2023

Medicare Questions? Answered.

A resource to help you navigate your Medicare options.

Brought to you by:

care@care
Insurance Company, Inc.

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Medicare Basics

Eligible for Medicare?

You are eligible for Original Medicare (Parts A and B) if:

65 You are at least 65 years old, or you are under 65 and qualify for disability.

AND

You are a U.S. citizen or a legal resident who has lived in the U.S. for at least five consecutive years.

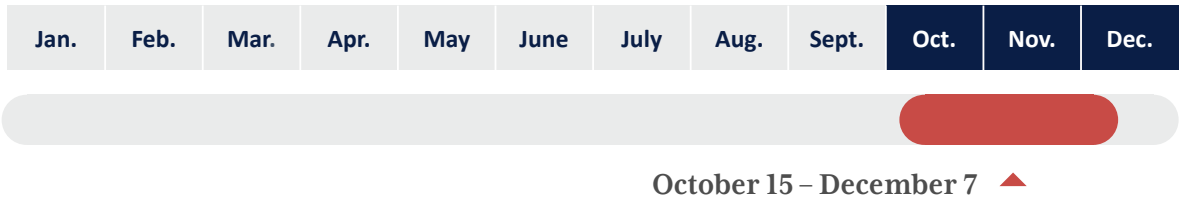
When to Enroll?

Birthday Month

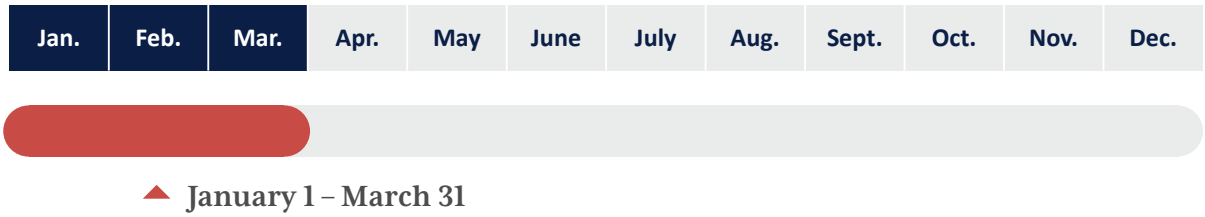
Initial Enrollment Period (IEP) – Once you turn 65 or are eligible for Medicare. This period begins three months before, includes your birthday month and ends three months after the month you turn 65.

In some cases, you are not required to enroll during the Initial Enrollment Period. If you are still employed when you turn 65 and you still have your employer's coverage, you are not required to enroll during the Initial Enrollment Period. You will not be subject to a late enrollment penalty if your coverage is considered creditable by Centers for Medicare & Medicaid Services (CMS). Prescription drug (Part D) coverage must be creditable or you may be subject to a lifetime late enrollment penalty once you enroll in a plan with Part D benefits.

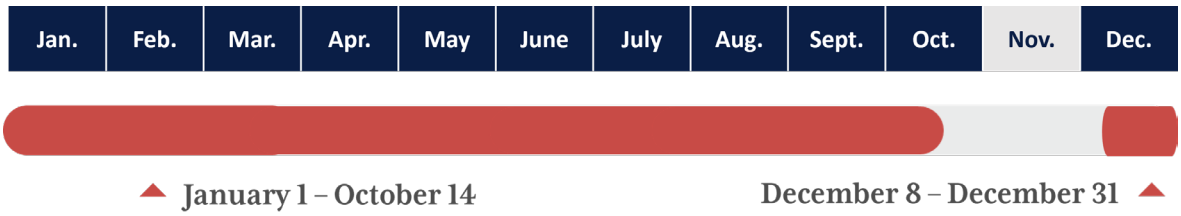
Annual Enrollment Period (October 15 – December 7) – This is your opportunity each year to add, drop, or switch your current Medicare plan.



Open Enrollment Period (January 1 – March 31) – This is your opportunity to make one final change if you are not happy with your current Medicare Advantage plan. The effective date will be the 1st of the month following the date in which the final change was made. Moving from Original Medicare to a Medicare Advantage plan is not allowed.



