2026

Summary of Benefits

CareBreeze Platinum (HMO-POS C-SNP) H1019-124

South Florida: Broward, Palm Beach

Broward and Palm Beach Counties

Our service area includes the following county/counties in Florida: Broward, Palm Beach.

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 **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 **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 (Drug Guide) to make sure your drugs are covered.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2027.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ This plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay/coinsurance for services received by non-contracted providers.
- ☐ This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

Let's talk about CareBreeze Platinum (HMO-POS C-SNP)

Find out more about the CareBreeze Platinum (HMO-POS C-SNP) plan – including the health and drug services it covers – in this easy-to-use booklet.

CareBreeze Platinum (HMO-POS C-SNP) is a Special Needs 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 CareBreeze Platinum (HMO-POS C-SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be diagnosed with Chronic Lung Disorders and live in our service area.

Plan name

CareBreeze Platinum (HMO-POS C-SNP)

How to reach us

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

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

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

CarePlusHealthPlans.com/ContactUs

More about CareBreeze Platinum (HMO-POS C-SNP)

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

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

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

You also have access to Care Managers. Care Managers are nurses or care coordinators who are skilled at helping to improve your quality of life by providing proactive support and coordinating key services to help you better manage your health. If you're managing a serious illness or chronic condition, we'll be there to support you and your doctor's plan for care.

CarePlus HEALTH PLANS

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

A healthy partnership

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

Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly plan premium	**$0** You must keep paying your Medicare Part B premium.
Part B premium reduction[1]	Your plan will reduce your Monthly Part B premium by up to **$156** but by no more than Original Medicare's Part B Premium for 2026.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** deductible.
Medical Maximum out-of-pocket responsibility	**$3,400** in-network **$3,400** combined in- and out-of-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

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

Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
INPATIENT HOSPITAL COVERAGE		
This plan covers an unlimited number of days for an inpatient stay.	**$150** copay per day for days 1-7 **$0** copay per day for days 8-90	**$275** copay per day for days 1-7 **$0** copay per day for days 8-90
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic mammography	**$0** copay	**$0** copay
Surgery services	**$200** copay	**$275** copay
AMBULATORY SURGERY CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Surgery services	**$100** copay	**$250** copay
DOCTOR VISITS		
Primary care provider (PCP)		
• PCP's office	**$0** copay	**Not Covered**
• Telehealth	**$0** copay	**Not Covered**

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***CarePlusHealthPlans.com/PAL****.*

CarePlus HEALTH PLANS

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Specialist		
• Specialist's office	**$20** copay	**$35** copay
• Telehealth	**$20** copay	**Not Covered**
PREVENTIVE CARE		
This plan covers all Medicare preventive services including: **Cancer Screenings** • Breast cancer screening (mammogram) • Cervical and vaginal cancer screening • Colorectal cancer screening • Lung cancer screening • Prostate cancer screening **Cardiovascular (heart) Care** • Abdominal aortic aneurysm screening • Cardiovascular disease risk reduction visit • Cardiovascular disease screenings **Diabetes Care** • Diabetes screenings • Diabetes self-management training • Medicare Diabetes Prevention Program (MDPP) **Dietary Guidance and Support** • Medical nutrition therapy • Obesity screening and therapy **Routine Screenings and Immunizations** • Annual Wellness Visit (AWV) • Immunizations • Routine physical exam • "Welcome to Medicare" preventive visit	**$0** copay Certain preventive services are covered only when received from your PCP.	**$0** copay or **50%** of the cost, depending on the service and where service is provided. Certain preventive services are covered only when received from your PCP.

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Screenings and Counseling Services • Bone mass measurement • Depression screening • Glaucoma screening • HIV screening • Screening & counseling to reduce alcohol misuse • Sexually transmitted infections (STIs) screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) 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 same hospital within 24 hours for the same condition, you pay $0 for the emergency care you received. **We cover emergency services worldwide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.**	**$150** copay	**$150** copay

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CarePlus HEALTH PLANS

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
URGENTLY NEEDED SERVICES		
• **Telehealth**	**$20** copay	**Not Covered**
• **Urgent care center**	**$20** copay	**$20** copay
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention. **We cover urgently needed services worldwide. If you have an urgently needed service outside of the U.S. and its territories, you will be responsible to pay for the rendered service(s) upfront and can request reimbursement.**		
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT scans)		
• Freestanding radiological facility	**$150** copay	**$200** copay
• Outpatient hospital	**$200** copay	**$300** copay
• PCP's office	**$150** copay	**Not Covered**
• Specialist's office	**$150** copay	**$200** copay
Basic radiological services (X-rays)		
• Freestanding radiological facility	**$50** copay	**$100** copay
• Outpatient hospital	**$125** copay	**$175** copay
• PCP's office	**$0** copay	**Not Covered**
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** copay	**$0** copay
Diagnostic mammography		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay

