams	**In-Network:** There is no coinsurance, copayment, or deductible for an

Covered Service	What you pay
For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to Vision Care later in this table for more detail. Our 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**.	**In-Network:** **$0** copayment – Prosthetics Provider
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Our 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**.	**In-Network:** **$0** copayment – Specialist's Office – Outpatient Hospital
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are:** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay
counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Kidney diseases and dialysis services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	**In-Network:** Kidney Disease Education Services **$0** copayment – PCP's Office – Specialist's Office Renal Dialysis Services **$0** copayment – Dialysis Center – Outpatient Hospital

Covered Service	What you pay
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table. Our 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**.	Durable Medical Equipment **$0** copayment – Durable Medical Equipment Provider
*** SilverSneakers® fitness program** SilverSneakers® is a fitness program for seniors that is included at no additional charge with qualifying Medicare health plans. Members have access to participating fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. Access online education on **SilverSneakers.com**, watch workout videos on SilverSneakers On-Demand™ or download the SilverSneakers GO™ fitness app for additional workout ideas. The plan offers a fitness benefit that includes access to the lowest-cost tier of membership at participating gyms and fitness centers across the nation, as well as live instructor-led group fitness classes designed for seniors. Any fitness center services that usually have an extra fee are not included in your membership.	**In-Network:** **$0** copayment
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) You are covered for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood you need.	A new benefit period will begin on day one when you first enroll in a Medicare Advantage plan, or when you have been discharged from an inpatient facility or skilled nursing facility for **60 consecutive days**. Per Benefit Period, you pay: **In-Network:** Skilled Nursing Care **$0** copayment per admission – Skilled Nursing Facility

Covered Service	What you pay
• Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital Our 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**.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
*** Smoking cessation program** In addition to the 2 Medicare-covered smoking and tobacco use cessation preventative benefit, we will cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This additional counseling attempt includes up to four face-to-face visits. This service can be used for either preventive measures or a diagnosis with a tobacco related disease.	**In-Network:** **$0** copayment
*** Special supplemental benefits for the chronically ill** **CarePlus CareEssentials Allowance®** **Over-the-Counter (OTC)** All members enrolled on the plan receive **$250** monthly allowance automatically loaded on a limited-use prepaid debit card to use at	**In-Network:** There is no coinsurance, copayment, or deductible to participate.

Covered Service	What you pay
participating retail locations to buy eligible products from these over-the-counter (OTC) categories: • Cold, flu, and allergy medicine • Tooth and dental care items • Stomach and digestion products • First aid items and medical supplies • Bladder control supplies • Hearing aids you can buy without a prescription • Pain relief medicine • Skin care items • Sleep aids • Products to help you stop smoking • Vitamins and supplements, and more If you already have a CarePlus Spending Account Card from your current plan, please keep it as your allowance will be loaded to this card. New members will receive a card in the mail. Please turn on, or activate, your card as soon as you get it. Use this card to spend your allowance. • Your allowance is added to the card on the first day of each month. • If you do not use all your money, the leftover amount moves, or rolls over, to the next month. • Any money left on the card will end at the end of the year. It may also end sooner if you leave this plan. • Our plan is not responsible if someone uses your allowance without permission because your card was lost or stolen. • Keep this card in a safe place, just like you would with any debit card. • Keep this card even after you spend the money. More money may be added later if you stay in the plan. • Limitations and restrictions may apply. Visit CarePlus.NationsBenefits.com to find stores or check your balance. You can also see the back of your spending account card for more information. **Plus**, this plan offers Special Supplemental Benefits for the Chronically Ill (SSBCI). To be eligible for SSBCI, you must meet **ALL** of the following requirements: 1. Be diagnosed with one or more of the Eligible Chronic Conditions listed below. 2. Have a high risk of hospitalization or other significant adverse health outcomes. 3. Require intensive care coordination. Eligible Chronic Conditions: • Autoimmune disorders • Cancer	

Covered Service	What you pay

- Cardiovascular disorders
- Chronic alcohol use and other substance use disorders
- Chronic and disabling mental health conditions
- Chronic gastrointestinal disease
- Chronic heart failure
- Chronic hyperlipidemia
- Chronic hypertension
- Chronic kidney disease
- Chronic lung disorders
- Conditions associated with cognitive impairment
- Conditions with functional challenges
- Dementia
- Diabetes mellitus
- HIV/AIDS
- Neurologic disorders
- Post-organ transplant
- Severe hematologic disorders
- Stroke

CarePlus may determine whether you have an eligible chronic condition in one or more of the following ways:

- **Medical Claim:** CarePlus has a medical claim on file that includes a diagnosis for one or more of the Eligible Chronic Conditions. The medical claim must have a date of service on or after 1/1/2022.

OR

- **Health Risk Assessment (HRA):** Indication on a Health Risk Assessment (HRA) that you have been diagnosed with at least one of the Eligible Chronic Conditions. The HRA must be completed on or after 1/1/2022. The HRA can be found by setting up and logging into your account at CarePlusHealthPlans.com/HRA.

Once CarePlus confirms that you have met the chronic condition requirement through one of the methods above, CarePlus will review your member file to determine whether you meet the remaining eligibility requirements. This review will determine whether you are eligible to receive additional benefits through the CarePlus CareEssentials Allowance®.

You may contact Member Services for additional information and assistance.

This plan offers the following SSBCI:

CarePlus CareEssentials Allowance®

If you are eligible for this SSBCI, you can buy eligible products from participating retail locations using the same money, with the same card, like:

- Groceries (produce, fruit, bread, meat, dairy, etc.)
- Personal care items (toothpaste, shampoo, body soap, deodorant, etc.)

Covered Service	What you pay
• Home supplies (toilet paper, paper towels, bathroom cleaner, laundry detergent, etc.) • Household assistive devices (grab bars, raised toilet seats, reaching aids, etc.) • Pet supplies (pet food, pet litter, flea shampoo, etc.; excludes grooming services, veterinary bills, and pet prescriptions) This allowance may be used to pay for approved services **if the service provider is able to process the payment,** such as: • Monthly living expenses (rent/mortgage, utilities, phone, internet, etc.) • Non-medical transportation costs (public transportation, taxi, Uber, Lyft, etc.) • Personal emergency response services through the plan's approved vendor • Pest control services • Companionship care services through the plan's approved vendor • Indoor air quality equipment services Merchant participation is subject to change and does not guarantee acceptance of the spending account card. Some rent and utility companies may not accept this form of payment. *This spending allowance is a special supplemental benefit program for members with specific chronic conditions who require intensive care coordination and are at a high risk of hospitalization or other adverse health outcomes. Qualifying conditions 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. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income if you seek assistance. Contact your local HUD office with questions.	
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD	**In-Network:** **$0** copayment – Specialist's Office – Outpatient Hospital

Covered Service	What you pay
• Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. Our 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**.	
*** Transportation** You are covered for unlimited one-way, non-emergency trips to plan-approved locations within the plan service area per calendar year. This benefit offers unlimited miles per one-way trip. Any one-way trip longer than 35 miles requires prior approval. Plan-approved locations include medical facilities, medical and dental offices, pharmacies and fitness centers. Members must schedule trips with the transportation provider at least 3 business days in advance of their appointment. If you have a smartphone, you can schedule your rides using the **CareTrip app**. You can download it from the Apple App Store® or Google Play®. If you use a wheelchair, have any other special needs, or would like to bring up to 1 companion on the trip, please notify the vendor when you schedule your trip. You may contact Member Services for more information on plan-approved locations and prior approval requirements. Member Services can also help you schedule a trip.	**In-Network:** **$0** copayment
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. You are covered for urgently needed services world-wide. If you have an urgent need for care while outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit proof of payment to for reimbursement. For more information please see Chapter 7. We may not reimburse you for all out of pocket expenses. This is because	**In-Network:** Urgently Needed Services **$0** copayment – Urgent Care Center **Out-of-Network:** Worldwide Coverage **$0** copayment – Urgent Care Center

Covered Service	What you pay
our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost-share. See **Physician/practitioner services, including doctor's office visits** for additional information about urgently needed services provided in the office setting.	
Virtual Cardiac Recovery Program (Uniformity Flexibility Benefit) **Eligibility and Description** Eligible members must have had an inpatient or observation hospitalization within the past 30 days related to a heart failure diagnosis, based on plan-established ICD-10 coding criteria. Members must also meet one of the following: (a) heart failure with reduced ejection fraction (HFrEF) or (b) heart failure with at least one additional condition (hypertension with complications, pneumonia excluding tuberculosis, or respiratory signs and symptoms). Additional conditions must be active within the same lookback period. Where ejection fraction is not directly available, clinically validated proxy criteria are used. All eligible members receive the same access. **Benefit Description** Program delivers coordinated care through supervised exercise, nutrition and medication follow-ups, and functional assessments via individualized care plans delivered through telehealth. Includes up to 36 sessions per episode following a qualifying hospitalization with a $0 copayment. May include remote monitoring, behavioral coaching, education, and provider visits. This benefit supplements, and does not replace, Medicare-covered cardiac rehabilitation. **Scope and Limitations** • Services must be medically necessary and related to the qualifying condition. • One episode per qualifying hospitalization; each hospitalization may trigger a new episode if criteria are met. • Prior authorization may be required based on eligibility confirmation and medical necessity. • Services must be provided by plan-approved vendors. **Coverage Determinations and Appeals** Requests are handled as Medicare Advantage organization determinations. Members may request coverage decisions and file appeals.	**In-Network:** **$0** copayment
Vision care Covered services include:	**In-Network:** Medicare Covered Vision Services **$0** copayment – Specialist's Office

Covered Service	What you pay
• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses, or anti-reflective coating). In addition, we cover **Mandatory Supplemental Vision Benefits** which include a routine vision exam and an allowance for eyewear. The (preventive service) only applies to Glaucoma Screening. Our 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**.	Glaucoma Screening **$0** copayment – Specialist's Office Diabetic Eye Exam **$0** copayment – All Places of Treatment Eyewear (Post Cataract Surgery) **$0** copayment – All Places of Treatment **Mandatory Supplemental Vision Benefits** *You are covered for Mandatory Supplemental Vision Benefit. See the **Mandatory Supplemental Vision Benefit** description at the end of this chart for details. **Please note:** the network of providers for your supplemental vision benefits may be different than the network of providers for the Original Medicare vision benefits listed above.
Welcome to Medicare preventive visit Our plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your Welcome to Medicare preventive visit.	**In-Network:** There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.