Special Election Period – There are certain times when beneficiaries may be able to enroll in a Medicare plan outside the initial, annual and open enrollment periods.



Some examples of Special Election Periods include:

- Lost employer coverage
- Moved outside of plan's service area
- Received assistance from the state
- Recently lost creditable prescription drug coverage (coverage that was as good as Medicare)
- Low Income Subsidy (LIS), extra help with RX

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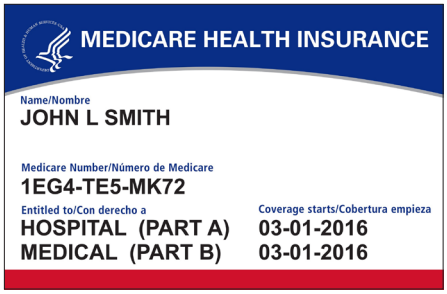
Medicare Basics

A

Part A of Medicare helps cover:

- Inpatient hospital care
- Skilled nursing facility care
- Home health care
- Hospice care
- Blood



B

Part B of Medicare helps cover:

- Doctors office visits
- Outpatient care
- Durable medical equipment
- Home health care
- Some preventive services
- Prescription drugs-under certain circumstances

Additional Coverage Options

C

Part C of Medicare is a Medicare Advantage plan. It covers:

- Part A
- Part B
- Sometimes Part D of Medicare
- Additional benefits not covered by Medicare

D

Part D of Medicare helps cover:

- Prescription drugs

Original Medicare as a Stand-alone

A

Part A of Medicare helps cover:

- Hospital stays
- Inpatient care

B

Part B of Medicare helps cover:

- Doctor's office visits
- Outpatient care

- Copay and coinsurance paid by you
- No drug coverage leaving you exposed to penalties
- No maximum out-of-pocket
- Part B deductible, in 2022 is $233 – not yet determined for 2023

Need more coverage? You have options!

Medicare Supplement Insurance

- Helps pay some of the out-of-pocket costs that come with Original Medicare
- You pay a monthly premium
- You pay copays or coinsurance for some services

Medicare Part D Plan

- Helps pay for prescription drugs
- Most plans have extra premium
- Subject to deductibles on some plans

A
B
+ D
C

Medicare Advantage Plan

- Combines Part A (hospital insurance) and Part B (medical insurance) into one plan
- Usually includes prescription drug coverage
- May offer additional benefits not provided by Original Medicare, dental, vision,hearing, fitness, etc.

What is Medicare Advantage?

A + B + D = C

Medicare Advantage plans:

- Are contracted through the Centers for Medicare & Medicaid Services (CMS).
- Are NOT Medicare Supplement plans. Supplements are additional insurance products that can be purchased to work with Original Medicare.
- Are still part of Medicare.
- May offer additional benefits not provided by original Medicare such as dental, vision, hearing, fitness, etc.
- Use private insurance companies to pay and partner with you on your healthcare services– not Medicare.

Are you eligible for Medicare Advantage?

You are eligible for Medicare Advantage if:

1. You are entitled to Part A

2. You are enrolled in Part B (premium may be required)

3. You are a U.S. Citizen or lawful resident

4. You are a permanent resident of the plan's service area

What to Expect When Joining a Medicare Advantage Plan

- You will continue to pay your Part B premium.
- Your current plan may be affected if you join a Medicare Advantage plan.
- You will use your CNC member ID card for most services.
- Medicare Advantage Plans must cover all the Medically necessary service the original Medicare covers.
- Medicare Supplement (Medigap policy) and Medicare Advantage plans (Part C) are not the same thing.
- Using network providers will help keep your costs lower, depending on your plan type (HMO/PPO).
- Medicare Advantage plans offer a maximum out-of-pocket amount for Part A hospital and Part B medical services.
- If you enroll in Part D late, you may have to pay a penalty.
- A Medicare Advantage plan offers additional benefits in addition to what Original Medicare covers, such as dental, vision,hearing, fitness, etc.
- If receiving assistance from a sales agent, broker, or other individual employed by or contracted with a Medicare Advantage plan, he/she may be paid a commission based on your enrollment in the plan.