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Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Diagnostic procedures and tests		
• Outpatient hospital	**$20** copay	**$35** copay
• PCP's office	**$0** copay	**Not Covered**
• Specialist's office	**$20** copay	**$35** copay
• Urgent care center	**$20** copay	**$35** copay
Lab services		
• Freestanding laboratory	**$0** copay	**$25** copay
• Outpatient hospital	**$0** copay	**$25** copay
• PCP's office	**$0** copay	**Not Covered**
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** copay	**$0** copay
Nuclear medicine and services		
• Freestanding radiological facility	**$150** copay	**$200** copay
• Outpatient hospital	**$200** copay	**$300** copay
Sleep study		
• Member's home	**$0** copay	**$0** copay
• Outpatient hospital	**$175** copay	**$175** copay
• Specialist's office	**$20** copay	**$20** copay
Therapeutic radiology (Radiation therapy)		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient hospital	**20%** of the cost	**20%** of the cost
• Specialist's office	**$0** copay	**$0** copay
HEARING SERVICES		
Medicare-covered hearing	**$20** copay	**$35** copay
Mandatory supplemental hearing benefit To find a routine hearing care provider or to check to see if your provider is in our network, go to **CarePlusHealthPlans.com/Doctor.**	**HER904** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$750** maximum benefit coverage amount for each prescription hearing aids (all types) up to 1 per ear per year. • Note: Includes 1 month battery supply and 1 year warranty.	**Not Covered**

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***CarePlusHealthPlans.com/PAL****.*

CarePlus HEALTH PLANS

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
DENTAL SERVICES		
Medicare-covered dental	**$20** copay	**$35** 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 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 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. For more information about your dental benefits, go to **CarePlusHealthPlans.com/Dental** to view the Dental Benefit	**DEN103** • **$0** copay for comprehensive oral exam up to 1 every 3 years. • **$0** copay for complete or partial dentures up to 1 set(s) every 5 years. • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant per year. • **$0** copay for denture reline, panoramic film, root canal up to 1 per year. • **$0** copay for bitewing x-rays up to 2 set(s) per year. • **$0** copay for emergency diagnostic exam, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for amalgam and/or composite filling, periodontal maintenance up to 4 per year. • **$0** copay for simple or surgical extraction up to 5 per year. • **$0** copay for necessary anesthesia with covered service up to as needed with covered codes per year. • **$0** copay for extractions for dentures up to unlimited per year. • Unlimited extractions are covered only for the purpose of member receiving dentures, all other extractions are limited to 5 per year.	**Not Covered**

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***CarePlusHealthPlans.com/PAL****.*

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Schedule for your dental plan. You may also call our Member Services department at 800-794-5907. If you use a TTY, call 711. You can call us seven days a week, from 8 a.m to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays. In-network dental providers have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dental provider, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment will still apply). No out-of-network coverage on this plan. To find a dentist or check to see if your dentist is in our network, go to **CarePlusHealthPlans.com/Dental Finder**.		
VISION SERVICES		
Eyewear (post cataract surgery)	**$0** copay	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay	**50%** of the cost
Medicare-covered vision services	**$20** copay	**$35** copay
Mandatory supplemental vision benefit	**VIS029**	**Not Covered**

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CarePlus HEALTH PLANS

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
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/Doctor**. Copayments, coinsurance, 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 by the end of the year will expire.	• **$0** copay for refraction and dilation (if necessary) with routine exam up to 1 per year. • **$400** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames plus fitting; or 3 pairs of select eyeglasses per year at no cost. • May choose prescription sunglasses as 1 pair. • Eyeglasses include ultraviolet protection and scratch-resistant coating.	
MENTAL HEALTH SERVICES		
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$150** copay per day for days 1-7 **$0** copay per day for days 8-90	**$275** copay per day for days 1-7 **$0** copay per day for days 8-90
Mental health therapy visits		
• Outpatient hospital	**$20** copay	**$35** copay
• Specialist's office	**$20** copay	**$35** copay
• Telehealth	**$20** copay	**Not Covered**
Outpatient substance abuse services		
• Outpatient hospital	**$20** copay	**$35** copay
• Specialist's office	**$20** copay	**$35** copay
• Telehealth	**$20** copay	**Not Covered**
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$160** copay per day for days 21-100	**$0** copay per day for days 1-20 **$160** copay per day for days 21-100
AMBULANCE		
Air	**20%** of the cost	**20%** of the cost
Ground	**$250** copay per trip	**$250** copay per trip