Covered Service	What you pay
*** Wigs (related to chemotherapy treatment)** You are covered for an unlimited maximum benefit per calendar year for wigs related to chemotherapy treatment. The provider who prescribed chemotherapy must notify us to authorize your wig purchase. Once you purchase a wig, submit your receipt to us for reimbursement. (See Chapter 7, Section 2 for instructions.) Our 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**.	**In-Network:** **$0** copayment

Mandatory Supplemental Dental Benefit DEN103

Coverage Description
You may receive the following non-Medicare covered routine dental-related services:

Plan information

The following information includes important information on benefit limits and cost details for in-network and out-of-network providers. More information about your plan is located below the coverage details section.

In-network providers

- In-network dental providers have agreed to provide covered services at contracted rates per the in-network fee schedules (INFS).
- If a member visits a participating network dental provider, the member cannot be billed for charges that exceed the negotiated fee schedule.
- There is 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/DentalFinder**.

Description of Benefit	In-Network You Pay	Out-of- Network You Pay
Preventive Services		
Exams Frequency/Limits – 2 procedure codes per calendar year		
Periodic oral exam – D0120	**0%**	**100%**
Exams Frequency/Limits – 2 procedure codes per calendar year		
Emergency diagnostic exam – D0140	**0%**	**100%**
Prophylaxis (Cleaning) Frequency/Limits – 2 procedure codes per calendar year		
Prophylaxis (cleaning) – D1110	**0%**	**100%**

Description of Benefit	In-Network You Pay	Out-of- Network You Pay
Bitewing X-rays Frequency/Limits – 2 procedure codes per calendar year		
Bitewing x-rays – D0270, D0272, D0273, D0274	**0%**	**100%**
Panoramic X-rays Frequency/Limits – 1 procedure code per calendar year		
Complete series – D0210	**0%**	**100%**
Panoramic film – D0330	**0%**	**100%**
Diagnostic Services Frequency/Limits – 1 procedure code every 3 calendar years		
Comprehensive exam – D0150	**0%**	**100%**
Comprehensive Services		
Periodontal Maintenance Frequency/Limits – 4 procedure codes per calendar year		
Periodontal maintenance following periodontal therapy – D4910	**0%**	**100%**
Restorations (Fillings) – **Amalgam and/or Composite** Frequency/Limits – 4 procedure codes per calendar year		
Amalgam (silver) – primary or permanent – D2140, D2150, D2160, D2161	**0%**	**100%**
Resin-based composite (white) – anterior (front) or posterior (back) – D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	**0%**	**100%**
Extractions (Pulling Teeth) Frequency/Limits – 5 procedure codes per calendar year		
Extraction, erupted tooth, or exposed root – D7140, D7210	**0%**	**100%**
Removal of impacted tooth – D7220, D7230, D7240	**0%**	**100%**
Surgical removal of residual tooth roots – D7250	**0%**	**100%**
Scaling – Generalized Inflammation Frequency/Limits – 1 procedure code per calendar year		
Scaling – moderate or severe gingival inflammation - D4346	**0%**	**100%**
Scaling and Root Planing Frequency/Limits – 1 procedure code per calendar year, per quadrant		
Periodontal scaling and root planing – D4341, D4342	**0%**	**100%**
Endodontic Services Frequency/Limits – 1 procedure code per calendar year		
Root canal – D3310, D3320, D3330	**0%**	**100%**
Complete/Partial Dentures Frequency/Limits – 1 upper and 1 lower complete or partial denture every 5 calendar years Includes necessary extractions to fit dentures (unlimited)		
Complete denture – maxillary (upper) or mandibular (lower) – D5110, D5120	**0%**	**100%**

Description of Benefit	In-Network You Pay	Out-of- Network You Pay
Immediate denture – maxillary (upper) or mandibular (lower) – D5130, D5140	**0%**	**100%**
Partial dentures – resin or metal, maxillary (upper) or mandibular (lower) - D5211, D5212, D5213, D5214	**0%**	**100%**
Denture Adjustments, Rebase or Reline (not allowed on spare dentures or if within six months of initial placement) Frequency/Limits – 1 procedure code per calendar year		
Complete denture adjustment – maxillary (upper) or mandibular (lower) – D5410, D5411	**0%**	**100%**
Rebase complete denture – maxillary (upper) or mandibular (lower) – D5710, D5711	**0%**	**100%**
Reline complete denture – maxillary (upper) or mandibular (lower) – D5730, D5731, D5750, D5751	**0%**	**100%**
Oral Surgery Frequency/Limits – 2 procedure codes per calendar year		
Oral Surgery - D7270, D7280, D7284, D7285, D7286, D7287, D7288, D7310, D7311, D7320, D7321, D7410, D7411, D7412, D7450, D7451, D7460, D7461, D7509, D7510, D7961, D7962, D7963, D7970, D7971, D7972	**0%**	**100%**
Anesthesia Frequency/Limits – As needed with covered codes per calendar year (in conjunction with extensive and/or complex procedures, subject to plan limitations and exclusions, subject to clinical review)		
Administration of analgesia, anxiolysis, inhalation of nitrous oxide – D9230	**0%**	**100%**
Administration of deep sedation/general anesthesia – D9222, D9223	**0%**	**100%**
Administration of intravenous moderate (conscious) sedation/analgesia – D9239, D9243	**0%**	**100%**
Administration of non-intravenous moderate (conscious) sedation/analgesia – D9246, D9247	**0%**	**100%**

Benefit limits

- Limitations and exclusions may apply.
- All services must be received in-office from a participating, in-network, general dentist or dental specialist (e.g., oral surgeon, endodontist, periodontist, etc.).
- Benefits are offered on a calendar year basis.
- The dentist may suggest and help arrange for additional services not listed in the preceding chart; however, any procedures received that either are not listed in this chart or exceed the benefit limitations listed in this chart 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.

Learn more about your benefits

- For more information about your dental benefits, go to **CarePlusHealthPlans.com/Dental** to view the complete Dental Benefit Schedule for your dental plan.
- If you have questions, please 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. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**.

Estimating dental costs

If the dental care you need is expected to exceed **$300**, we suggest you or your dentist send a dental treatment plan for us to review ahead of time so that we can provide you with an estimate for services. The pretreatment plan should include:

1. A list of services you will receive, using American Dental Association terminology and codes.
2. Your dentist's written description of the proposed treatment.
3. X-rays that show your dental needs.
4. Itemized cost of the proposed treatment.
5. Any other diagnostic materials we request.

How payments are calculated

For covered dental services, we will pay as follows:

- We will determine the total covered expense.
- We will review the covered expense against the maximum benefits allowed.
- We will pay the remaining expense to you or your dentist.

Date of service definition

For dental claim billing purposes, the "Date of Service" (DOS) is defined as follows:

- The date teeth are prepared for fixed bridges, crowns, inlays or onlays
- The date the impression or digital scan is made for dentures or partials
- The date the impression or digital scan of the abutment/implant is taken for implant crowns
- The date the pulp chamber of a tooth is opened for root canal therapy
- The date periodontal surgery is performed
- The date the service is performed for services not listed above

Treatment options

- For dental conditions that have two or more possible treatments, CarePlus will cover the lowest cost treatment, as long as it is proven to provide satisfactory results.
- If you choose to receive a higher cost treatment, you will be responsible to pay for the difference.

Mandatory Supplemental Hearing Benefit HER100

Coverage Description

To use your benefit, you must call NationsHearing at 888-742-8038 to schedule an appointment.

Description of Benefit	In–Network You Pay
Routine hearing exam (1 per calendar year)	**$0**

Description of Benefit	In–Network You Pay
Up to 2 prescription hearing aids every year (1 per ear per year). In-network benefit is limited to the NationsHearing Level 1 prescription hearing aids, which come in various brands and options. Select Level 1 prescription hearing aids are available in rechargeable style options. **To use your in-network benefit, you must call NationsHearing at 888-742-8038 (TTY: 711) to schedule an appointment.** In-network hearing aid purchase includes: – 1 fitting appointment during first year following a hearing aid purchase with the original provider – 3 follow-up provider visits during first year following hearing aid purchase with the original provider – 60-day trial period – 3-year extended warranty – 3 years of batteries per non-rechargeable aid (up to 60 cells per ear per year) Benefit does not include or cover any of the following: – OTC hearing aids – Hearing aid accessories – Additional provider visits – Additional batteries (or batteries when a rechargeable hearing aid is purchased) – Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and are not covered by the plan.	**$0** per Level 1 Aid

Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.

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

Mandatory Supplemental Vision Benefit VIS841

Coverage Description
You may receive the following non-Medicare covered routine vision-related services:

Description of Benefit	You Pay
Routine Eye Exam • Eye health exam including vision test with refraction and dilation, when necessary • 1 exam per calendar year	**$0**

Description of Benefit	You Pay
Choice of 1 Eyewear Option per plan year:	
Eyewear Option 1 • Eyeglasses – frame, lenses, and fitting • Contact lenses, conventional or disposable, and fitting	Any amount over **$115**
Eyewear Option 2 • Choice of 1 pair of select eyeglasses**, frame(s), lenses, and fitting(s), per plan year	**$0****
All eyeglasses may include the following add-ons: ultraviolet protection and scratch-resistant coating. (Member responsible for the costs of additional add-ons.)	**$0**

**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**.

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

SECTION 3 Services covered outside of CareNeeds Platinum (HMO D-SNP)

All services covered by Original Medicare are also covered by our plan. If you have questions about services that are not covered by CareNeeds Platinum (HMO D-SNP) but are available through Florida Medicaid, please see your Medicaid Member Handbook or contact Medicaid. Contact information for Florida Medicaid can be found in "Exhibit A" in the back of this document.

