2024

Summary of Benefits

CareOne Platinum (HMO-POS)

Treasure Coast
Brevard and Indian River Counties

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

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-794-4105 (TTY: 711)**.

Understanding the Benefits

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

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

Let's talk about CareOne Platinum (HMO-POS)

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

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

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage on our website, **CarePlusHealthPlans.com/Plans**.

To be eligible

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

Plan name:

CareOne Platinum (HMO-POS)

How to reach us:

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

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

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

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

Or visit our website:

CarePlusHealthPlans.com/ContactUs

More about CareOne Platinum (HMO-POS)

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

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

As a member you must select an in-network doctor in your service area listed in this document to act as your Primary Care Provider (PCP). CareOne Platinum (HMO-POS) has a network of doctors, hospitals, pharmacies and other providers. However, this plan also covers certain services received from out-of-network providers within the plan's service area. If you use providers who aren't in our network, you may be subject to higher out-of-pocket costs.

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

CarePlus HEALTH PLANS

A healthy partnership

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

Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly plan premium	**$0** You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** deductible.
Maximum out-of-pocket responsibility	**$3,750** in-network **$3,750** combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL CARE		
Your plan covers an unlimited number of days for an inpatient stay.	**$100** copay per day for days 1-7 **$0** copay per day for days 8-90	**$120** copay per day for days 1-7 **$0** copay per day for days 8-90
OUTPATIENT HOSPITAL COVERAGE Services listed below may also be covered at other places of treatment. Please refer to specific services listed in this document for additional information.		
Advanced imaging services (MRI, MRA, PET and CT scan)	**$80** copay	**$100** copay
Basic radiological services (X-rays)	**$80** copay	**$100** copay
Cardiac rehabilitation services	**$10** copay	**$20** copay
Chemotherapy drugs	**20%** of the cost	**20%** of the cost
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic mammography	**$0** copay	**$0** copay
Diagnostic procedures and tests - other	**$80** copay	**$100** copay
Lab services	**$0** copay	**$0** copay
Medicare Part B covered drugs	**20%** of the cost	**20%** of the cost
Mental health services	**$10** copay	**$20** copay
Nuclear medicine services	**$80** copay	**$100** copay

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

CarePlus HEALTH PLANS

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Occupational therapy	**$10** copay	**$20** copay
Opioid treatment program services	**$10** copay	**$20** copay
Physical therapy	**$10** copay	**$20** copay
Pulmonary rehabilitation services	**$10** copay	**$20** copay
Renal dialysis services	**20%** of the cost	**20%** of the cost
Sleep study (facility based)	**$80** copay	**$100** copay
Speech therapy	**$10** copay	**$20** copay
Substance abuse care	**$10** copay	**$20** copay
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)	**$10** copay	**$20** copay
Surgery services	**$80** copay	**$100** copay
Therapeutic radiology (Radiation therapy)	**$55** copay	**$55** copay
Wound care	**$10** copay	**$20** copay
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Surgery services	**$80** copay	**$95** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	Not covered
Specialist's office	**$10** copay	**$20** copay
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual Wellness Visit (AWV) • Bone mass measurement • Breast cancer screening (mammogram)	**$0** copay Certain preventive services are covered only when received from your PCP. Any additional preventive services approved by Medicare during the contract year will be covered.

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

	IN-NETWORK	OUT-OF-NETWORK
	• Cardiovascular disease risk reduction visit • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screenings • Diabetes self-management training • Glaucoma screening • HIV screening • Immunizations • Lung Cancer Screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screening • Routine physical exam • Sexually transmitted infections (STIs) screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit Certain preventive services are covered only when received from your PCP. Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE		
Emergency services at emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$90** copay	**$90** copay