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: ***CarePlusHealthPlans.com/PAL****.*

Medical Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
TRANSPORTATION		
Mandatory supplemental transportation benefit The member ***must*** contact transportation vendor at least 72 hours (3 business days) in advance of their appointment to arrange transportation.	**$0** copay for plan approved location up to 50 one-way trip(s) per year. This benefit offers unlimited miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
Uniformity flexibility non-emergency medical transportation benefit The member ***must*** contact transportation vendor at least 72 hours (3 business days) in advance of their appointment to arrange transportation.	**$0** copayment for plan approved location up to unlimited one-way trip(s) per year for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit offers unlimited miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
MEDICARE PART B DRUGS Some rebatable Part B drugs may be subject to a lower coinsurance.		
Allergy shots and serum		
• PCP's office	**$0** copay	**Not Covered**
• Specialist's office	**$0** copay	**$0** copay
Chemotherapy drugs		
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• Specialist's office	**20%** of the cost	**50%** of the cost
Other Part B drugs		
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• PCP's office	**20%** of the cost	**Not Covered**
• Pharmacy	**20%** of the cost	**50%** of the cost
• Specialist's office	**20%** of the cost	**50%** of the cost
Part B Insulin		
• Outpatient hospital	**20%** of the cost	**50%** of the cost
• PCP's office	**20%** of the cost	**Not Covered**
• Pharmacy	**20%** of the cost	**50%** of the cost
• Specialist's office	**20%** of the cost	**50%** of the cost
You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.		

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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 this plan.
100-day supply	Up to 100-day supply on eligible drugs
Excluded drug coverage	Additional drug coverage for the following: Erectile dysfunction (ED) drugs Prescription vitamins
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

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

INITIAL COVERAGE

You pay the following until your total yearly out-of-pocket drug costs reach **$2,100**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing						
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**100-day***	**30-day**	**100-day***	**30-day**	**100-day***
Tier 1: Preferred Generic	$0	$0	$0	$0	$0	$0
Tier 2: Generic	$5	$15	$12	$36	$5	$0
Tier 3: Preferred Brand	$45	$135	$47	$141	$45	$90
Tier 4: Non-Preferred Drug	50%	50%	50%	50%	50%	50%
Tier 5: Specialty Tier	33%	N/A	33%	N/A	33%	N/A
Tier 6: Select Care Drugs	$0	$0	$0	$0	$0	$0

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

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

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

Insulin Cost-Sharing						
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**100-day***	**30-day**	**100-day***	**30-day**	**100-day***
Tier 1: Preferred Generic	$0	$0	$0	$0	$0	$0
Tier 2: Generic	25% up to $5	25% up to $15	25% up to $12	25% up to $36	25% up to $5	$0
Tier 3: Preferred Brand	25% up to $35	25% up to $105	25% up to $35	25% up to $105	25% up to $35	25% up to $70
Tier 4: Non-Preferred Drug	25% up to $35	25% up to $105	25% up to $35	25% up to $105	25% up to $35	25% up to $105
Tier 5: Specialty Tier	25% up to $35	N/A	25% up to $35	N/A	25% up to $35	N/A
Tier 6: Select Care Drugs	$0	$0	$0	$0	$0	$0

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

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

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

CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,100** you pay **$0** for plan-covered Part D and Excluded drugs.

EXCLUDED DRUG COVERAGE

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

EXTRA HELP

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

Prior to reaching your annual **$2,100** out-of-pocket limit, you will pay one of the following depending on your level of Extra Help:

- **$5.10** for generic/preferred multi-source drug or biosimilar; **$12.65** for any other drug; OR
- **$1.60** for generic/preferred multi-source drug or biosimilar; **$4.90** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,100** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of Extra Help you receive. Additional information will be available on your LIS rider.

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

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

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Acupuncture services (Medicare-covered)	**$0** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$0** 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.
Chiropractic services (Medicare-covered)	**$20** copay	**$35** copay
Podiatry services (Medicare-covered)	**$20** copay	**$35** copay
MEDICAL EQUIPMENT/SUPPLIES		
Continuous glucose monitor (CGM)		
• DME provider	**$0** copay	**$0** copay
• Pharmacy	**$0** copay	**$0** copay
Diabetic monitoring supplies		
• Diabetic supplier	**$0** copay	**$0** copay
• Network retail pharmacy	**$0** copay	**$0** copay
Durable medical equipment (DME) – High Cost	**20%** of the cost	**50%** of the cost
Durable medical equipment (DME) – All Other	**20%** of the cost	**50%** of the cost
Medical supplies at medical supplier	**20%** of the cost	**20%** of the cost
Prosthetics devices and related supplies at prosthetics provider	**$0** copay	**20%** of the cost

Additional Benefits (cont.)