SECTION 4 Services that aren't covered by our plan *OR* Medicare

This section tells you what services are excluded by Medicare.
The chart below lists services and items that aren't covered by our plan OR Medicare under any conditions or are covered by our plan OR Medicare only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3)

Services not covered by Medicare	Covered only under specific conditions
Charges for equipment which is primarily and customarily used for a nonmedical purpose, even though the item has some remote medically related use	Not covered under any condition
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Genetic/molecular testing without successful completion of a molecular diagnostic services program (MoIDX®) technical assessment Genetic/ Molecular Tests analyze things like DNA, RNA, proteins, or other biological markers in the body. If your doctor talks to you about one of these tests, make sure you understand whether it is covered by your plan. Genetic/ molecular tests that are not FDA approved must be evaluated and approved with a technical assessment (TA) by Palmetto GBA as part of the MolDX program, to be covered by CarePlus and the Centers for Medicare and Medicaid Services (CMS). CMS requires that the TA must demonstrate the test's clinical utility in that it improves patient outcomes or changes physician management decisions and is also a valid test with proven clinical validity, and analytical validity. **Only genetic/molecular testing that have a successfully completed TA will be considered for coverage. A complete list is available on the** DEX® Diagnostics Exchange Registry. You can learn more about the medical necessity requirements of coverable genetic/ molecular testing at CMS.gov and CarePlusHealthPlans.com/CoveragePolicies. Please confirm with your provider if the genetic/molecular testing in question is on the DEX® Diagnostics Exchange Registry.	Not covered under any condition
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Nonconventional interocular lenses (IOLs) following cataract surgery, including: • **an astigmatism correcting function of an intraocular lens** • **a presbyopia correcting function of an intraocular lens**	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Purchase, instead of rental, of durable medical equipment that Original Medicare does not allow to be purchased outright	Not covered under any condition
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

In addition to any exclusions or limitations described in the Medical Benefits Chart, or anywhere else in this Evidence of Coverage, **the following items and services aren't covered under Original Medicare or by our plan:**

- Radial keratotomy, LASIK surgery, and other low vision aids. However, eyeglasses are covered for people after cataract surgery, and as described in the Medical Benefits Chart, subject to limitations.

- Services provided to veterans in Veterans Affairs (VA) facilities.

- Expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
  - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
  - Furnished by, or payable under, any plan or law through any government or any political subdivision – this does not include Medicare or Medicaid.
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
- Any expense arising from the completion of forms.

Dental Mandatory Supplemental Benefit Exclusions
Dental exclusions include, but are **not limited to**, the following:

- Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee schedule on covered services (coinsurance payment still applies).

- Services received from an out-of-network dentist are not covered benefits.
- Expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
  - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
  - Furnished by, or payable under, any plan or law through any government or any political subdivision – this does not include Medicare or Medicaid.
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any expense arising from the completion of forms.
- Your failure to keep an appointment with the dentist.
- Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures to include, but are not limited to:
  - Facings on crowns or pontics – the portion of a fixed bridge between the abutments – posterior to the second bicuspid;
  - Any service to correct congenital malformation;
  - Any service performed primarily to improve appearance;
  - Characterizations and personalization of prosthetic devices; or
  - Any procedure to change the spacing and/or shape of the teeth;
- Charges for:
  - Any type of implant and all related services, including crowns or the prosthetic device attached to it;
  - Precision or semi-precision attachments;
  - Other customized attachments;
  - Temporary or interim dental services;
  - Additional charges related to material or equipment used in the delivery of dental care;
  - The removal of any implants unless a covered service.
- Any service related to:
  - Altering vertical dimension of teeth.
  - Restoration or maintenance of occlusion.
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction.
  - Bite registration or bite analysis.
  - Bone grafting at site(s) of which documentation does not support future restoration
- Infection control, including but not limited to sterilization techniques.
- Fees for treatment performed by someone other than a dentist, except for scaling, teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision of the dentist in accordance with generally accepted dental standards.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service not specifically listed in the Coverage Information.
- Any service that is not eligible for benefits based upon clinical review; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Orthodontic services.
- Retainer Crown services when bridge coverage is not included in the benefit.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the reimbursement limit for the service.

- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Local anesthetics, irrigation, bases, pulp caps, temporary dental services, study models/diagnostic casts, treatment plans, occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
- When the primary service(s) is denied all associated service(s) in conjunction with it are additionally denied.
- Any test, intraoperative, x-rays, laboratory, removal of existing posts, filling material, Thermafill carriers, and any other follow-up care is considered integral to root canal therapy. A separate fee for these services is not considered a covered expense.
- Repair and replacement of orthodontic appliances.
- Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
- The oral surgery benefits under this plan do not include:
  - Any services for orthognathic surgery;
  - Any services for destruction of lesions by any method;
  - Any services for tooth transplantation;
  - Any services for removal of a foreign body from the oral tissue or bone;
  - Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
  - Any separate fees for pre and post-operative care.
- General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services.
- General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
  - Pain control unless a documented allergy to local anesthetic is provided;
  - Anxiety;
  - Fear of pain;
  - Pain management;
  - Emotional inability to undergo surgery.
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan.
- We do not cover services that generally are considered to be medical services except those specifically noted as covered in the Coverage Information.

Hearing Mandatory Supplemental Benefit Exclusions

Hearing exclusions include, but are **not limited to**, the following:

- Any fees for exams, tests, evaluations or any services in excess of the stated maximums.
- Any expenses which are covered by Medicare or any other government program or insurance plan, or for which you are not legally required to pay.
- Services provided for clearance/consultation by a provider.
- Any refitting fees for lost or damaged hearing aids.

- Any fees for any services rendered by a non-network hearing aid provider. In-network hearing aid providers reserve the right to only service devices purchased from in-network providers.
- Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds (except when covered under Medicaid), hearing aid accessories, return fees, warranty claim fees, and hearing aid batteries (beyond the covered limit).

Vision Mandatory Supplemental Benefit Exclusions
Vision exclusions include, but are **not limited to**, the following:

- Any benefits received at a non-network optical provider.
- Refitting or change in lens design after initial fitting.
- Any expense arising from the completion of forms.
- Any service not specifically listed in your supplemental benefit including local, state or federal taxes which must be paid in full by the insured person to the provider.
- Orthoptic or vision training.
- Subnormal vision aids and associated testing.
- Aniseikonic lenses.
- Athletic or industrial lenses.
- Any service we consider cosmetic.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the allowance for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Plano lenses.
- Medical or surgical treatment of eye, eyes or supporting structures.
- Non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plans providing vision care.
- Corrective vision treatment of an experimental nature.
- Solutions and/or cleaning products for glasses or contact lenses.
- Non-prescription items.
- Costs associated with securing materials.
- Pre and post-operative services.
- Orthokeratology.
- Routine maintenance of materials.
- Artistically painted lenses.
- Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
  - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
  - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid).
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
- Your failure to keep an appointment.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.

- Any service that we determine is not a visual necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Replacement of lenses or eyeglass frames furnished under this supplemental benefit that are lost or broken, unless otherwise available under the supplemental benefit.
- Any examination or material required by an employer as a condition of employment or safety eyewear.
- Pathological treatment.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

CHAPTER 5:
Using plan coverage for Part D drugs

How can you get information about your drug costs if you're getting Extra Help with your Part D drug costs?

Most of our members qualify for and are getting Extra Help from Medicare to pay for their prescription drug plan costs. If you're in the Extra Help program, some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you. We sent you a separate insert, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, call Member Services at 800-794-5907 (TTY users call 711) and ask for the LIS Rider. (Phone numbers for Member Services are printed on the inside back cover of this document.)

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs may be covered under your Medicaid benefits.

Our plan will generally cover your drugs as long as you follow these rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) or you can fill your prescription through your plan's mail-order service.
- Your drug must be in our plan's Prescription Drug Guide (Formulary) (we call it the Drug Guide for short). (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication).
- Your drug may require approval from our plan based on certain criteria before we will agree to cover it. (Go to Section 4 for more information)

SECTION 2 Fill your prescription at a network pharmacy or through our plan's mail-order service

In most cases, your prescriptions are covered only if they're filled at our plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term "covered drugs" means all the Part D drugs in our plan's Drug Guide.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your Provider Directory, visit our website (**CarePlusHealthPlans.com/FindCare**), and/or call Member Services at 800-794-5907 (TTY users call 711).

You may go to any of our network pharmacies. Some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The Provider Directory will tell you which network pharmacies offer preferred cost-sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, visit our website at **CarePlusHealthPlans.com/FindCare**. You can also get help from Member Services at 800-794-5907 (TTY users call 711) or use the Provider Directory.

Specialized pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Member Services at 800-794-5907 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your Provider Directory (**CarePlusHealthPlans.com/FindCare**) or call Member Services at 800-794-5907 (TTY users call 711).

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as **mail-order drugs** in our Drug Guide.

Our plan's mail-order service allows you to order **up to a 100-day supply.**

We have mail-order pharmacies in our network that offer standard cost-sharing and mail-order pharmacies that offer preferred cost-sharing. You may use either but your portion of the cost will usually be lower with a mail-order

pharmacy that offers preferred cost-sharing. If you use a mail-order pharmacy not in our plan's network, your prescription will not be covered.

To get order forms and information about filling your prescriptions by mail, please contact Member Services.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 business days from when your prescriptions are received. When you plan to use a mail-order pharmacy, it's a good precaution to ask your doctor to write two prescriptions for your drugs: one you'll send for ordering by mail, and one you can fill in person at an in-network pharmacy if your mail order doesn't arrive on time. That way, you won't have a gap in your medication if your mail order is delayed. If you have trouble filling your prescription at an in-network pharmacy while waiting for mail order, please contact your prescriber's office.

New prescriptions the pharmacy gets directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of all new prescriptions at any time by calling Member Services.

If you get a prescription automatically by mail that you don't want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Member Services.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider’s office, contact us by calling Member Services.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 14 business days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling Member Services at 800-794-5907 (TTY users call 711).

If you get a refill automatically by mail that you don’t want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs in our plan's Drug Guide. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your Provider Directory (**CarePlusHealthPlans.com/FindCare**) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at 800-794-5907 (TTY users call 711) for more information.

2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services at 800-794-5907 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- **If you need a prescription because of a medical emergency**
  - We will cover prescriptions that are filled at an out-of-network pharmacy (up to a 30-day supply) if the prescriptions are related to care for a medical emergency. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a prescription drug claim form, located at **CarePlusHealthPlans.com/Resources.** If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2 explains how to ask our plan to pay you back.)
- **If you need coverage while you're traveling away from our plan's service area**
  - If you take a prescription drug on a regular basis and you're going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our prescription mail-order service or through a network retail pharmacy that offers an extended supply. If you're traveling outside of your plan's service area but within the United States and territories and become ill, or run out of your prescription drugs, call Member Services to find a network pharmacy in your area where you can fill your prescription. If a network pharmacy is not available, we will cover prescriptions that are filled at an out-of-network pharmacy (up to a 30-day supply) if you follow all other coverage rules identified within this document. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription.
  - **If the prescription is covered, it will be covered at an out-of-network rate.** You may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. You can ask us to reimburse you for our

share of the cost by submitting a paper claim form. (Chapter 7, Section 2 explains how to ask our plan to pay you back.)