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Drug Coverage Stages

Yearly Deductible Stage 1

Care N' Care does not have deductibles on drugs so this payment stage **does not** apply to Care N' Care members.

Initial Coverage Stage 2

During this stage you pay a flat fee (copay) or a percentage of a drug's total cost (coinsurance) for each prescription you fill and the plan pays the rest.

Once your total drug costs (amount paid by the plan and by you or others on your behalf) reach **$4,660**, you move to the Coverage Gap Stage.

Coverage Gap Stage 3

During this stage you pay no more than **25%** of the total cost for generic and brand name drugs.

Once your out-of-pocket costs (amount paid by you and other programs or organizations) reach **$7,400** you move to the Catastrophic Coverage Stage.

Catastrophic Coverage Stage 4

In this stage, you pay no more than a small copay or coinsurance amount for each filled prescription.

The plan and Medicare pay the rest until the end of the calendar year.

Care N' Care's Enhanced Alternative Part D Benefit

- Tier 1 will have gap coverage on all Medicare Advantage Prescription Drug (MAPD) plans
- All plans include partial gap coverage for select tier 2 and tier 3 COPD Inhalers.
- Insulins on formulary are on the Insulin Saver Program and include gap coverage, $35 for 1 month supply OR $70 for 3-month supply

Drug Coverage Definitions

Prior Authorization: The plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from the plan before you fill your prescriptions. If you don't get approval, the plan may not cover the drug. These drugs are listed in the drug formulary with the symbol "PA".

Quantity Limits: For certain drugs, the plan limits the amount of the drug that will be covered. For example, the plan provides 30 tablets per prescription for Januvia 100mg tablets. This may be in addition to a standard one-month or three-month supply. These drugs are listed in the drug formulary with the symbol "QL" followed by the quantity and day supply limitation.

Non-formulary Exception Request: You can ask your plan to cover a drug even if it is not in the formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask the plan to provide the drug at a lower cost-sharing level.

Step Therapy: In some cases, your plan may require you to first try certain drugs to treat your medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan may cover Drug B. These drugs are listed in the drug formulary with the symbol "ST".

Drug Tiers:

Tier 1 – Preferred Generics (this is the lowest-cost tier): Includes generic drugs that are available at the lowest cost.

Tier 2 – Generics: Includes generic drugs that are available at a higher cost to you than drugs in Tier 1. Also includes some very low cost brand drugs.

Tier 3 – Preferred Brands: Includes brand and generic drugs that are available at a lower cost to you than drugs in Tier 4.

Tier 4 – Non-Preferred Drugs: Includes brand and generic drugs that are available at a higher cost to you than drugs in Tier 3.

Tier 5 – Specialty Drugs (this is the highest-cost tier): Includes some injectables and other high-cost drugs.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call your Customer Experience Team for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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Choosing the Right Plan for You

Comparing Your Options

Benefits and Features	Medicare Advantage	Medicare Supplement (Medigap)	Original Medicare
Help during hospital stays			
Help paying for doctor visits			
Preventive services			
Maximum out-of-pocket to help manage costs			No Protection
Worldwide travel coverage Routine vision coverage			No Coverage
Dental benefits		No Coverage	No Coverage
Routine hearing exam and hearing aid coverage		No Coverage	No Coverage
Routine vision coverage		No Coverage	No Coverage
Prescription drug coverage		No Coverage	No Coverage

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How Does an HMO Plan Work?

- You choose an in-network primary care physician who will help coordinate your healthcare needs.
- You have a network of doctors, specialists and facilities contracted with the plan to provide services.
- The plan's contracted network arrangements with providers allow the plan to create savings that are passed on to you.
- A referral is needed to see specialists and receive certain services.
- Lower out-of-pocket costs.
- You have the ability to select a different in-network primary care physician as needed.

How Does a PPO Plan Work?

