care n care Insurance Company, Inc.

Southwestern Health Resources
Texas Health Resources® UTSouthwestern Medical Center®

2022

Summary of Benefits

CARE N' CARE CHOICE (PPO)

CARE N' CARE CHOICE PLUS (PPO)

CARE N' CARE CHOICE PREMIUM (PPO)

CARE N' CARE CHOICE MA-ONLY (PPO)

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 a Care N' Care (PPO) plan, 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 an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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 Choice

[1]Services may require prior authorization

Premiums and Benefits	Care N' Care Choice (PPO)	
	In-Network	Out-Of-Network
Monthly Plan Premium	You pay $0 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 for in-network services unless specifically excluded.	You pay no more than $7,500 annually for combined in and out-of-network services unless specifically excluded.
Inpatient Hospital[1]	Day 1: $250 per day Days 2-6: $150 per day Days 7 and beyond: $0 per day	You pay 35% of the cost
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $250 copay You pay a $200 copay	 You pay a $350 copay You pay a $275 copay
Doctor Visits • Primary • Specialist	 You pay a $0 copay You pay a $35 copay	 You pay a $25 copay You pay a $70 copay
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings)	You pay a $0 copay	You pay a $30 copay

[1]Services may require prior authorization

Premiums and Benefits	Care N' Care Choice (PPO)	
	In-Network	Out-Of-Network
Emergency Care	You pay $90 per visit Emergency copay is waived if you are admitted to the hospital within 3 days due to the same condition.	You pay $90 per visit 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	You pay a $30 copay per visit
Diagnostic Services/Labs/Imaging[1] • Basic diagnostic tests and procedures • Sleep Study • Lab Services • MRI, CAT Scan • X-Rays	 You pay a $10 copay You pay a $150 copay You pay a $10 copay You pay a $200 You pay a $10 copay	 You pay a $25 copay You pay a $200 copay You pay a $25 copay You pay a $200 copay You pay a $25 copay
Hearing Services • Routine hearing exam • Hearing aid	 You pay a $45 copay* You pay a $699 copayment per aid for Advanced Aids* You pay a $999 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket	 You pay a $45 copay* You pay a $699 copayment per aid for Advanced Aids* You pay a $999 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket
Dental Services • Oral exam & Cleaning • X-Ray • Fluoride • Treatments • Comprehensive Services	 You pay a $0 copay You pay a $0 copay You pay a $0 copay Covered with additional Premium, see Optional Supplemental Benefits.	 You pay a $0 copay You pay a $0 copay You pay a $0 copay Covered with additional Premium, see Optional Supplemental Benefits.
Vision Services • Routine Eye Exam • Glasses, Lenses and Frames	 You pay a $0 copay You pay a $0 copay. Plan maximum benefit of $100.	 You pay a $50 Copay. You will be reimbursed up to a maximum amount of $30 for a routine eye exam with submission of paid receipt and completed reimbursement form. You pay a $30 copay. Plan maximum benefit of $100.
Telehealth Services • Primary Care Physician Services • Mental Health Specialty Services	 You pay a $0 Copay You pay a $40 Copay	 You pay a $25 Copay You pay a $60 Copay

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

Premiums and Benefits	Care N' Care Choice (PPO)	
	In-Network	Out-Of-Network
Mental Health Services[1] • Outpatient group therapy/individual therapy visit	You pay a $40 copay	You pay a $60 copay
Skilled Nursing Facility[1]	Days 1-20: $0 copay Days 21-100: $167.50 copay per day	You pay 40% of the cost
Physical Therapy	You pay a $40 copay	You pay a $60 copay
Ambulance[2] • Ground Ambulance • Air Ambulance	You pay a $200 copay You pay 20% of the cost	You pay a $200 copay You pay 20% of the cost
Transportation	Not Covered	Not Covered
Medicare Part B Drugs[1]	You pay 20% of the cost	You pay 30% of the cost

Outpatient Prescription Drugs				
Pharmacy 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	$4 copay	$8 copay	$0 copay	$0 copay
Tier 2: Generics	$14 copay	$28 copay	$14 copay	$28 copay
Tier 3: Preferred Brands	$47 copay	$94 copay	$47 copay	$94 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.