– **Please recognize, however, that multiple non-emergency occurrences of out-of-network pharmacy claims will result in claim denials. In addition, we cannot pay for any stolen medications or prescriptions that are filled by pharmacies outside the United States and territories, even for a medical emergency, for example on a cruise ship when outside of the United States.**

There are other times you can get your prescription covered if you go to an out-of-network pharmacy.

These situations will be covered at an out-of-network rate. In these situations, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If you go to an out-of-network pharmacy or provider, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2 explains how to ask our plan to pay you back.) We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- You can't get a covered drug that you need immediately because there are no open in-network pharmacies within a reasonable driving distance.
- Your prescription is for a specialty drug in-network pharmacies don't usually keep in stock.
- You were eligible for Medicaid at the time you got the prescription, even if you weren't enrolled yet. This is called retroactive enrollment.
- You're evacuated from your home because of a state, federal, or public health emergency and don't have access to an in-network pharmacy.
- If you get a covered prescription drug from an institutional-based pharmacy while a patient in an emergency room, provider-based clinic, outpatient surgery clinic, or other outpatient setting.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be in our plan's Drug Guide

Section 3.1 The Drug Guide tells which Part D drugs are covered

Our plan has a Prescription Drug Guide (formulary). In this Evidence of Coverage, **we call it the Drug Guide.**

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug Guide only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs may be covered under your Medicaid benefits. For information about prescription drugs covered only by Medicaid, contact Florida Medicaid at the phone number in "Exhibit A" of this document.

We generally cover a drug in our plan's Drug Guide as long as you follow the other coverage rules explained in this chapter and use of the drug for a medically accepted indication. A medically accepted indication is a use of the drug that's either:

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug Guide includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug Guide, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of the types of drugs that may be on the Drug Guide.

Over-the-counter drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services at 800-794-5907 (TTY users call 711).

Drugs that aren't in the Drug Guide

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug in the Drug Guide.
- In some cases, you may be able to get a drug that isn't in our Drug Guide. (For more information, go to Chapter 9.)

Section 3.2 Five (5) cost-sharing tiers for drugs in the Drug Guide

Every drug in our plan's Drug Guide is in one of Five (5) cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- **Cost-Sharing Tier 1 – Preferred Generic:** Generic or brand drugs that are available at the lowest cost share for this plan

- **Cost-Sharing Tier 2 – Generic:** Generic or brand drugs that our plan offers at a higher cost to you than Tier 1 Preferred Generic drugs
- **Cost-Sharing Tier 3 – Preferred Brand:** Generic or brand drugs that our plan offers at a lower cost to you than Tier 4 Non-Preferred Drug drugs
- **Cost-Sharing Tier 4 – Non-Preferred Drug:** Generic or brand drugs that our plan offers at a higher cost to you than Tier 3 Preferred Brand drugs
- **Cost-Sharing Tier 5 – Specialty Tier:** Some injectables and other high-cost drugs

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug Guide. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is in the Drug Guide

To find out if a drug is in our Drug Guide, you have these options:

- Check the most recent Drug Guide we provided electronically. (The Drug Guide includes information for the covered drugs most commonly used by our members. We cover additional drugs that aren't included in the Drug Guide. If one of your drugs isn't listed in the Drug Guide, visit our website or call Member Services at 800-794-5907 (TTY users call 711) to find out if we cover it.)
- Visit our plan's website (**CarePlusHealthPlans.com/DrugGuide**). The Drug Guide on the website is always the most current.
- Call Member Services at 800-794-5907 (TTY users call 711) to find out if a particular drug is on our plan's Drug Guide or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (**CarePlusHealthPlans.com/MyPlan**) to search for drugs on the Drug Guide to get an estimate of what you'll pay and see if there are alternative drugs on the Drug Guide that could treat the same condition. You can also call Member Services at 800-794-5907 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug Guide.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug Guide. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your healthcare provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 800-794-5907 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception**. We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 800-794-5907 (TTY users call 711) or on our website at **CarePlusHealthPlans.com/PAL**.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at 800-794-5907 (TTY users call 711) or on our website at **CarePlusHealthPlans.com/PAL**.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't in our Drug Guide or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't in the Drug Guide or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.

- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be in our plan's Drug Guide** OR **is now restricted in some way.**

- **If you're a new member,** we'll cover a temporary supply of your drug during the first 90 days of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who have been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

  Transition Supply for Current Members with changes in treatment setting: If the setting where you receive treatment changes during our plan year, you may need a short-term supply of your drugs during the transition. For example:

  – You're discharged from a hospital or skilled nursing facility (where your Medicare Part A payments include drug costs) and need a prescription from a pharmacy to continue taking a drug at home (using your Part D plan benefit); or

  – You transfer from one skilled nursing facility to another.

  If you do change treatment settings and need to fill a prescription at a pharmacy, we'll cover up to a 31-day supply of a drug covered by Medicare Part D, so your drug treatment won't be interrupted.

  If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization for continued coverage of your drug.

  Policies for Temporary Drug Supplies During the Transition Period

  We consider the first 90 days of the 2027 plan year a transition period if you're a new member, you changed plans, or there were changes in your drug coverage. As described above, there are several ways we make sure you can get a temporary supply of your drugs, if needed, during the transition period.

  During the first 90 days, you can get a temporary supply if you have a current prescription for a drug that's not in our Drug Guide or requires prior authorization because of restrictions. The conditions for getting a temporary supply are described below.

One-Time Transition Supply at a Retail or Mail-Order Pharmacy

We'll cover up to a 30-day supply of a drug covered by Medicare Part D. While you have your temporary supply, talk to your doctor about what to do after you use the temporary supply. You may be able to switch to a covered drug that would work just as well for you. You and your doctor can request an exception if you believe it's medically necessary to continue the same drug.

Transition Supply if you're in a Long-Term Care Facility

We'll cover up to a 31-day supply of a drug covered by Medicare Part D. This coverage is available anytime during the 90 day transition period, as long as your current prescription is filled at a pharmacy in a long-term care facility.

If you have a problem getting a prescribed drug later in our plan year (after the 90 day transition period), we'll cover up to a 31-day emergency supply of a drug covered by Medicare Part D. The emergency supply will let you continue your drug treatment while you and your doctor request an exception or prior authorization to continue.

Transition Period Extension

If you have requested an exception or made an appeal for drug coverage, it may be possible to extend the temporary transition period while we're processing your request. Call Member Services (phone numbers are printed on the inside back cover of this document) if you believe we need to extend the transition period to make sure you continue to receive your drugs as needed.

Costs for Temporary Supplies

Your copayment or coinsurance for a temporary drug supply will be based on your plan's approved drug cost-sharing tiers. If you receive Extra Help in 2027, your copayment or coinsurance won't exceed your Low Income Subsidy amount.

For questions about a temporary supply, call Member Services at 800-794-5907 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan that may work just as well for you. Call Member Services at 800-794-5907 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it's not in our plan's Drug Guide. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we'll authorize coverage for the drug before the change takes effect.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 800-794-5907 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 for what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Cost-Sharing Tier 5 - Specialty Tier aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug Guide can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug Guide. For example, our plan might:

- **Add or remove drugs from the Drug Guide**.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change our plan's Drug Guide.

Information on changes to drug coverage

When changes to the Drug Guide occur, we post information on our website about those changes. We also update our online Drug Guide regularly. Sometimes you'll get direct notice if changes were made for a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug Guide *and* immediately removing or making changes to a like drug in the Drug Guide.**
  - We may immediately remove a like drug from the Drug Guide, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these immediate changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug Guide.
  - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug Guide and removing or making changes to a like drug in the Drug Guide.**
  - When adding another version of a drug to the Drug Guide, we may remove a like drug from the Drug Guide, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug Guide.
  - We'll tell you at least 30 days before we make the change or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs in the Drug Guide that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug Guide. If you're taking that drug, we'll tell you after we make the change.
- **Making other changes to drugs in the Drug Guide.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we may make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you take.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or ask for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug Guide that don't affect you during this plan year

We may make certain changes to the Drug Guide that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug Guide.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug Guide for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are excluded. This means Medicare doesn't pay for these drugs.

If you appeal and the drug asked for is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover off-label use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. Off-label use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren't covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. Please contact Florida Medicaid for more information. Contact information for Florida Medicaid can be found in "Exhibit A" in the back of this document.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain

- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in "Exhibit A" in the back of this document.)

SECTION 8 How to fill a prescription

To fill your prescription, provide both our plan membership information and your Florida Medicaid membership information, which can be found on your membership cards, at the network pharmacy you choose. The network pharmacy will automatically bill our plan for our share of the costs of your drug. You'll need to pay the pharmacy your share of the cost when you pick up your prescription.

Be sure to show your Florida Medicaid ID card in addition to your CareNeeds Platinum (HMO D-SNP) membership card to make your provider aware that you may have additional coverage.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your Provider Directory (**CarePlusHealthPlans.com/FindCare**) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, contact Member Services at 800-794-5907 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that isn't in our Drug Guide or is restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also get drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be secondary to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that your plan has drug coverage that's expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time

- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we'll work with your provider to correct the problem.

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioids or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) and other programs to help members manage medications

We have programs that can help our members with complex health needs. One program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your

medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For any questions about these programs, please contact Member Services at 800-794-5907 (TTY users call 711).

CHAPTER 6: What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (**CarePlusHealthPlans.com/MyPlan**), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided in the "Real-Time Benefit Tool" by calling Member Services at 800-794-5907 (TTY users call 711).

How can you get information about your drug costs if you're getting Extra Help with your Part D prescription drug costs?

Most of our members qualify for and are getting Extra Help from Medicare to pay for their prescription drug plan costs. If you get Extra Help, **some information in this** Evidence of Coverage **about the costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, call Member Services at 800-794-5907 (TTY users call 711) and ask for the LIS Rider.

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they're for covered Part D drugs and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of **$2,400** in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>aren't included</u> in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments you make toward drugs not normally covered in a Medicare Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all of your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 800-794-5907 (TTY users call 711).