- You have a network of doctors, specialists and facilities contracted with the plan to provide services.
- You can see providers who are out-of-network. Reminder – providers that do not contract with the plan are not obligated to treat you, except in emergency situations. Cost-sharing will be lower at in-network providers.
- You should expect to pay more if you choose to use out-of-network providers.
- Referrals in most situations are not required depending on your specialist, some services may require an authorization prior to receiving the service.
- The plan may not impose prior authorization requirements for out-of-network services, but the member or provider can request an advance determination of coverage.

Choosing the Right Plan for You

Things to Consider:

Provider Network

- Verify primary care doctor accept the plan.
- Verify specialty doctors accept the plan.
- Verify facilities/hospitals accept the plan.

Prescription Benefits

- Is it important to have low or no Part D deductible?
- Is having access to convenient pharmacy locations, both local and nationwide important?
- Is it important to have a mail order program available to you?
- Is having gap coverage important?
- Are low drug copayments important?

Dental, Vision and Hearing Benefits

- Is it important to have eye exams and glasses covered?
- Is having a large vision network important?
- Is it important to have dental cleanings, exams and X-rays covered?
- Is hearing aid coverage important?

Ready to Enroll?

Easy as One, Two, Three!

1. Review your enrollment guide with a licensed sales agent to learn more about plan benefits and decide on the Care N' Care health plan that best fits your needs.

2. Complete the enrollment form.

3. Your licensed sales agent will submit your enrollment form to Care N' Care for Medicare approval.

Only a Click or a Phone Call Away

Toll-Free at 1-877-905-9209 (TTY users should call 711) October 1 - March 31, 8 a.m. to 8 p.m., CST, seven days a week or April 1 - September 30, 8 a.m. to 8 p.m., CST, Monday through Friday or go to our website to enroll.
cnchealthplan.com/enroll

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What Happens Next?

1

Enrollment Receipt

After submitting your completed enrollment form you will receive an enrollment receipt. If enrolling with a licensed sales agent, the agent will complete the receipt located in the enrollment guide, or if you enroll online, you will receive a confirmation number and have the ability to print a copy of your completed application for your files.

2

Confirmation Letter

Once Medicare approves your enrollment, you will receive a letter from Care N' Care confirming your approval by Medicare to the plan.

3

Welcome Call

A member of the Customer Experience Team will call to welcome you to Care N' Care, and confirm the information provided on the enrollment form, such as your home address and primary care physician. They can also assist with any questions you may have.

4

Identification (ID) Card

Members will receive two ID cards. ID cards will be mailed separately from any other materials provided by Care N' Care. Use your Care N' Care member ID card when visiting your doctor, pharmacy, facility or hospital.

5

Member Material

Members will receive a material kit within 30 days of enrollment. The member material kit provides all of the information required by Medicare, including how to get a copy of your evidence of coverage, drug formulary and a provider/pharmacy directory.

6

Welcome to the Care N' Care Family

Enrollment Tools

Care N' Care Enrollment Guide

Care N' Care's Enrollment Guide offers important information to help you when choosing the right Medicare Advantage plan for you. The guide includes plan and benefit details, contact information to reach a Care N' Care Medicare Specialist, and enrollment forms.

Enrollment tools inside the guide are:

Summary of Benefits

A detailed plan overview that provides important plan information. Also includes a pre-enrollment checklist.

Additional Plan Information

More detailed information about the plan's additional programs and services offered beyond what Original Medicare offers.

Medicare Plan Ratings

The Medicare Star Ratings program rates all health and prescription drug plans each year, based on the plan's quality and performance.

Non-Discrimination Notice and Language Interpreter Services

Provides information on how to file a grievance if you feel the plan discriminated in any way and contains instructions on how to access free language interpreter services to answer questions you may have about a plan.

Enrollment Request Form Guide

Provides everything needed to enroll, including the application and instructions on how to complete.

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cnchealthplan.com/enroll

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Experience Care N' Care

Care N' Care (HMO/PPO) is a local Medicare Advantage health plan owned by Southwestern Health Resources (SWHR), providing North Texas Medicare beneficiaries affordable alternatives that improve and simplify Medicare coverage.