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CarePlus HEALTH PLANS

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Physician and professional services at emergency room	**$0** copay	**$0** copay
URGENTLY NEEDED SERVICES		
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention.	**$10** copay at an urgent care center	**$10** copay at an urgent care center
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scan)		
• Freestanding radiological facility	**$80** copay	**$95** copay
• Primary care physician's office	**$80** copay	Not covered
• Specialist's office	**$80** copay	**$95** copay
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$10** copay	**$20** copay
• Primary care physician's office	**$0** copay	Not covered
• Specialist's office	**$10** copay	**$20** copay
• Urgent care center	**$10** copay	**$20** copay
Diagnostic colonoscopy at an ambulatory surgery center	**$0** copay	**$0** copay
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
Diagnostic procedures and tests		
• Primary care physician's office	**$0** copay	Not covered
• Specialist's office	**$10** copay	**$20** copay
• Urgent care center	**$10** copay	**$20** copay
Lab services		
• Freestanding laboratory	**$0** copay	**$0** copay
• Primary care physician's office	**$0** copay	Not covered
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** copay	**$0** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Nuclear medicine and services at a freestanding radiological facility	**$60** copay	**$60** copay
Sleep study		
• Member's home	**$0** copay	**$0** copay
• Specialist's office	**$10** copay	**$20** copay
Therapeutic Radiology (Radiation therapy)		
• Freestanding radiological facility	**20%** of the cost	**20%** of the cost
• Specialist's office	**$10** copay	**$20** copay
HEARING SERVICES		
Medicare-covered hearing	**$10** copay	**$20** copay
Mandatory supplemental hearing benefit The provider location for routine hearing can be found at **CarePlusHealthPlans.com/Doctor** > Medical > Enter Zip Code > Type Audiologist in box under "Name, specialty, condition*" > Search	**HER902** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$600** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. • Note: Includes 1 month battery supply and 2 year warranty.	Not covered
DENTAL SERVICES The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$10** copay	**$20** copay
Mandatory supplemental dental benefit All services must be received in-office from a participating, in-network, general dentist or dental specialist (e.g., oral surgeon, endodontist, periodontist, etc.). Limitations and exclusions may apply. Benefits are offered on a calendar year basis. Any amount	**DEN609** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for complete dentures, crown recementation, panoramic film	Not covered

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CarePlus HEALTH PLANS

	IN-NETWORK	OUT-OF-NETWORK
unused at the end of the year will expire. The dentist may suggest and help arrange for additional services not listed in this benefit schedule; however, any procedures received that either are not listed in this benefit schedule or exceed the benefit limitations listed in this schedule are not covered. The member is responsible for the costs of these additional services and will 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. For more information about your dental benefits, go to **CarePlusHealthPlans.com/Resources** to view the Dental Benefit Schedule for your dental plan. You may also call Member Services at 1-800-794-5907 (TTY: 711). Hours of operation: October 1 – March 31, daily 8 a.m. – 8 p.m. and April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day. In-network dental providers have agreed to provide covered services at contracted rates (per the in-network fee schedules, or	or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$2,000** maximum benefit coverage amount per year for preventive and comprehensive benefits.	

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	IN-NETWORK	OUT-OF-NETWORK
INFS). If a member visits a participating network dental provider, the member cannot be billed for charges that exceed the negotiated fee schedule. No out-of-network coverage on this plan. To find a dentist or check to see if your dentist is in our Florida GoldPlus Dental network, use our Dental Finder tool. Go to **CarePlusHealthPlans.com/Dental-Finder** and enter your Zip code.		
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered vision services	**$10** copay	**$20** copay
Mandatory supplemental vision benefit The provider locator for routine vision can be found at **CarePlusHealthPlans.com/Doctor** > Medical > Enter Zip Code > Type Optometrist in box under “Name, specialty, condition*” > Search.	**VIS843** • **$0** copay for refraction and dilation (if necessary) with routine exam up to 1 per year. • **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames plus fitting; or, 2 pairs of select eyeglasses at no cost. • May choose prescription sunglasses as 1 pair. • Eyeglasses include ultraviolet protection and scratch resistant coating.	Not covered

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$100** copay per day for days 1-7 **$0** copay per day for days 8-90	**$120** copay per day for days 1-7 **$0** copay per day for days 8-90
Therapy visits		
• Partial hospitalization	**$10** copay	**$20** copay
• Specialist's office	**$10** copay	**$20** copay
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$150** copay per day for days 21-100	**$0** copay per day for days 1-20 **$150** copay per day for days 21-100
PHYSICAL THERAPY		
Comprehensive outpatient rehab facility	**$10** copay	**$20** copay
Specialist's office	**$10** copay	**$20** copay
AMBULANCE		
Air	**20%** of the cost	**20%** of the cost
Ground	**$150** copay per trip	**$150** copay per trip
TRANSPORTATION		
	$0 copay for plan approved location up to 26 one-way trip(s) per year. This benefit offers unlimited miles per trip. The member must contact transportation vendor to arrange transportation.	Not Covered

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
MEDICARE PART B DRUGS		
Allergy shots and serum		
• Primary care physician's office	**$0** copay	Not covered
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs at a specialist's office	**20%** of the cost	**20%** of the cost
Other Part B drugs Some rebatable Part B drugs may be subject to a lower coinsurance. You 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 deductible it does not apply to Part B insulin.		
• Pharmacy	**20%** of the cost	**20%** of the cost
• Primary care physician's office	**20%** of the cost	Not covered
• Specialist's office	**20%** of the cost	**20%** of the cost

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CarePlus HEALTH PLANS

Prescription Drug Benefits

PLAN HIGHLIGHTS

$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below
Deductible	**$0** Deductible
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by your plan
Additional gap coverage	Additional gap coverage for the following: Tier 1 drugs Tier 2 drugs Insulin
Excluded drug coverage	Additional drug coverage for the following: Erectile dysfunction (ED) drugs Prescription Vitamins
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