Tracking your out-of-pocket total costs

- The SmartSummary® report you get includes the current total of your out-of-pocket costs. When this amount reaches **$2,400**, the SmartSummary® will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for CareNeeds Platinum (HMO D-SNP) members

There are **3 drug payment stages** for your drug coverage under CareNeeds Platinum (HMO D-SNP). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *SmartSummary*® explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, and charities.
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a SmartSummary. The SmartSummary includes:

- **Information for that month**. This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.

- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you**. Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the SmartSummary, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Member Services at 800-794-5907 (TTY users call 711). Be sure to keep these reports.

SECTION 4 The Deductible Stage

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage doesn't apply to most members. If you get Extra Help, this payment stage doesn't apply to you.

Look at the separate insert (the LIS Rider) for information about your deductible amount.

If you don't get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. You'll pay a yearly deductible of **$700** on Cost-Sharing Tier 4 and Cost-Sharing Tier 5 drugs. **You must pay the full cost of your Cost-Sharing Tier 4 and Cost-Sharing Tier 5 drugs** until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost

cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay **$700** for your Cost-Sharing Tier 4 and Cost-Sharing Tier 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has Five (5) cost-sharing tiers

Every drug in our plan's Drug Guide is in one of Five (5) cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Cost-Sharing Tier 1 - Preferred Generic:** Generic or brand drugs that are available at the lowest cost-share for this plan.
- **Cost-Sharing Tier 2 - Generic:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Preferred Generic drugs.
- **Cost-Sharing Tier 3 - Preferred Brand:** Generic or brand drugs that the plan offers at a lower cost to you than Tier 4 Non-Preferred Drug drugs.
- **Cost-Sharing Tier 4 - Non-Preferred Drug:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 3 Preferred Brand drugs.
- **Cost-Sharing Tier 5 - Specialty Tier:** Some injectables and other high-cost drugs.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug Guide.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy
- Our plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's Provider Directory (**CarePlusHealthPlans.com/Directories**).

Section 5.2 Your costs for a *one-month* supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *one-month* supply of a covered Part D drug

Tier	Retail cost sharing (in-network) (up to a 30-day supply)	Standard mail-order cost sharing (in-network) (up to a 30-day supply)	Preferred mail-order cost sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost sharing (in-network) (up to a 31-day supply)	*Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 Preferred Generic	**$0**	**$10**	**$0**	**$0**	**$0**
Cost-Sharing Tier 1 Insulins	**$0**	**25% up to $10**	**$0**	**$0**	**$0**
Cost-Sharing Tier 2 Generic	**$0**	**$20**	**$0**	**$0**	**$0**
Cost-Sharing Tier 2 Insulins	**$0**	**16% up to $20**	**$0**	**$0**	**$0**
Cost-Sharing Tier 3 Preferred Brand	**17%**	**17%**	**17%**	**17%**	**17%**
Cost-Sharing Tier 3 Insulins	**17% up to $35**	**17% up to $35**	**17% up to $35**	**17% up to $35**	**17% up to $35**
Cost-Sharing Tier 4 Non-Preferred Drug	**41%**	**41%**	**41%**	**41%**	**41%**

Tier	Retail cost sharing (in-network) (up to a 30-day supply)	Standard mail-order cost sharing (in-network) (up to a 30-day supply)	Preferred mail-order cost sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost sharing (in-network) (up to a 31-day supply)	*Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 4 Insulins	**25% up to $35**	**25% up to $35**	**25% up to $35**	**25% up to $35**	**25% up to $35**
Cost-Sharing Tier 5 Specialty Tier	**25%**	**25%**	**25%**	**25%**	**25%**
Cost-Sharing Tier 5 Insulins	**25% up to $35**	**25% up to $35**	**25% up to $35**	**25% up to $35**	**25% up to $35**
*You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy. Please see Chapter 5, Section 2.4 for more information on using a pharmacy that's not in our plan's network.					

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

Go to Section 8 for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you plan refill dates better.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a

100-day supply.

Specialty drugs or other drugs deemed ineligible by the plan do not qualify for an extended supply. Please see your Drug Guide to find out what drugs are restricted.

Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

Tier	Retail cost sharing (in-network) (up to a 100-day supply)	Standard mail-order cost sharing (in-network) (up to a 100-day supply)	Preferred mail-order cost sharing (in-network) (up to a 100-day supply)
Cost-Sharing Tier 1 Preferred Generic	**$0**	**$30**	**$0**
Cost-Sharing Tier 1 Insulins	**$0**	**25% up to $30**	**$0**
Cost-Sharing Tier 2 Generic	**$0**	**$60**	**$0**
Cost-Sharing Tier 2 Insulins	**$0**	**16% up to $60**	**$0**
Cost-Sharing Tier 3 Preferred Brand	**17%**	**17%**	**17%**
Cost-Sharing Tier 3 Insulins	**17% up to $105**	**17% up to $105**	**17% up to $105**
Cost-Sharing Tier 4 Non-Preferred Drug	**41%**	**41%**	**41%**
Cost-Sharing Tier 4 Insulins	**25% up to $105**	**25% up to $105**	**25% up to $105**
Cost-Sharing Tier 5 Specialty Tier	A long-term supply is not available for drugs in Tier 5.		

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

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,400**. You then move to the Catastrophic Coverage Stage.

The SmartSummary that you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the **$2,400** out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the **$2,400** limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your Part D covered drugs.

SECTION 7 Additional benefits information

If you are eligible for Medicaid benefits, we may provide additional coverage for select prescription drugs not normally covered in a Medicare prescription drug plan.

Please refer to your Drug Guide for information about coverage of additional prescription drugs or call Member Services if you have any questions.

SECTION 8 What you pay for Part D Vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug Guide. Our plan covers most adult Part D vaccines at no cost to you, even if you haven't paid your deductible. Go to our plan's Drug Guide or call Member Services at 800-794-5907 (TTY users call 711) for coverage and cost -sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy, or a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times, when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

CHAPTER 7:
Asking us to pay our share of a bill for covered medical services or drugs

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Our network providers bill our plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you got, you should send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we'll pay the provider directly.

If you already paid for a Medicare service or item covered by our plan, you can ask our plan to pay you back (paying you back is often called **reimburse** you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

If you're cost-share protected by Florida Medicaid, see Chapter 4 Section 1.1 for more information on Medicare cost share protection from Medicaid.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got emergency or urgently needed medical care from a provider who's not in our plan's network**

   - You can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you made.
     - If the provider is owed anything, we'll pay the provider directly.

– If you already paid more than your share of the cost for the service, we'll determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly. But sometimes they make mistakes and ask you to pay more than your share of the cost.

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges. We don't allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made. Ask us to pay you back for the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to fill a prescription

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn more about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our plan membership card with you

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be in our plan's Drug Guide (Formulary) or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your Part C (medical and dental) claim to us within 365 days** of the date you got the service, item, or Part B drug. **You must submit your Part D (prescription drug) claim to us within 36 months** of the date you got the drug.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it'll help us process the information faster. The data we need to make a decision are listed below. Because we might need other information to make a reimbursement determination in some cases, we strongly encourage you to provide any other information you can to support your request.
  - Your name and the member ID from your CarePlus ID card
  - Your receipt or other proof of your payment
  - An itemized statement from the provider showing the services provided that includes the following information. If the information is not included on the provider's itemized statement, you will need to contact the provider to request it.
    - Date(s) of service for those services provided
    - Provider or supplier's name, address, National Provider Identifier (NPI), and Tax ID Number (TIN)
    - If a different provider ordered the service or referred you to the rendering provider, the name, address, NPI and TIN for the ordering/referring provider
    - Description of each service or supply provided, and the following service codes:
      - Revenue code(s), if applicable
      - Relevant CPT and HCPCS code(s)
    - Charge for each service provided
    - Description of illness or injury and diagnosis code(s)
    - Place of treatment
  - Your, or your legal representative's signature

- Download a copy of the form from our website (**CarePlusHealthPlans.com/Members**) or call Member Services at 800-794-5907 (TTY users call 711) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Requests for payment - Medical Care
CarePlus Health Plans, Inc.
Attention: Direct Member Reimbursement
P.O. Box 14601
Lexington, KY 40512-4601

Requests for payment - Dental Services
HumanaDental for CarePlus
P.O. Box 14611
Lexington, KY 40512-4611

Requests for payment for Part D drugs
CarePlus Health Plans, Inc.
Attention: Direct Member Reimbursement
P.O. Box 14140
Lexington, KY 40512-4140

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost for the service or drug. If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we won't pay for our share of the cost of the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 800-794-5907 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive healthcare services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with CarePlus Health Plans, Inc., Member Services Department at 800-794-5907, TTY 711. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Sección 1.1 Debemos proveer la información de una manera que a usted le resulte útil y en conformidad con su sensibilidad cultural (en idiomas que no sean inglés, en Braille, en texto con letras grandes u otros formatos alternativos, etc.)

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de manera competente desde el punto de vista cultural y sean accesibles para todos los afiliados, incluidos aquellos con dominio limitado del inglés, habilidades de lectura limitadas, incapacidad auditiva o aquellos con orígenes culturales y étnicos diversos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre

otros, la prestación de servicios de traducción, servicios de interpretación, telemáquinas de escribir o conexión TTY (teléfono de texto o teléfono de telemáquina).

Nuestro plan cuenta con servicios gratuitos de intérpretes disponibles para responder preguntas de afiliados que no hablan inglés. También podemos darle información en braille, en letra grande o en otros formatos alternativos sin costo en caso de ser necesario. Se nos exige darle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de parte de nosotros de una forma que se ajuste a sus necesidades, llame a Servicios para Afiliados.

Nuestro plan debe brindarles a las mujeres inscritas la opción de acceso directo a un especialista en salud femenina dentro de la red para servicios de cuidado de la salud preventivos y de rutina para mujeres.

Si no hay disponibles proveedores de la red del plan para una especialidad, es responsabilidad del plan localizar proveedores especializados fuera de la red que le proporcionen el cuidado necesario. En este caso, solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la cual no hay especialistas en la red del plan que cubran un servicio que usted necesita, llame al plan para obtener información sobre dónde ir para obtener este servicio al costo compartido dentro de la red.

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar una queja formal ante el Departamento de Servicios para Afiliados de CarePlus Health Plans, Inc. al 800-794-5907, TTY 711. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from our plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a Notice of Privacy Practice, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you or someone you've given legal power to make decisions for you first.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you're a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held at our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at 800-794-5907 (TTY users call 711).

Insurance ACE Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You do not need to do anything unless you have a request or complaint.
This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at **https://huma.na/insuranceace**.