Outpatient Prescription Drugs
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).

Care N' Care Choice Plus (PPO)

Premiums and Benefits	Care N' Care Choice Plus (PPO)	
	In-Network	Out-Of-Network
Monthly Plan Premium	You pay $55 You must continue to pay your Medicare part B Premium	
Deductible	No Deductible	
Maximum Out-of-Pocket	You pay no more than $3,500 annually for in-network services unless specifically excluded.	You pay no more than $7,000 annually for combined in and out-of-network services unless specifically excluded.
Inpatient Hospital[1]	Days 1-6: $250 per day Days 7 and beyond: $0 per day	You pay 25% of the cost
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	You pay a $200 copay You pay a $175 copay	You pay a $350 copay You pay a $275 copay
Doctor Visits • Primary • Specialist	You pay a $10 copay You pay a $25 copay	You pay a $40 copay You pay a $50 copay
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings)	You pay a $0 copay	You pay a $30 copay
Emergency Care	You pay $90 per visit Emergency copay is waived if you are admitted to the hospital within 3 days due to the same condition.	You pay $90 per visit 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	You pay a $30 copay per visit

Premiums and Benefits	Care N' Care Choice Plus (PPO)	
	In-Network	Out-Of-Network
Diagnostic Services/Labs/ Imaging[1]		
• Basic diagnostic tests and procedures	You pay a $5 copay at a Dr. Office You pay a $10 copay at an outpatient facility.	You pay a $15 copay at a Dr. Office You pay a $25 copay at an outpatient facility.
• Sleep Study	You pay a $125 copay	You pay a $175 copay
• Lab Services	You pay a $5 copay at a Dr. Office or a stand-alone lab facility. You pay a $10 copay at an outpatient facility. You pay a $175	You pay a $15 copay at a Dr. Office or a stand-alone lab facility. You pay a $25 copay at an outpatient facility. You pay a $200 copay
• MRI, CAT Scan		
• X-Rays	You pay a $5 copay	You pay a $30 copay
Hearing Services		
• Routine hearing exam	You pay a $45 copay*	You pay a $45 copay*
• Hearing aid	You pay a $699 copayment per aid for Advanced Aids* You pay a $999 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket	You pay a $699 copayment per aid for Advanced Aids* You pay a $999 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket
Dental Services		
• Oral exam & Cleaning	You pay a $0 copay	You pay a $0 copay
• X-Ray	You pay a $0 copay	You pay a $0 copay
• Fluoride Treatments	You pay a $0 copay	You pay a $0 copay
• Comprehensive Services	Covered with additional Premium, see Optional Supplemental Benefits.	Covered with additional Premium, see Optional Supplemental Benefits.
Vision Services		
• Routine Eye Exam	You pay a $0 copay	You pay a $40 Copay. You will be reimbursed up to a maximum amount of $30 for a routine eye exam with submission of paid receipt and completed reimbursement form
• Glasses, Lenses and Frames	You pay a $0 copay with a maximum benefit amount of $100.	You pay a $30 copay with a maximum benefit amount of $100.
Telehealth Services		
• Primary Care Physician Services	You pay a $10 Copay	You pay a $40 Copay
• Mental Health Specialty Services	You pay a $40 Copay	You pay a $55 Copay
Mental Health Services[1]		
• Outpatient group therapy/individual therapy visit	You pay a $40 copay	You pay a $55 copay

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

Premiums and Benefits	Care N' Care Choice Plus (PPO)	
	In-Network	Out-Of-Network
Skilled Nursing Facility[1]	Days 1-20: $0 copay per day Days 21-100: $184 copay per day	You pay 35% of the cost
Physical Therapy	You pay a $25 copay	You pay a $45 copay
Ambulance[2]		
• Ground Ambulance	You pay a $225 copay	You pay a $225 copay
• Air Ambulance	You pay 20% of the cost	You pay 20% of the cost
Transportation	Not Covered	Not Covered
Medicare Part B Drugs[1]	You pay 20% of the cost	You pay 30% 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	$2 copay	$4 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	$95 copay	$190 copay	$95 copay	$190 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").