With both HMO and PPO Medicare Advantage health plans, Care N' Care offers all benefits included in Original Medicare plus additional benefits and services, including a local Customer Experience Team to help navigate the member's healthcare experience. Offered in the following counties: Collin, Cooke , Dallas, Denton, Erath, Hood, Johnson, Palo Pinto, Parker, Rockwall, Somervell, Tarrant and Wise.

Southwestern Health Select Plan offered in Collin, Cooke, Dallas, Denton, Rockwall and Tarrant counties.

A part of

Southwestern Health Resources

Texas Health Resources®

UT Southwestern Medical Center®

Who is Southwestern Health Resources?

A national leader in population-based healthcare.

As a patient-centered integrated network of academic and community clinicians, researchers, hospitals and ambulatory facilities, SWHR partners with physicians to relentlessly pursue a new model of value-based, high-quality, data-driven healthcare for everyone in the communities they serve.

Combining the strengths of UT Southwestern Medical Center, Texas Health Resources and more than 2,500 community physicians, SWHR offers the largest provider network in North Texas.

What does this mean for Care N' Care members?

Local support paired with one of the largest provider networks in North Texas and one of the largest nonprofit health systems in the United States.

Access to a robust network of physicians and facilities, including UT Southwestern Medical Center and Texas Health Resources.

Quality, focused care driven by local medical leadership.

Local Service

As a member of Care N' Care, you are more than just a member – you are part of our family. And like you, North Texas is our home, not just another office location. We have a Customer Experience Team that is dedicated to providing the very best member experience and assist you with your healthacre needs.

At Care N' Care, the Customer Experience Team can assist with:

- Finding a physician and scheduling appointments
- Plan and benefit questions
- Special healthcare needs
- Prescription drug assistance
- Claims questions and billing resolutions
- Senior activities in your local community

Notes:

Definitions of Important Words

Annual Enrollment Period – A set time each fall when beneficiaries can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 through December 7.

Catastrophic Coverage Stage – The stage in the Part D drug benefit where you pay only a small copay or coinsurance amount for each filled prescription. The plan and Medicare pay the rest until the end of the calendar year.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible – The amount you must pay for healthcare or prescriptions before a plan begins to pay.

Health Maintenance Organizations (HMO) – A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Low Income Subsidy (LIS) - A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year.

Initial Coverage Stage – During this stage you pay a flat fee (copay) or a percentage of a drug's total cost (coinsurance) for each prescription you fill.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage).

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage Plan can cancel their plan enrollment and switch to Original Medicare or make changes to their Part D coverage. The Open Enrollment Period is from January 1 through March 31.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Original Medicare ("Original Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital or other healthcare provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit

program as Part D.)

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total
combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company or a healthcare plan for health or prescription drug coverage.

Primary Care Physician (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and healthcare providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other healthcare provider.

Prior Authorization: A drug plan requirement that requires you or your physician get prior authorization for certain drugs. This means that you will need to get approval from your plan before you fill prescriptions. If you don't get approval, the plan may not cover the drug. These drugs are listed in the drug formulary with the symbol "PA".

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that the plan covers per prescription or for a defined period of time.

Special Election Period – A set time when beneficiaries can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, or if you move into a nursing home.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before the plan will cover the drug your physician may have initially prescribed.

Care N' Care Insurance Company, Inc. (Care N' Care) is an HMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Care N' Care members, except in emergency situations. Please call our customer service number or see your evidence of coverage for more information, including the cost-sharing that applies to out-of-network services.

Every year, Medicare evaluates plans based on a five-star rating system.

Care N' Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Care N' Care (HMO/PPO)

Contact Information

Web Address

cnchealthplan.com

Medicare Specialist

1-877-905-9209 (TTY 711) for questions related to Care N' Care Medicare Advantage Plans October 1 - March 31, 8 a.m. to 8 p.m. CST seven days a week, or April 1 - September 30 8 a.m. to 8 p.m. CST, Monday through Friday.

Medicare Information

For more information about Medicare, call Medicare at 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, seven days a week or visit https://www.medicare.gov.

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