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is nonpublic personal or health information?
Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term "information" in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information

relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we collect information about you?
We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?
The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

How do we protect your information?
We have a responsibility to protect the privacy of your information in all formats including electronic and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:
- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

How do we use and disclose your information?
We use and disclose your information:
- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:
- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment, and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends, if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your health-care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.

- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Additional restrictions on use and disclosure for specific types of information:
- Some federal and state laws may restrict the use and disclosure of certain sensitive health information such as: Substance Use Disorder ("SUD") subject to 42 CFR Part 2 ("Part 2") records; Biometric Information; Child or Adult Abuse or Neglect, including Sexual Assault; Communicable Diseases; Genetic Information; HIV/AIDS; Mental Health; Reproductive Health; and Sexually Transmitted Diseases.
- If we receive SUD Part 2 records, we will not use or disclose such records, or provide testimony relaying the content of such records, in any civil, criminal, administrative, or legislative proceeding against you unless such disclosure is based on your written consent (separate from your consent for any other use or disclosure), or a court order after notice and an opportunity to be heard is provided to you, as provided by Part 2. A court order authorizing the use or disclosure of SUD Part 2 Records must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Will we use your information for purposes not described in this notice?
We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing.
The following uses and disclosures will require your written permission:
- Most uses and disclosures of psychotherapy notes and SUD counseling notes
- Marketing purposes
- Sale of personal and health information
- Medical information that is disclosed pursuant to this Notice to an entity that is not a HIPAA-covered entity or business associate, may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws (such as HIPAA).

What do we do with your information when you are no longer a member?
Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?
We are committed to responding to your rights request in a timely manner
- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications - To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation.

- If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*
- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice - You have the right to request and receive a written copy of this notice any time.
- Restriction - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

*This right applies only to our Massachusetts residents in accordance with state regulations.

If I believe that my privacy has been violated, what should I do?
If you believe that your privacy has been violated, you may file a complaint with us by calling us at: **1-866-861-2762** any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also email your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected, and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

How do I exercise my rights or obtain a copy of this notice?
All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:
- Contacting us at 1-866-861-2762
- Accessing our website at **CarePlusHealthPlans.com/Privacy** and going to the Privacy Practices link
- Send completed request form to:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of CareNeeds Platinum (HMO D-SNP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services at 800-794-5907 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know about your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other healthcare providers. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your healthcare. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make healthcare decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance in these situations are called **advance directives.** Documents like a **living will** and **power of attorney for healthcare** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at 800-794-5907 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint with your state's Quality Improvement Organization (QIO). Contact information can be found in "Exhibit A" in the back of this document.

- **A right to make recommendations regarding the organization's member rights and responsibilities policy.**

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we made

At CarePlus, a process called Utilization Management (UM) is used to determine whether a service or treatment is covered and appropriate for payment under your benefit plan. CarePlus does not reward or provide financial incentives to doctors, other individuals or CarePlus employees for denying coverage or encouraging under use of services. In fact, CarePlus works with your doctors and other providers to help you get the most appropriate care for your medical condition. If you have questions or concerns related to Utilization Management, staff are available

at least eight hours a day during normal business hours. CarePlus has free language interpreter services available to answer questions related to Utilization Management from non-English speaking members. Contact Member Services at 800-794-5907 (TTY users call 711) for answers to these or any other questions you may have about your benefit plan.

CarePlus decides about coverage of new medical procedures and devices on an ongoing basis. This is done by checking peer-reviewed medical literature and consulting with medical experts to see if the new technology is effective and safe. CarePlus also relies on guidance from the Centers for Medicare & Medicaid Services (CMS), which often makes national coverage decisions for new medical procedures or devices.

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected and it's not about discrimination, you can get help dealing with the problem you're having from these places:

- **Call our plan's Member Services at 800-794-5907 (TTY users call 711).**
- **Call your local SHIP**. You'll find numbers and website URLs in Exhibit A in the back of this document.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048.)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 800-794-5907 (TTY users call 711).**
- **Call your local SHIP**. You'll find numbers and website URLs in Exhibit A in the back of this document.
- Contact **Medicare**.
  - Visit Medicare.gov to read the publication Medicare Rights & Protections (available at: Medicare Rights & Protections.)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048.)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 800-794-5907 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other healthcare providers that you're enrolled in our plan.** Show our plan membership card and your Medicaid card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must continue to pay your Medicare premiums to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan**.
- **If you move, tell Social Security (or the Railroad Retirement Board).**
- **A right to make recommendations regarding the organization's member rights and responsibilities policy.**

CHAPTER 9:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on 2 things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you'd like help deciding whether to use the Medicare process or the Medicaid process, or both, call Member Services at 800-794-5907 (TTY users call 711).

2. The type of problem you're having:

   - For some problems, you need to use the **process for coverage decisions and appeals**.

   - For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it’s sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We’re always available to help you. Even if you have a complaint about our treatment of you, we’re obligated to honor your right to complain. You should always call Member Services at 800-794-5907 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn’t connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP).

Each state has a government program with trained counselors. The program isn't connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you

should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Exhibit A at the end of this document.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- You visit Medicare.gov.

You can get help and information from Florida Medicaid

You will find contact information for Florida Medicaid in Exhibit A at the end of this booklet.

SECTION 3 Which process to use for your problem

Because you have Medicare and get help from Florida Medicaid, you have different processes you can use to handle your problem or complaint. Which process you use depends on if the problem is about Medicare benefits or Florida Medicaid benefits. If your problem is about a benefit covered by Medicare, use the Medicare process. If your problem is about a benefit covered by Florida Medicaid, use the Medicaid process. If you'd like help deciding whether to use the Medicare process or the Medicaid process, please contact Member Services at 800-794-5907 (TTY users call 711).

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

Is your problem about Medicare benefits or Medicaid benefits?	
My problem is about **Medicare** benefits. Go to **Section 4**, **Handling problems about your Medicare benefits.**	My problem is about **Medicaid** coverage. Go to **Section 12, Handling problems about your Medicaid benefits.**

SECTION 4 Handling problems about your Medicare benefits

Is your problem or concern about your benefits or coverage? This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.	
Yes. Go to **Section 5, A guide to coverage decisions and appeals.**	**No.** Go to **Section 11, How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Medicare Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuse to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under

certain circumstances, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7.

If you're not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services** at 800-794-5907 (TTY users call 711).
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services and ask for the Appointment of Representative form. (The form is also available on Medicare's website at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at CarePlusHealthPlans.com/representative.)
  - For medical care, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services at 800-794-5907 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also

available on Medicare's website at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at CarePlusHealthPlans.com/representative.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details about each of these situations:

- **Section 6:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 7:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 8:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 9:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (Applies only to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at 800-794-5907 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

   Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs.

- You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.
- **If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines
  - Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.

– Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 6.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.**
  Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.**

Step 3: We consider your appeal, and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.

- If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
- If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, go to **Section 11**.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 6.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests.** For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug,** we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization. **For expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.

- **If the independent review organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage you're requesting meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 explains the Level 3, 4, and 5 appeals processes.

Section 6.5 If you're asking us to pay you back for our share of a bill you got for medical care

We can't reimburse you directly for a Medicaid service or item. If you get a bill that's more than your copay for Medicaid-covered services and items, send the bill to us. **Don't pay the bill yourself.** We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that healthcare provider if you followed the rules for getting the service or item.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care isn't covered, or you did not follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating covered outpatient prescription drug or Part D drug every time. We also use the term Drug Guide instead of List of Covered Drugs or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not in our plan's Drug Guide. **Ask for an exception. Section 7.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 7.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**

- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not in the Drug Guide is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not in our Drug Guide**. If we agree to cover a drug that isn't in the Drug Guide, you'll need to pay the cost-sharing amount that applies to drugs in Cost-Sharing Tier 4 – Non-Preferred Drug. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug Guide.

2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Prescription Drug Guide. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug in our Drug Guide is in one of Five (5) cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.

    - If our Drug Guide contains alternative drug(s) for treating your medical condition that is in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.

    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

- You can't ask us to change the cost-sharing tier for any drug in Cost-Sharing Tier 5 – Specialty Tier.
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug Guide typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're requesting and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally **won't** approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 How to ask for a coverage decision, including an exception

Legal Term:

A fast coverage decision is called an **expedited coverage determination.**

<u>Step 1:</u> Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which is available on our website. Chapter 2 has contact information. To submit a coverage determination request online, please go to: **CarePlusHealthPlans.com/RxDecisions.** This page of our website describes the processes for requesting coverage decisions and appealing our decisions. It also includes links to downloadable and printable Coverage Determination Request Forms, in English and Spanish, with instructions for faxing and mailing your requests. There is also a link to submit your request online if you want to submit your request electronically. Just click on the link to complete the online form and follow the directions on each page. If you have questions or need help, contact Member Services at the number on the back of your Member ID card. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 5.1 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're requesting an exception, provide the supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.

- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

<u>Step 4:</u> If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 7.5 How to make a Level 1 appeal

Legal Terms:

An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.**

A fast appeal is also called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision, we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at 800-451-4651, TTY: 711**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Redetermination Request Form, which is available on our website **CarePlusHealthPlans.com/RxDecisions**. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we have agreed to provide within 72 hours after we get your appeal.

- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 How to make a Level 2 appeal

Legal Term

The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the independent review entity. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

- ***For fast appeals:***
  - **If the independent review organization says yes to part or all of what you asked for,** we must **provide the drug coverage** that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.
- ***For standard appeals:***
  - **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.

– **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If the independent review organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go to Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 explains the Level 3, 4, and 5 appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice. If you don't get the

notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 800-794-5907 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to ask for **an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows only that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 800-794-5907 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 800-794-5907 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Contact information for your SHIP can be found in “Exhibit A” in the back of this document.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other healthcare professionals who are paid by the federal government to check on and help improve

the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (An Important Message from Medicare About Your Rights) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than midnight the day of your discharge**.
  - **If you meet this deadline**, you can stay in the hospital after your discharge date without paying for it while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, you may have to pay all the costs for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 800-794-5907 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users call 1-877-486-2048.) Or you can get a sample notice online at CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you’ll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says no, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says no to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said no to your appeal, and you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to **Level 2** of the appeals process.

Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ends.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, we'll stop paying our share of the cost for your care.

If you think we're ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 9.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows only that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 800-794-5907 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Contact information for your SHIP can be found in "Exhibit A" in the back of this document.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. **The Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you got (Notice of Medicare Non-Coverage) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.)