Outpatient Prescription Drugs
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).

Care N' Care Choice Premium (PPO)

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

Premiums and Benefits	Care N' Care Choice Premium (PPO)	
	In-Network	Out-Of-Network
Monthly Plan Premium	You pay $200 You must continue to pay your Medicare part B Premium	
Deductible	No Deductible	
Maximum Out-of-Pocket	You pay no more than $3,500 annually for in-network services unless specifically excluded.	You pay no more than $10,000 annually for combined in and out-of-network services unless specifically excluded.
Inpatient Hospital[1]	You pay a $0 Copay	You pay 30% of the cost
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	You pay a $0 Copay	You pay 30% of the cost You pay 35% of the cost
Doctor Visits • Primary • Specialist	You pay a $0 Copay	You pay 30% of the cost You pay 30% of the cost
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings)	You pay a $0 Copay	You pay 30% of the cost
Emergency Care	You pay a $0 Copay	You pay a $0 Copay
Urgently Needed Services	You pay a $0 Copay	You pay a $0 Copay
Diagnostic Services/Labs/Imaging[1] • Basic Diagnostic tests and procedures • Sleep Study • Lab Services • MRI, CAT Scan • X-Rays	You pay a $0 Copay	You pay 30% of the cost

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

Premiums and Benefits	Care N' Care Choice Premium (PPO)	
	In-Network	Out-Of-Network
Hearing Services • Routine hearing exam • Hearing aid	You pay a $45 copay* You pay a $699 copayment per aid for Advanced Aids* You pay a $999 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket	You pay a $45 copay* You pay a $699 copayment per aid for Advanced Aids* You pay a $999 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket
Dental Services • Oral exam & Cleaning • X-Ray • Fluoride Treatments • Comprehensive Services	You pay a $0 Copay Covered with additional Premium, see Optional Supplemental Benefits.	You pay 0% of the cost You pay 0% of the cost You pay 0% of the cost Covered with additional Premium, see Optional Supplemental Benefits.
Vision Services • Routine Eye Exam • Glasses, Lenses and Frames	You pay a $0 copay You pay a $0 copay with a maximum benefit amount of $150	You pay a $35 Copay. You will be reimbursed up to a maximum amount of $30 for a routine eye exam with submission of paid receipt and completed reimbursement form. You pay a $30 copay with a maximum benefit amount of $150
Telehealth Services • Primary Care Physician Services • Mental Health Specialty Services	You pay a $0 Copay You pay a $0 Copay	You pay a 30% of the cost You pay a 30% of the cost
Mental Health Services[1] • Outpatient group therapy/individual therapy visit	You pay a $0 Copay	You pay 30% of the cost
Skilled Nursing Facility[1]	Days 1-100: $0 Copay	You pay 30% of the cost
Physical Therapy	You pay a $0 Copay	You pay 30% of the cost
Ambulance[2] • Ground Ambulance • Air Ambulance	You pay a $0 Copay	You pay 35% of the cost You pay 35% of the cost
Transportation	Not Covered	Not Covered

Premiums and Benefits	Care N' Care Choice Premium (PPO)	
	In-Network	Out-Of-Network
Medicare Part B Drugs[1]	$0 Copay	You pay 30% 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	$10 copay	$20 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	$90 copay	$180 copay	$90 copay	$180 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).

