2025

Summary of Benefits

CareBreeze Platinum (HMO C-SNP)

Jacksonville

Clay, Duval, and St. Johns Counties

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

Pre-Enrollment Checklist

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

Understanding the Benefits

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

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2026.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ 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 C-SNP)

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

CareBreeze Platinum (HMO C-SNP) is a Coordinated Care HMO plan with a Medicare contract. Enrollment in this CarePlus plan depends on contract renewal.

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

To be eligible

To join CareBreeze Platinum (HMO 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 C-SNP)

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

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

A healthy partnership

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

Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$95** but by no more than Original Medicare's Part B Premium for 2025.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan has a **$0** deductible.
Maximum out-of-pocket responsibility	**$3,800** in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Medical Benefits

INPATIENT HOSPITAL COVERAGE	
This plan covers an unlimited number of days for an inpatient stay	**$200** copay per day for days 1-5 **$0** copay per day for days 6-90
OUTPATIENT HOSPITAL COVERAGE	
Diagnostic colonoscopy	**$0** copay
Diagnostic mammography	**$0** copay
Surgery services	**$110** copay
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**$0** copay
Surgery services	**$95** copay
DOCTOR VISITS	
Primary Care Provider (PCP)	• PCP's office: **$0** copay • Telehealth: **$0** copay
Specialist	• Specialist's office: **$20** copay • Telehealth: **$20** 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 this plan. This is called "preauthorization." To learn more about services that require a referral or preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **CarePlusHealthPlans.com/PAL**.*

CarePlus HEALTH PLANS

Medical Benefits (cont.)

PREVENTIVE CARE	
This plan covers all Medicare preventive services including: • **Abdominal aortic aneurysm screening** • **Alcohol misuse screening & counseling** • **Annual Wellness Visit (AWV)** • **Bone mass measurement** • **Breast cancer screening (mammogram)** • **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** Any additional preventive services approved by Medicare during the contract year will be covered.	**$0** copay
EMERGENCY CARE	
Emergency services at emergency room If you are admitted to the same hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$90** copay
Physician and professional services at emergency room	**$0** copay

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Medical Benefits (cont.)

URGENTLY NEEDED SERVICES	
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	• Telehealth: **$20** copay • Urgent care center: **$20** copay
DIAGNOSTIC SERVICES, LABS & IMAGING	
Advanced imaging services (MRI, MRA, PET and CT scan)	• Freestanding radiological facility: **$95** copay • Outpatient hospital: **$110** copay • PCP's office: **$95** copay • Specialist's office: **$95** copay
Basic radiological services (X-rays)	• Freestanding radiological facility: **$20** copay • Outpatient hospital: **$110** copay • PCP's office: **$0** copay • Specialist's office: **$20** copay • Urgent care center: **$20** copay
Diagnostic mammography	• Freestanding radiological facility: **$0** copay • Specialist's office: **$0** copay
Diagnostic procedures and tests	• Outpatient hospital: **$110** copay • PCP's office: **$0** copay • Specialist's office: **$20** copay • Urgent care center: **$20** copay
Lab services	• Freestanding laboratory: **$0** copay • Outpatient hospital: **$0** copay • PCP's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **$0** copay
Nuclear medicine and services	• Freestanding radiological facility: **$60** copay • Outpatient hospital: **$110** copay
Sleep study	• Member's home: **$0** copay • Outpatient hospital: **$110** copay • Specialist's office: **$20** copay
Therapeutic radiology (Radiation therapy)	• Freestanding radiological facility: **$50** copay • Outpatient hospital: **20%** of the cost • Specialist's office: **$20** copay

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CarePlus HEALTH PLANS

Medical Benefits (cont.)

HEARING SERVICES

Medicare-covered hearing	**$20** 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** > Medical > Enter Zip Code > Type Audiologist in box under "Name, specialty, condition*" > Search	In-Network: **HER722** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$250** 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 2 year warranty.

DENTAL SERVICES

Medicare-covered dental	**$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 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 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	In-Network: **DEN821** • **$0** copay for comprehensive oral exam up to 1 every 3 years. • **$0** copay for complete 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 crown, 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 periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for simple or surgical extraction up to 3 per year. • **$0** copay for amalgam and/or composite filling, periodontal maintenance up to 4 per year. • **$0** copay for necessary anesthesia with covered service up to unlimited per year.

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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 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** > enter ZIP Code > Select Search category >Type dentist name or specialty or select "all dental providers".