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

INITIAL COVERAGE

You pay the following until your total yearly drug costs for covered drugs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Pharmacy Cost-Sharing						
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 1: Preferred Generic	$0	$0	$10	$30	$0	$0
Tier 2: Generic	$5	$15	$20	$60	$5	$0
Tier 3: Preferred Brand	$30	$90	$47	$141	$30	$80
Tier 4: Non-Preferred Drug	$95	$285	$100	$300	$95	$275
Tier 5: Specialty Tier	33%	N/A	33%	N/A	33%	N/A

Other pharmacies are available in your network. To find which pharmacies are available in your network, go to **CarePlusHealthPlans.com/PharmacyFinder**.
*Some drugs are limited to a 30-day supply.

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

Insulin Cost-Sharing						
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 2: Generic	$5	$15	$20	$60	$5	$0
Tier 3: Preferred Brand	$30	$90	$35	$105	$30	$80
Tier 5: Specialty Tier	$35	N/A	$35	N/A	$35	N/A

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

*Some drugs are limited to a 30-day supply.

COVERAGE GAP

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$8,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

Tier 1 (Preferred Generic) - All Drugs

Tier 2 (Generic) - All Other Drugs, Insulin

Tier 3 (Preferred Brand) - Insulin

Tier 5 (Specialty Tier) - Insulin

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach **$8,000** you pay **$0** for plan-covered Part D and Excluded drugs.

EXCLUDED DRUG COVERAGE

Erectile dysfunction (ED) drugs	Covered at Tier 1 cost-share amount.
Prescription Vitamins	Covered at Tier 1 cost-share amount.

EXTRA HELP

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

Prior to reaching your annual **$8,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.50** for generic/preferred multi-source drug or biosimilar; **$11.20** for any other drug; OR
- **$1.55** for generic/preferred multi-source drug or biosimilar; **$4.60** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$8,000** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

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

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

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Chiropractic services (Medicare-covered)	**$10** copay	**$20** copay
Podiatry services (Medicare-covered)	**$10** copay	**$20** copay
Acupuncture services (Medicare-covered)	**$10** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$20** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MEDICAL EQUIPMENT/SUPPLIES		
Diabetic monitoring supplies		
• Diabetic supplier	**$0** copay	**$0** copay
• Network retail pharmacy	**$0** copay	**$0** copay
Durable medical equipment (DME) and related supplies – High Cost	**20%** of the cost	**20%** of the cost
Durable medical equipment (DME) and related supplies – All Other	**10%** of the cost	**10%** of the cost
Medical supplies at medical supplier	**20%** of the cost	**20%** of the cost
Prosthetics devices and related supplies at prosthetics provider	**20%** of the cost	**20%** of the cost
REHABILITATION SERVICES		
Cardiac rehabilitation services at a specialist's office	**$10** copay	**$20** copay
Occupational therapy		
• Comprehensive outpatient rehab facility	**$10** copay	**$20** copay
• Specialist's office	**$10** copay	**$20** copay
Physical therapy		
• Comprehensive outpatient rehab facility	**$10** copay	**$20** copay
• Specialist's office	**$10** copay	**$20** copay

Pulmonary rehabilitation services at a specialist's office	**$10** copay	**$20** copay
Speech therapy • Comprehensive outpatient rehab facility • Specialist's office	 **$10** copay **$10** copay	 **$20** copay **$20** copay
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD) at a specialist's office	**$10** copay	**$20** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care physician's office	**$0** copay	**Not Covered**
Specialist's office	**$10** copay	**Not Covered**
Substance abuse or behavioral health services	**$0** copay	**Not Covered**
Urgent care services	**$10** copay	**Not Covered**

More benefits with **your plan**

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

Routine Acupuncture
$0 copay for acupuncture visits up to 25 visit(s) per year.

Authorization rules may apply.

Chiropractic services
$10 copay for routine chiropractic visits up to 12 visit(s) per year.

Routine foot care
$10 copay for routine podiatry visits up to unlimited visit(s) per year.

NationsMarket® Fresh, Prepared Meal Program
CarePlus' freshly made home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order
$40 monthly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.
Unused amount expires at the end of the month.
- The allowance is available to use on the 1st of every month.
- Limitations and restrictions may apply.

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

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

SilverSneakers® fitness program
Basic fitness center membership including in person and digital fitness classes.

CarePlus HEALTH PLANS

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IMPORTANT

At CarePlus, it is important you are treated fairly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Find out **more**

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

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

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth. This service may not be offered by all in-network plan providers. Check directly with your provider about the availability of telehealth services, or you can also visit our website at **CarePlusHealthPlans.com/Doctor** to access our online, searchable directory. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

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

CarePlus HEALTH PLANS

CareOne Platinum (HMO-POS)
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Brevard and Indian River Counties

CarePlusHealthPlans.com

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