REHABILITATION SERVICES

Cardiac rehabilitation services		
• Outpatient hospital	**$20** copay	**$35** copay
• Specialist's office	**$20** copay	**$35** copay
Occupational therapy		
• Comprehensive outpatient rehab facility	**$20** copay	**$35** copay
• Outpatient hospital	**$20** copay	**$35** copay
• Specialist's office	**$20** copay	**$35** copay
Physical therapy		
• Comprehensive outpatient rehab facility	**$20** copay	**$35** copay
• Outpatient hospital	**$20** copay	**$35** copay
• Specialist's office	**$20** copay	**$35** copay
Pulmonary rehabilitation		
• Outpatient hospital	**$20** copay	**$35** copay
• Specialist's office	**$20** copay	**$35** copay
Speech therapy		
• Comprehensive outpatient rehab facility	**$20** copay	**$35** copay
• Outpatient hospital	**$20** copay	**$35** copay
• Specialist's office	**$20** copay	**$35** copay
Supervised exercise therapy (SET) for Peripheral Artery Disease (PAD)		
• Outpatient hospital	**$20** copay	**$35** copay
• Specialist's office	**$20** copay	**$35** copay

More benefits with **this plan**

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

CareEssentials Allowance*
Members diagnosed with a qualifying chronic health condition may receive a **$35** monthly allowance on a prepaid spending card to use at participating retail locations for essentials needed to support their health.

Plus, members can also use this money for eligible groceries, utilities, rent, and more.

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

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

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

Authorization rules may apply.

The in-network provider must be used for this service.

If you choose to utilize another provider, you are responsible for all charges.

Routine Chiropractic services
$20 copay for routine chiropractic visits up to 12 visit(s) per year.

Routine foot care
$20 copay for routine podiatry visits up to unlimited visit(s) per year.

***** This spending allowance and Chronic Condition Care Assistance are special program(s) for members with specific health conditions. 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 and other requirements apply. See the plan's Evidence of Coverage for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income if you seek assistance. Contact your local HUD office if you have questions.

CarePlus HEALTH PLANS

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

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

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

Limited to 4 times per year.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Over-the-Counter (OTC) mail order
$10 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.

The in-network provider must be used for this service.

If you choose to utilize another provider, you are responsible for all charges.

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

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

The in-network provider must be used for this service.

If you choose to utilize another provider, you are responsible for all charges.

Find out **more**

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

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

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

CareBreeze Platinum (HMO-POS C-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2026 based on a review of the CareBreeze Platinum (HMO-POS C-SNP) Model of Care.

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

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

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

CarePlus HEALTH PLANS

Activate your secure MyCarePlus account.

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

Already have an account?

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

Don't have an account yet?

Create one using the same link above in just minutes.

Notice of Non-Discrimination

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

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **800-794-5907 (TTY: 711)**. If you believe that CarePlus Health Plans, Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with CarePlus Health Plans, Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington KY 40512-4618, **800-794-5907 (TTY: 711)**, or **Accessibility1@CarePlus-HP.com**. If you need help filing a grievance, CarePlus Health Plans, Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

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

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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 مجانًا. اتصل على الرقم **1-800-794-5907 (الهاتف النصي: 711)**.

Հայերեն Armenian: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **1-800-794-5907 (TTY: 711)**:

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: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **1-800-794-5907 (TTY: 711)**.

Hrvatski Croatian: Dostupni su besplatni jezik, dodatna pomoć i usluge 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 linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **1-800-794-5907 (TTY: 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: નિઃશુલ્ક 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. Chiama il numero **1-800-794-5907 (TTY: 711)**.

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

GHHNOA2025CP

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: Saad t'áá jiik'eh, t'áadoole'é binahjį' bee adahodooníígíí diné bich'į' anídahazt'i'í, dóó ahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahólǫ. Kohjį' hodíilnih **1-800-794-5907 (TTY: 711)**.

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

Português 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: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **1-800-794-5907 (TTY: 711)**.

தமிழ் Tamil: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **1-800-794-5907 (TTY: 711)** ஐ 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 **(TTY: 711) 1-800-794-5907**

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

CarePlus HEALTH PLANS

Notes

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CareBreeze Platinum (HMO-POS C-SNP)
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