Care N' Care Choice MA-Only (PPO)

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

Premiums and Benefits	Care N' Care Choice MA-Only (PPO)	
	In-Network	Out-Of-Network
Monthly Plan Premium	You pay $0 You must continue to pay your Medicare part B Premium	
Deductible	No Deductible	
Maximum Out-of-Pocket	You pay no more than $2,500 annually for in-network services unless specifically excluded.	You pay no more than $5,100 annually for combined in and out-of-network services unless specifically excluded.
Inpatient Hospital[1]	Days 1-6: $50 per day Days 7 and beyond: $0 per day	You pay 10% of the cost
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $100 copay You pay a $50 copay	 You pay a $225 copay You pay a $50 copay
Doctor Visits • Primary • Specialist	 You pay a $0 copay You pay a $10 copay	 You pay a $20 copay You pay a $20 copay
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings)	You pay a $0 copay	You pay a $30 copay
Emergency Care	You pay $100 per visit Emergency copay is waived if you are admitted to the hospital within 3 days due to the same condition.	You pay $100 per visit 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	You pay a $30 copay per visit
Diagnostic Services/Labs/ Imaging[1] • Basic diagnostic tests and procedures • Sleep Study • Lab Services • MRI, CAT Scan • X-Rays	 You pay a $0 copay at a Dr. Office You pay a $6 copay at an outpatient facility. You pay a $100 copay You pay a $0 copay at a Dr. Office or a stand-alone lab facility. You pay a $5 copay at an outpatient facility. You pay a $150 You pay a $0 copay	 You pay a $10 copay at a Dr. Office You pay a $25 copay at an outpatient facility. You pay a $150 copay You pay a $10 copay at a Dr. Office or a stand-alone lab facility. You pay a $25 copay at an outpatient facility. You pay a $200 copay You pay a $10 copay at a Dr. Office or a stand-alone lab facility. You pay a $25 copay at an outpatient facility.

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

Premiums and Benefits	Care N' Care Choice MA-Only (PPO)	
	In-Network	Out-Of-Network
Hearing Services • Routine hearing exam • Hearing aid	You pay a $45 copay* You pay a $699 copayment per aid for Advanced Aids* You pay a $999 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket	You pay a $45 copay* You pay a $699 copayment per aid for Advanced Aids* You pay a $999 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket
Dental Services • Oral exam & Cleaning • X-Ray • Fluoride Treatments • Comprehensive Services	You pay a $0 copay You pay a $0 copay You pay a $0 copay Covered with additional Premium, see Optional Supplemental Benefits.	You pay a $0 copay You pay a $0 copay You pay a $0 copay Covered with additional Premium, see Optional Supplemental Benefits.
Vision Services • Routine Eye Exam • Glasses, Lenses and Frames	You pay a $0 copay You pay a $0 copay with a maximum benefit amount of $150.	You pay a $35 Copay. You will be reimbursed up to a maximum amount of $30 for a routine eye exam with submission of paid receipt and completed reimbursement form. You pay a $30 copay with a maximum benefit amount of $150.
Telehealth Services • Primary Care Physician Services • Mental Health Specialty Services	You pay a $0 Copay You pay a $35 Copay	You pay a $20 Copay You pay a$50 Copay
Mental Health Services[1] • Outpatient group therapy/individual therapy visit	You pay a $35 copay	You pay a $50 copay
Skilled Nursing Facility[1]	Days 1-5: $0 copay Days 6-20: $10 copay per day Days 21-100: $100 copay per day	You pay 10% of the cost
Physical Therapy	You pay a $10 copay	You pay a $20 copay
Ambulance[2] • Ground Ambulance • Air Ambulance	You pay a $225 copay You pay 20% of the cost	You pay a $225 copay You pay 20% of the cost
Transportation	Not Covered	Not Covered
Medicare Part B Drugs[1]	You pay 20% of the cost	You pay 30% of the cost

Supplemental Dental Rider
Members who choose to add the Supplemental Dental Rider to their plan will receive comprehensive dental services for an additional $26 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 cn-chealthplan.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.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.