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.

- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the Detailed Explanation of Non-Coverage from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say no, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say no to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said no to your Level 1 appeal. You could ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you have got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2 (for a total of 5 levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Levels 3, 4 and 5

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge or an attorney adjudicator** who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide not to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that's favorable to you. We'll decide whether to appeal this decision to Level 5.
  - If we decide not to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is only used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? – Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all about the timeliness of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms:

- A **complaint** is also called a **grievance.**
- **Making a complaint** is called **filing a grievance.**
- **Using the process for complaints** is called **using the process for filing a grievance.**
- A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services** at 800-794-5907 (TTY users call 711) **is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **Grievance Filing Instructions**

  File a verbal grievance by calling Member Services at 800-794-5907 (TTY: 711).

  Send a written grievance to:
  Complaints about Medical Care or Part D drugs:
  CarePlus Grievances and Appeals Dept.
  P.O. Box 14165
  Lexington, KY 40512-4165

Complaints about Dental Services:
HumanaDental for CarePlus
P.O. Box 14165
Lexington, KY 40512-4165

When filing a grievance, please provide:
☐ Name
☐ Address
☐ Telephone number
☐ Member identification number
☐ A summary of the complaint and any previous contact with us related to the complaint
☐ The action you're requesting from us
☐ A signature from you or your authorized representative and the date. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the Appointment of Representative form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at CarePlusHealthPlans.com/representative.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you'd like to act on your behalf. You must give us a copy of the signed form.

- **Option for Fast Review of your Grievance**

  You may request a fast review, and we'll respond within 24 hours upon receipt, if your grievance concerns one of the following circumstances:

  – We've extended the timeframe for making an organization determination/reconsiderations, and you believe you need a decision faster. We can't take extra time to make a decision if your request is for a Part B drug.

  – We denied your request for a fast review of a 72-hour organization/coverage decision.

  – We denied your request for a fast review of a 72-hour appeal.

  It's best to call Member Services if you want to request fast review of your grievance. If you mail your request, we'll call you to let you know we received it.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.

- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about quality of care, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 11.4 You can also tell Medicare about your complaint

You can submit a complaint about CareNeeds Platinum (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

PROBLEMS ABOUT YOUR MEDICAID BENEFITS

SECTION 12 Handling problems about your Medicaid benefits

Is your problem or concern about your benefits or coverage?
(This includes problems about whether particular medical care is covered or not, the way in which the care is covered, and problems related to payment for medical care.)

Yes. My problem is about benefits or coverage.

Go on to **Section 12.1** of this chapter, **Step-by-step: How to request a State Fair Hearing for problems about benefits or coverage.**

No. My problem isn't about benefits or coverage.

Follow the Medicare process explained in **Section 11** of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns**.

Section 12.1 Step-by-step: How to request a State Fair Hearing for problems about benefits or coverage

If you are eligible for Florida Medicaid benefits and experience a problem getting the Medicaid benefits our plan covers for you, follow the steps below to have your appeal reviewed:

Step 1: To submit your appeal follow the Medicare appeal process explained in Section 6 of this chapter.

If your appeal is denied, you will receive a letter explaining why it was denied.

Step 2: Review the denial letter and decide if you want to move on to the next step, a State Fair Hearing. A State Fair Hearing is a state level review of your case and must be requested through the Agency for Health Care Administration (AHCA) Medicaid Hearing Unit. Instructions on how to request a State Fair Hearing are included in the denial letter.

You may request a State Fair Hearing if:

- **Your appeal was for a Medicaid-covered benefit listed in the Medical Benefits Chart in Chapter 4, and**
- **We denied the benefit because we said it was not medically necessary.**

Step 3: Follow the instructions in the denial letter for contacting the Agency for Health Care Administration (AHCA) Medicaid Hearing Unit. Either you or your designated representative may request a review of your case. You must make your request in writing 120 calendar days from the date listed on the plan's appeal decision letter.

If you receive services during your plan appeal and you qualify for a continuation of services, you may file a request for your services to continue no later than 10 calendar days from the date of the appeal decision letter. If you continue your services beyond the date you requested and the State Fair Hearing decision is not favorable, we may ask you to pay for these services.

Step 4: The State Fair Hearing Officer does a review of your appeal and gives you an answer.

The State Fair Hearing Officer will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

If you have additional questions about the State Fair Hearing process please contact AHCA at **1-877-254-1055 (Toll Free) (TDD 1-866-467-4970)** or email your questions to **MedicaidHearingUnit@ahca.myflorida.com**. You can also contact Member Services at the number on the back of your Member ID card.

CHAPTER 10: Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in CareNeeds Platinum (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you want to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare with a separate Medicare prescription drug plan
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. If you receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

- Call your Florida Medicaid at to learn about your Medicaid plan options (can be found in "Exhibit A" in the back of this document).
- Other Medicare health plan options are available during the **Open Enrollment Period.** Section 2.2 tells you more about the Open Enrollment Period.
- **Your membership will usually end on the first day of the month after we get your request to change your plan.** Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Open Enrollment Period

You can end your membership during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
  - Another Medicare health plan, with or without drug coverage.
  - Original Medicare with a separate Medicare drug plan.
  - Original Medicare without a separate Medicare drug plan.
  - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

You get Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will end in our plan when your new plan's coverage begins on January 1.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make one change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have Florida Medicaid
- If you're eligible for Extra Help with paying for your Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage,
- Original Medicare with a separate Medicare drug plan,
- Original Medicare without a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you get Extra Help from Medicare to pay for your drug coverage drugs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change your plan.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services** at 800-794-5907 (TTY users call 711)
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from CareNeeds Platinum (HMO D-SNP) when your new plan's coverage starts.
Original Medicare with a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from CareNeeds Platinum (HMO D-SNP) when your new plan's coverage starts.
Original Medicare without a separate Medicare drug plan	• **Send us a written request to disenroll.** Call Member Services at 800-794-5907 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from CareNeeds Platinum (HMO D-SNP) when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Florida Medicaid benefits, call Florida Medicaid. Contact information for Florida Medicaid can be found in "Exhibit A" in the back of this document. Ask how joining another plan or returning to Original Medicare affects how you get your Florida Medicaid coverage.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 CareNeeds Platinum (HMO D-SNP) must end your plan membership in certain situations

CareNeeds Platinum (HMO D-SNP) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. If you are no longer eligible for the plan, your membership will end after a 6 month grace period. You will receive a letter explaining that we must disenroll you from our plan if you do not regain your eligibility for Florida Medicaid assistance within the grace period.
- If you don't pay your medical spenddown, if applicable
- If you move out of our service area
- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Member Services at 800-794-5907 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you lie or withhold information about other insurance you have that provides drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Member Services at 800-794-5907 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

CareNeeds Platinum (HMO D-SNP) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this Evidence of Coverage document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Member Services at 800-794-5907 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, CareNeeds Platinum (HMO D-SNP), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Additional Notice about Subrogation (Recovery from a Third Party)

Our right to recover payment

If we pay a claim for you, we have subrogation rights. This is a very common insurance provision that means we have the right to recover the amount we paid for your claim from any third party that is responsible for the medical

expenses or benefits related to your injury, illness, or condition. You assign to us your right to take legal action against any responsible third party, and you agree to:

1. Provide any relevant information that we request; and
2. Participate in any phase of legal action, such as discovery, depositions, and trial testimony, if needed.

If you don't cooperate with us or our representatives, or you do anything that interferes with our rights, we may take legal action against you. You also agree not to assign your right to take legal action to someone else without our written consent.

Our right of reimbursement

We also have the right to be reimbursed if a responsible third party pays you directly. If you receive any amount as a judgment, settlement, or other payment from any third party, you must immediately reimburse us, up to the amount we paid for your claim.

Our rights take priority

Our rights of recovery and reimbursement have priority over other claims, and will not be affected by any equitable doctrine. This means that we're entitled to recover the amount we paid, even if you haven't been compensated by the responsible third party for all costs related to your injury or illness. If you disagree with our efforts to recover payment, you have the right to appeal, as explained in Chapter 9.

We are not obligated to pursue reimbursement or take legal action against a third party, either for our own benefit or on your behalf. Our rights under Medicare law and this Evidence of Coverage will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition.

SECTION 5 How Medicare Works with Other Insurance

Why do we need to know if you have other coverage?

We coordinate benefits in accordance with the Medicare Secondary Payer rules, which allow us to bill, or authorize a provider of services to bill, other insurance carriers, plans, policies, employers, or other entities when the other payer is responsible for payment of services provided to you. We are also authorized to charge or bill you for amounts the other payer has already paid to you for such services. We shall have all the rights accorded to the Medicare Program under the Medicare Secondary Payer rules.

Who pays first when you have other coverage?

When you have additional coverage, how we coordinate your coverage depends on your situation. With coordination of benefits, you will often get your care as usual through our plan providers, and the other plan or plans you have will simply help pay for the care you receive. If you have group health coverage, you may be able to maximize the benefits available to you if you use providers who participate in your group plan **and** our plan. In other situations, such as for benefits that are not covered by our plan, you may get your care outside of our plan.

Employer and employee organization group health plans

Sometimes, a group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You have coverage under a group health plan (including both employer and employee organization plans), either directly or through your spouse, and
- The employer has twenty (20) or more employees (as determined by Medicare rules), and
- You are not covered by Medicare due to disability or End-Stage Renal Disease (ESRD).

If the employer has fewer than twenty (20) employees, generally we will provide your primary health benefits. If you have retiree coverage under a group health plan, either directly or through your spouse, generally we will provide primary health benefits. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people who are disabled

If you have coverage under a group health plan, and you have Medicare because you are disabled, generally we will provide your primary health benefits. This happens if:

- You are under age 65, and
- You do not have ESRD, and
- You do not have coverage directly or through your spouse under a large group health plan.

A large group health plan is a health plan offered by an employer with 100 or more employees, or by an employer who is part of a multiple-employer plan where any employer participating in the plan has 100 or more employees. If you have coverage under a large group health plan, either directly or through your spouse, your large group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You do not have ESRD, and
- Are under age 65 and have Medicare based on a disability.

In such cases, we will provide only those benefits not covered by your large employer group plan. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people with End-Stage Renal Disease (ESRD)

If you are or become eligible for Medicare because of ESRD and have coverage under an employer or employee organization group health plan, either directly or through your spouse, your group health plan is responsible for providing primary health benefits to you for the first thirty (30) months after you become eligible for Medicare due to your ESRD. We will provide secondary coverage to you during this time, and we will provide primary coverage to you thereafter. If you are already on Medicare because of age or disability when you develop ESRD, we will provide primary coverage.