VISION SERVICES	
Eyewear (post cataract surgery)	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services	**$20** copay
Mandatory supplemental vision benefit To find a routine vision care provider or to check to see if your provider is in our network, go to **CarePlusHealthPlans.com/Doctor** > Medical > Enter Zip Code > Type Optometrist in box under "Name, specialty, condition*" > Search.	In-Network: **VIS841** • **$0** copay for refraction and dilation (if necessary) with routine exam up to 1 per year. • **$115** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames plus fitting; or 1 pair of select eyeglasses per year at no cost. • Eyeglasses include ultraviolet protection and scratch-resistant coating.

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Medical Benefits (cont.)

MENTAL HEALTH SERVICES	
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$200** copay per day for days 1-5 **$0** copay per day for days 6-90
Mental health therapy visits	• Outpatient hospital: **$20** copay • Partial hospitalization: **$20** copay • Specialist's office: **$20** copay
Outpatient substance abuse services	• Outpatient hospital: **$20** copay • Partial hospitalization: **$20** copay • Specialist's office: **$20** copay • Telehealth: **$20** copay
SKILLED NURSING FACILITY (SNF)	
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$125** copay per day for days 21-100
AMBULANCE	
Air	**20%** of the cost
Ground	**$200** copay per trip
TRANSPORTATION	
The member *must* contact transportation vendor to arrange transportation.	**$0** copay for plan approved location up to 26 one-way trip(s) per year. This benefit offers unlimited miles per trip.
MEDICARE PART B DRUGS Some rebatable Part B drugs may be subject to a lower coinsurance	
Allergy shots and serum	• PCP's office: **$0** copay • Specialist's office: **$0** copay
Chemotherapy drugs	• Outpatient hospital: **20%** of the cost • Specialist's office: **20%** of the cost
Other Part B drugs	• Outpatient hospital: **20%** of the cost • PCP's office: **20%** of the cost • Pharmacy: **20%** of the cost • Specialist's office: **20%** of the cost
Part B Insulin You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.	• Outpatient hospital: **20%** of the cost • PCP's office: **20%** of the cost • Pharmacy: **20%** of the cost • Specialist's office: **20%** of the cost

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Prescription Drug Benefits

PLAN HIGHLIGHTS

$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below.
Deductible	**$0** deductible
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.
100-day supply	Up to 100-day supply on eligible drugs
Excluded drug coverage	Additional drug coverage for the following: 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 out-of-pocket costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**100-day***	**30-day**	**100-day***	**30-day**	**100-day***
Tier 1: Preferred Generic	$0	$0	$10	$30	$0	$0
Tier 2: Generic	$5	$15	$20	$60	$5	$0
Tier 3: Preferred Brand	$45	$135	$47	$141	$45	$125
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 2: Generic	$5	$15	$20	$60	$5	$0
Tier 3: Preferred Brand	$35	$105	$35	$105	$35	$95
Tier 5: Specialty Tier	$35	N/A	$35	N/A	$35	N/A

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

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

CATASTROPHIC COVERAGE

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

EXCLUDED DRUG COVERAGE

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

EXTRA HELP

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

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

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

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

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

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

Additional Benefits

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

CarePlus HEALTH PLANS

Additional Benefits (cont.)

REHABILITATION SERVICES

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

More benefits with **this plan**

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

CareEssentials Allowance*
$25 monthly allowance on a prepaid card to use for essentials you need to support your health.

This allowance can be used to buy approved products from participating retail locations (like groceries, over-the-counter health and wellness items, personal care items, home supplies, etc.) or pay for approved services (monthly living expenses like rent, non-medical transportation costs like a taxi, Uber, Lyft, etc.).

Allowance amount cannot be combined with other allowances which may be on the Card.

Unused amount rolls over to the next month and expires at the end of the plan year.

See the CarePlus Spending Account Card section for more information.

CarePlus Spending Account Card
The CarePlus Spending Account Card is what you use to spend allowances included in this plan. Please activate your card as soon as you receive it in the mail. Limitations and restrictions may apply.

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.

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.

* Benefit(s) mentioned may be part of a special supplemental program for chronically ill members with one of the following conditions: Diabetes mellitus, Cardiovascular disorders, Chronic and disabling mental health conditions, Chronic lung disorders, Chronic heart failure. This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefit(s). Other requirements may apply.

CarePlus HEALTH PLANS

Over-the-Counter (OTC) mail order

$35 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

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

Notice of Non-Discrimination

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

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

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

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

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

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

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CarePlus HEALTH PLANS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Find out **more**

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

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

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

CareBreeze Platinum (HMO C-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2025 based on a review of CareBreeze Platinum (HMO 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.

CarePlus HEALTH PLANS

CareBreeze Platinum (HMO C-SNP)
H1019118000 ENG
Clay, Duval, and St. Johns Counties

CarePlusHealthPlans.com

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