care n care Insurance Company, Inc.

Southwestern Health Resources
Texas Health Resources® UTSouthwestern Medical Center®

2022

# Summary of Benefits

## CARE N' CARE CLASSIC (HMO)
## SOUTHWESTERN HEALTH SELECT (HMO)

**January 1, 2022 - December 31, 2022**

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

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage".

To join Care N' Care Classic (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Texas: **Collin, Cooke, Dallas, Denton, Erath, Hood, Johnson, Parker, Palo Pinto, Rockwall, Somervell, Tarrant, and Wise.** Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

To join Southwestern Health Select (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Texas: **Collin, Dallas, Denton, Tarrant, Rockwall.** Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://www.medicare.gov or get a copy by calling 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.

This document is available in other formats such as Braille or large print. For more information, please call us at 1-877-905-9210 (TTY users should call 711) to speak to a Medicare Specialist, October 1 - March 31, 8am to 8pm, CST, seven days a week or April 1 - September 30, 8am to 8pm, CST, Monday though Friday or, visit us at cnchealthplan.com.

## Care N' Care Classic (HMO)

[1]Services may require prior authorization

| Premiums and Benefits | Care N' Care Classic (HMO) |
|---|---|
| Monthly Plan Premium | You pay $0<br><br>You must continue to pay your Medicare part B Premium |
| Deductible | No Deductible |
| Maximum Out-of-Pocket | You pay no more than $3,900 Annually<br>Includes copays and other costs for medical services for the year unless specifically excluded. |
| Inpatient Hospital[1] | Day 1: $275 per day<br>Days 2-6: $125 per day<br>Days 7 -90 $0 per day |
| Outpatient Surgery[1]<br>• Outpatient Hospital<br>• Ambulatory Surgical Center | <br>You pay a $250 copay<br>You pay a $200 copay |
| Doctor Visits<br>• Primary<br>• Specialist | <br>You pay a $0 copay<br>You pay a $20 copay. Referral is required for specialist visits. |

[1]Services may require prior authorization [2]Prior Authorization is required for Non-Emergency transportation

| Premiums and Benefits | Care N' Care Classic (HMO) |
|---|---|
| Preventive Care<br>(e.g. Flu Vaccine, Diabetic Screenings) | You pay nothing. |
| Emergency Care | You pay $90 per visit<br>Emergency copay is waived if you are admitted to the hospital within 3 days due to the same condition. |
| Urgently Needed Services | You pay a $30 copay per visit |
| Diagnostic Services/Labs/Imaging[1]<br>• Basic Diagnostic tests and Procedures<br>• Sleep Study<br>• Lab Services<br>• MRI, CAT Scan<br>• X-Rays | <br>You pay a $0 copay<br><br>You pay a $100 copay<br>You pay a $0 copay<br>You pay a $200 copay<br>You pay a $0 copay |
| Hearing Services<br>• Routine hearing exam<br>• Hearing aid | <br>You pay a $45 copay*<br>You pay a $599 copayment per aid for Advanced Aids*<br>You pay a $899 copayment per aid for Premium Aids*<br>*Does not count towards Maximum Out-of-Pocket |
| Dental Services<br>• Oral exam & Cleaning<br>• X-Ray<br>• Fluoride Treatments<br>• Comprehensive Services | <br>You pay a $0 copay<br>You pay a $0 copay<br>You pay a $0 copay<br>Covered with additional Premium, see Optional Supplemental Benefits. |
| Vision Services<br>• Routine Eye Exam<br>• Glasses, Lenses and Frames | <br>You pay a $0 copay<br>You pay a $0 copay with a maximum benefit amount of $150 |
| Telehealth Services<br>• Primary Care Physician Services<br>• Mental Health Specialty Services | <br>You pay a $0 Copay<br>You pay a $40 Copay |
| Mental Health Services[1]<br>• Outpatient group therapy/ individual therapy visit | <br>You pay a $40 copay |
| Skilled Nursing Facility[1] | Days 1-20: $0 copay<br>Days 21-100: $184 copay per day |
| Physical Therapy | You pay a $20 copay |
| Ambulance[2]<br>• Ground Ambulance<br>• Air Ambulance | <br>You pay a $275 copay<br>You pay 20% of the cost |
| Transportation | Not Covered |
| Medicare Part B Drugs[1] | You pay 20% of the cost |