Workers' Compensation and similar programs

If you have suffered a job-related illness or injury and workers' compensation benefits are available to you, workers' compensation must provide its benefits first for any healthcare costs related to your job-related illness or injury before we will provide any benefits under this Evidence of Coverage for services rendered in connection with your job-related illness or injury.

Accidents and injuries

The Medicare Secondary Payer rules apply if you have been in an accident or suffered an injury. If benefits under "Med Pay," no-fault, automobile, accident, or liability coverage are available to you, the "Med Pay," no-fault, automobile, accident, or liability coverage carrier must provide its benefits first for any healthcare costs related to the accident or injury before we will provide any benefits for services related to your accident or injury.

Liability insurance claims are often not settled promptly. We may make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In these situations, our payments are conditional. Conditional payments must be refunded to us upon receipt of the insurance or liability payment.

If you recover from a third party for medical expenses, we are entitled to recovery of payments we have made without regard to any settlement agreement stipulations. Stipulations that the settlement does not include damages for medical expenses will be disregarded. We will recognize allocations of liability payments to non-medical losses only when payment is based on a court order on the merits of the case. We will not seek recovery from any portion of an award that is appropriately designated by the court as payment for losses other than medical services (e.g., property losses).

Where we provide benefits in the form of services, we shall be entitled to reimbursement on the basis of the reasonable value of the benefits provided.

Non-duplication of benefits

We will not duplicate any benefits or payments you receive under any automobile, accident, liability, or other coverage. You agree to notify us when such coverage is available to you, and it is your responsibility to take any actions necessary to receive benefits or payments under such automobile, accident, liability, or other coverage. We may seek reimbursement of the reasonable value of any benefits we have provided in the event that we have duplicated benefits to which you are entitled under such coverage. You are obligated to cooperate with us in obtaining payment from any automobile, accident, or liability coverage or other carrier.

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to section 4 of this chapter, **Additional Notice about Subrogation (Recovery from a Third Party)** for more information on our recovery rights.

More information

This is just a brief summary. Whether we pay first or second - or at all - depends on what types of additional insurance you have and the Medicare rules that apply to your situation. For more information, consult the brochure published by the government called "Medicare & Other Health Benefits: Your Guide to Who Pays First." It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the Code of Federal Regulations.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints) in this Evidence of Coverage.

CHAPTER 12: Definitions

Advanced Imaging Services – Specialized imaging method that takes more detailed images than standard X-rays. There are several kinds of imaging services, including Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan or other similar technology.

Allowed Amount – The maximum amount a plan will pay for a healthcare benefit.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you are getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of CareNeeds Platinum (HMO D-SNP), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars.(Go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See **"Interchangeable Biosimilar"**).

Brand Name Drug – A prescription drug that's manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Care Plan – A plan for what services you'll get and how you'll get them. Your plan may include medical services and behavioral health services, and other services.

CarePlus' National Transplant Network (NTN) – A network of CarePlus- and Medicare-approved transplant facilities/centers.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent **$2,400** for Part D covered drugs during the covered year. During this payment stage, you pay nothing for our covered Part D drugs.
Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used only for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Oral Exam/Evaluation – This is when a general dentist and/or dental specialist examines the patient. It applies to: new patients, established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have not had active treatment for three or more years.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Computed Tomography Imaging (CT/CAT) Scan – Combines the use of a digital computer together with a rotating X-ray device to create detailed cross-sectional images of different organs and body parts.

Contracted Rate – The rate the health plan pays to an in-network provider or pharmacy for covered services or prescription drugs.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of Five (5) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Diagnostic Mammogram – A specialized X-ray exam given to a patient who shows signs or symptoms of breast disease.

Diagnostic Procedure – An exam to identify a patient's strengths and weaknesses in a specific area, in order to find out more about their condition, disease, or illness.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that's ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Formulary – A document that lists all prescription drugs covered by a plan.

Freestanding Dialysis Center – A licensed health facility, other than a hospital, that provides dialysis treatment with no overnight stay.

Freestanding Lab – A licensed health facility, other than a hospital, that provides lab tests to prevent, identify, or treat an injury or illness, with no overnight stay.

Freestanding Radiology (Imaging) Center – A licensed health facility, other than a hospital, that provides one or more of the following services to prevent, identify, or treat an injury or illness, with no overnight stay: X-rays; nuclear medicine; radiation oncology (including MRIs, CT scans and PET scans).

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Health Risk Assessment – A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Health Maintenance Organization (HMO) – A type of health insurance plan where members must receive care from the plan's network of doctors, hospitals, and other health care providers.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services given to a patient in their own home for the treatment of an illness or injury. Covered services are listed in Chapter 4, Medical Benefits Chart under the heading, "Home health agency care." If you need home health care services, our plan will cover these services for you, provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your

geographic area. If you elect hospice and continue to pay premiums you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospice Care – Specialized care for people who are terminally ill, focused on comfort not cure. This also includes counseling for patients' families. Depending on the situation, this type of care may be in the home, a hospice facility, a hospital, or a nursing home, and is given by a team of licensed health professionals.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of people eligible for both Medicare and Medicaid. These people are also known as full-benefit dually eligible people.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug Guide) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Magnetic Resonance Angiography (MRA) – A noninvasive method and a form of magnetic resonance imaging (MRI) that can measure blood flow through blood vessels.

Magnetic Resonance Imaging (MRI) – A diagnostic imaging modality method that uses a magnetic field and computerized analysis of induced radio frequency signals to noninvasively image body tissue.

Mail-Order Pharmacy – A pharmacy that fills and sends prescriptions through the mail to the member's home.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for any late enrollment penalty, Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount. If you are eligible for Medicare cost-sharing assistance under Medicaid, you aren't responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. (**Note:** Because our members also get help from Florida Medicaid, very few members ever reach this out-of-pocket maximum.)

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that's either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel its plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage Organization – A private company that runs Medicare Advantage Plans to offer members more options, and sometimes extra benefits. Medicare Advantage plans are also called “Part C.” They provide all your Part A (Hospital) and Part B (Medical) coverage, and some may also provide Part D (prescription drug) coverage.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Allowable Charge – The most amount of money that can be charged for a particular medical service covered by Medicare. These are set amounts decided by Medicare.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare

Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan isn't a Medigap policy.)

Member (member of our plan, or plan member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network – See "Network Pharmacy" and "Network Provider."

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Nuclear Medicine – Radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function, or localizing disease or tumors.

Observation Services – Outpatient hospital services given to help the doctor decide if a patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital. Even if you stay overnight in a regular hospital bed, you might be an outpatient.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare or Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under

Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Our Plan – The plan you are enrolled in, CareNeeds Platinum (HMO D-SNP).

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Periodic Oral Exam – An exam done on established patients to determine changes in dental and health status since a previous periodic or comprehensive evaluation.

Periodontal Scaling and Root Planing – Scaling is a common dental procedure for patients with gum disease. This is a type of dental cleaning that reaches below the gumline to remove plaque buildup. The process of scaling and root planing the teeth is often referred to as a deep cleaning.

Plan Provider – See "Network Provider."

Positron Emission Tomography (PET) Scan – A medical imaging technique that involves injecting the patient with an isotope and using a PET scanner to detect the radiation emitted.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drug Guide (Formulary) – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prophylaxis (cleaning) – Removal of plaque, calculus, and stains from the tooth structures and implants in the permanent and transitional dentition. Prophylaxis is only for people who do not exhibit any of the signs and symptoms of periodontal disease, including bone loss, bleeding, mobility, exudate, and recession. Prophylaxis is, thus, a preventive procedure for patients who don't yet have periodontal disease and should only be used with patients who are periodontally healthy.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that's designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Radiology – X-rays and other specialized procedures that use high-energy radiation to identify and treat diseases.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Mammogram – A specialized X-ray procedure to find out early if a patient has breast cancer.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health and drug plans or return to Original Medicare due to certain events or changes in their life. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you. This is also referred to as a Special Election Period or "SEP."

Special Needs Plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgent Care Center – A licensed health facility where doctors and nurses provide services to identify and treat a sudden injury or illness, with no overnight stay.

Urgently Needed Services –A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Exhibit A- State Agency Contact Information

This section provides the contact information for the state agencies referenced in Chapter 2 and in other locations within this Evidence of Coverage. If you have trouble locating the information you seek, please contact Member Services at the phone number on the back cover of this booklet.

FLORIDA	
SHIP Name and Contact Information	Serving Health Insurance Needs of Elders (SHINE) Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000 800-963-5337 (toll free) 800-955-8770 (TTY) 850-414-2150 (fax) 800-963-5337 https://www.floridaSHINE.org
Quality Improvement Organization	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 888-317-0751 TTY 711 844-878-7921 (FAX) https://acentraqio.com/aboutus/contact/
State Medicaid Office	Florida Medicaid 2727 Mahan Drive Tallahassee, FL 32308-5407 888-419-3456 (toll free) 850-412-3600 (local) 850-922-2993 (fax) 800-955-8771 (TTY) https://ahca.myflorida.com
AIDS Drug Assistance Program	Florida AIDS Drug Assistance Program (ADAP) HIV/AIDS Section 4052 Bald Cypress Way Tallahassee, FL 32399 844-381-2327 800-545-7432 (Spanish) 800-243-7101 (Creole) 888-503-7118 (TTY) https://www.floridahealth.gov/individual-family-health/injury-prevention-wellness/hiv-aids/hiv-aids-management/

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. 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)**.

CarePlus HEALTH PLANS™

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

GHHNDN2026CP_ENG_0526

Notice of Availability - Auxiliary Aids and Services Notice

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 والتنسيق 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。

ភាសាខ្មែរ [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 hóló. **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**

Notes

CareNeeds Platinum (HMO D-SNP) Member Services

Method	Member Services – Contact Information
Call	800-794-5907 Calls to this number are free. 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. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
Write	CarePlus Health Plans, Inc. P.O. Box 14168 Lexington, KY 40512-4168
Website	**CarePlusHealthPlans.com/ContactUs**

State Health Insurance Assistance Program
The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Contact information for your SHIP can be found in "Exhibit A" in this document.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CarePlus Health Plans, Inc.
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Lexington, KY 40512-4168

Important Information

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