| Outpatient Prescription Drugs | | | | |
|---|---|---|---|---|
| Deductible | You pay $0 | | | |
| **Initial Coverage** | | | | |
| In-Network Pharmacy | Retail 30-day supply | Retail 90-day Supply | Mail Order 30-day supply | Mail Order 90-day supply |
| Tier 1: Preferred Generics | $0 copay | $0 copay | $0 copay | $0 copay |
| Tier 2: Generics | $12 copay | $24 copay | $12 copay | $24 copay |
| Tier 3: Preferred Brands | $45 copay | $90 copay | $45 copay | $90 copay |
| - *Select Insulins** | *$35 copay* | *$70 copay* | *$35 copay* | *$70 copay* |
| Tier 4: Non-Preferred Drugs | $100 copay | $200 copay | $100 copay | $200 copay |
| Tier 5: Specialty Drugs | 33% of the cost | 33% of the cost | 33% of the cost | 33% of the cost |
| *To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically on our website at www.cnchealthplan.com. You can identify Select Insulins by the abbreviation "SSM" found in the "Requirements/Limits" column in the Drug List.<br><br>Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").<br><br>If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.<br><br>Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. | | | | |
| **Coverage Gap** | | | | |
| During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be no more than $35 for a retail or mail order 30-day supply or $70 for a retail or mail order 90-day supply. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically on our website at www.cnchealthplan.com. You can identify Select Insulins by the abbreviation "SSM" found in the "Requirements/Limits" column in the Drug List.<br><br>For Tier 1 and select Tier 2 and 3 generic drugs, you pay either your Tier 1, 2, or 3 copayment or 25% of the costs, whichever is lower. For all other covered generic drugs, you pay 25% of the costs. For select Tier 3 brand drugs, you pay no more than the Tier 3 copayment. For all other brand name drugs, you pay 25% of the cost (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $7,050. This amount and rules for counting costs toward this amount have been set by Medicare.<br><br>If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.<br><br>Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help"). | | | | |
| **Catastrophic Coverage** | | | | |
| During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2022). Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount (either coinsurance for 5% of the cost of the drug, or $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs). | | | | |

## Southwestern Health Select

[1]Services may require prior authorization [2]Prior Authorization is required for Non-Emergency transportation

| Premiums and Benefits | Southwestern Health Select (HMO) |
|---|---|
| Monthly Plan Premium | You pay $0<br>You must continue to pay your Medicare part B Premium |
| Deductible | No Deductible |
| Maximum Out-of-Pocket | You pay no more than $2,900 Annually<br>Includes copays and other costs for medical services for the year unless specifically excluded. |
| Inpatient Hospital[1] | Day 1: $225 per day<br>Days 2-5: $75 per day<br>Days 6-90: $0 per day |
| Outpatient Surgery[1]<br>• Outpatient Hospital<br>• Ambulatory Surgical Center | <br>You pay a $200 copay<br>You pay a $150 copay |
| Doctor Visits[1]<br>• Primary<br>• Specialist | <br>You pay a $0 copay<br>You pay a $10 copay. Referral is required for specialist visits. |
| Preventive Care<br>(e.g. Flu Vaccine, Diabetic Screenings) | <br>You pay nothing. |
| Emergency Care | You pay $90 per visit |
| Urgently Needed Services | You pay a $30 copay per visit |
| Diagnostic Services/Labs/Imaging[1]<br>• Basic Diagnostic tests and Procedures<br>• Sleep Study<br>• Lab Services<br>• MRI, CAT Scan<br>• X-Rays | <br>You pay a $0 copay<br><br>You pay a $100 copay<br>You pay a $0 copay<br>You pay a $200 copay<br>You pay a $0 copay |
| Hearing Services<br>• Routine hearing exam<br>• Hearing aid | <br>You pay a $45 copay<br>You pay a $599 copayment per aid for Advanced Aids<br>You pay a $899 copayment per aid for Premium Aids |
| Dental Services<br>• Oral exam & Cleaning<br>• X-Ray<br>• Fluoride Treatments<br>• Comprehensive Services | <br>You pay a $0 copay<br>You pay a $0 copay<br>You pay a $0 copay<br>Available with additional premium under Optional supplemental benfits |
| Vision Services<br>• Routine Eye Exam<br>• Glasses, Lenses and Frames | <br>You pay a $0 copay<br>You pay a $0 copay with a maximum benefit amount of $150 (same as HMO classic) |

| Premiums and Benefits | Southwestern Health Select (HMO) |
|---|---|
| Telehealth Services<br>• Primary Care Physician Services<br>• Mental Health Specialty Services | <br>You pay a $0 Copay<br>You pay a $40 Copay |
| Mental Health Services[1]<br>• Outpatient group therapy/ individual therapy visit | You pay a $40 copay |
| Skilled Nursing Facility[1] | Days 1-20: $0 copay<br>Days 21-100: $184 copay per day |
| Physical Therapy | You pay a $10 copay |
| Ambulance[2]<br>• Ground Ambulance<br>• Air Ambulance | <br>You pay a $275 copay<br>You pay 20% of the cost |
| Transportation | Not Covered |
| Medicare Part B Drugs[1] | You pay 20% of the cost |

| Outpatient Prescription Drugs | | | | |
|---|---|---|---|---|
| Deductible | You pay $0 | | | |
| **Initial Coverage** | | | | |
| In-Network Pharmacy | Retail 30-day supply | Retail 90-day Supply | Mail Order 30-day supply | Mail Order 90-day supply |
| Tier 1: Preferred Generics | $0 copay | $0 copay | $0 copay | $0 copay |
| Tier 2: Generics | $10 copay | $20 copay | $0 copay | $0 copay |
| Tier 3: Preferred Brands | $40 copay | $80 copay | $40 copay | $80 copay |
| - *Select Insulins** | *$35 copay* | *$70 copay* | *$35 copay* | *$70 copay* |
| Tier 4: Non-Preferred Drugs | $100 copay | $200 copay | $100 copay | $200 copay |
| Tier 5: Specialty Drugs | 33% of the cost | 33% of the cost | 33% of the cost | 33% of the cost |

*To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically on our website at www.cnchealthplan.com. You can identify Select Insulins by the abbreviation "SSM" found in the "Requirements/Limits" column in the Drug List.

Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.

Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

**Coverage Gap**

During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be no more than $35 for a retail or mail order 30-day supply or $70 for a retail or mail order 90-day supply. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically on our website at www.cnchealthplan.com. You can identify Select Insulins by the abbreviation "SSM" found in the "Requirements/Limits" column in the Drug List.

For Tier 1 and select Tier 2 and 3 generic drugs, you pay either your Tier 1, 2, or 3 copayment or 25% of the costs, whichever is lower. For all other covered generic drugs, you pay 25% of the costs. For select Tier 3 brand drugs, you pay no more than the Tier 3 copayment. For all other brand name drugs, you pay 25% of the cost (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $7,050. This amount and rules for counting costs toward this amount have been set by Medicare.

If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.

Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

**Catastrophic Coverage**

During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2022). Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount (either coinsurance for 5% of the cost of the drug, or $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs).

**Supplemental Dental Rider**

Members who choose to add the Supplemental Dental Rider to their plan will receive comprehensive dental services for an additional $25 monthly premium. The rider provides coverage on dental services that require a preauthorization and coinsurance for each dental service.

**Additional Benefits Include*:**

- Fillings
- Extractions
- Root Canals
- Dentures (full and partial) and denture adjustments
- Crowns
- Oral Surgery
- Implants

*For full benefit detail, refer to the Evidence of Coverage. Detailed dental codes can also be found on the Care N' Care website, at cnchealthplan.com/our-plans-2022/our-benefits-2022/

# 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 Medicare Specialist at 1-877-905-9210.

## Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit cnchealthplan.com or call 1-877-905-9210 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, or pay a higher share of the cost.

- ☐ 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.

## Understanding Important Rules

- ☐ If you select a plan with a monthly premium then in addition to your monthly plan premium you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.