care n care
Insurance Company, Inc.

2020

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, 2020 - December 31, 2020
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.

This document is available in other formats such as Braille or large print. For more information, please call us at 1-877-665-2622 (TTY users should call 711) to speak to a Medicare Specialist, or visit us at cnchealthplan.com

CARE N' CARE CHOICE (PPO)

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	Day 1: $250 per day Days 2-6: $125 per day Days 7 and beyond: $0 per day	You pay 35% of the cost
Outpatient Surgery • 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 $15 copay You pay a $35 copay	 You pay a $50 copay You pay a $60 copay

Premiums and Benefits	Care N' Care Choice (PPO)	
	In-Network	Out-Of-Network
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings)	You pay nothing. There are some covered services that have a cost.	You pay a $30 copay
Emergency Care	You pay $75 per visit Emergency copay is waived if you are admitted to the hospital within 3 days due to the same condition.	You pay $75 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		
• Diagnostic tests and procedures	You pay a $10 copay	You pay a $25 copay
• Sleep Study	You pay a $150 copay	You pay a $200 copay
• Lab Services	You pay a $10 copay	You pay a $25 copay
• MRI, CAT Scan	You pay a $200	You pay a $250 copay
• X-Rays	You pay a $10 copay	You pay a $25 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 $25 copay	You pay a $25 copay
• X-Ray	You pay a $25 copay	You pay a $25 copay
• Denture Adjustments	You pay a $25 copay	You pay a $25 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 $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.
• Glasses, Lenses and Frames	You pay a $0 copay with a maximum benefit amount of $100	You pay a $30 copay and you will be reimbursed up to a maximum amount of $50 for frames, lenses/glasses with submission of paid receipt and completed reimbursement form.

Premiums and Benefits	Care N' Care Choice (PPO)	
	In-Network	Out-Of-Network
Mental Health Services • Outpatient group therapy/individual therapy visit	You pay a $40 copay	You pay a $60 copay
Skilled Nursing Facility	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 • 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	You pay 20% of the cost	You pay 30% of the cost

Outpatient Prescription Drugs			
Deductible	You pay $0		
Initial Coverage	Retail Rx 30-day supply	Retail or Mail Order 90-day Supply	
Tier 1: Preferred Generics Tier 2: Generics Tier 3: Preferred Brands Tier 4: Non-Preferred Drugs Tier 5: Specialty Drugs	$5 copay $15 copay $47 copay $100 copay 33% of the cost	$10 copay $30 copay $94 copay $200 copay 33% of the cost	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			
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 $6,350. This amount and rules for counting costs toward this amount have been set by Medicare.			
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, 2020). 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 $3.60 for a generic drug or a drug that is treated like a generic and $8.95 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 $3,400 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	Days 1-6: $250 per day Days 7 and beyond: $0 per day	You pay 25% of the cost
Outpatient Surgery • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $200 copay You pay a $150 copay	 You pay a $325 copay You pay a $225 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 nothing. There are some covered services that have a cost.	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 • Diagnostic tests and procedures • Sleep Study • Lab Services • MRI, CAT Scan • X-Rays	 You pay a $5 copay at a Dr. Office You pay a $10 copay at an outpatient hospital facility. You pay a $125 copay You pay a $5 copay at a Dr. Office You pay a $10 copay at an outpatient hospital facility. You pay a $175 You pay a $5 copay	 You pay a $15 copay at a Dr. Office You pay a $25 copay at an outpatient hospital facility. You pay a $175 copay You pay a $15 copay at a Dr. Office You pay a $25 copay at an outpatient hospital facility. You pay a $200 copay You pay a $30 copay

Premiums and Benefits	Care N' Care Choice Plus (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 • Denture Adjustments • Comprehensive Services	You pay a $20 copay You pay a $20 copay You pay a $20 copay Covered with additional Premium, see Optional Supplemental Benefits.	You pay a $20 copay You pay a $20 copay You pay a $20 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 $100	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 You pay a $30 copay and you will be reimbursed up to a maximum amount of $50 for frames, lenses/glasses with submission of paid receipt and completed reimbursement form.
Mental Health Services • Outpatient group therapy/individual therapy visit	You pay a $40 copay	You pay a $55 copay
Skilled Nursing Facility	Days 1-20: $20 copay per day Days 21-100: $160 copay per day	You pay 35% of the cost
Physical Therapy	You pay a $25 copay	You pay a $45 copay
Ambulance • 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	You pay 20% of the cost	You pay 30% of the cost

Outpatient Prescription Drugs			
Deductible	You pay $0		
Initial Coverage	Retail Rx 30-day supply	Retail or Mail Order 90-day Supply	
Tier 1: Preferred Generics Tier 2: Generics Tier 3: Preferred Brands Tier 4: Non-Preferred Drugs Tier 5: Specialty Drugs	$2 copay $12 copay $45 copay $90 copay 33% of the cost	$4 copay $24 copay $90 copay $180 copay 33% of the cost	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			
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 $6,350. This amount and rules for counting costs toward this amount have been set by Medicare.			
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, 2020). 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 $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs).			

CARE N' CARE CHOICE PREMIUM (PPO)

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 $3,100 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	$0 Copay	You pay 30% of the cost
Outpatient Surgery • Outpatient Hospital • Ambulatory Surgical Center	$0 Copay	You pay a $225 copay You pay a $200 copay
Doctor Visits • Primary • Specialist	$0 Copay	You pay a $35 copay You pay a $40 copay

Premiums and Benefits	Care N' Care Choice Premium (PPO)	
	In-Network	Out-Of-Network
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings)	You pay nothing. There are some covered services that have a cost.	You pay a $30 copay
Emergency Care	$0 Copay	$0 Copay
Urgently Needed Services	$0 Copay	$0 Copay
Diagnostic Services/ Labs/Imaging • Diagnostic tests and procedures • Sleep Study • Lab Services • MRI, CAT Scan • X-Rays	$0 Copay	You pay a $10 copay at a Dr. Office You pay a $25 copay at an outpatient hospital facility. You pay a $150 copay You pay a $10 copay at a Dr. Office You pay a $25 copay at an outpatient hospital facility. You pay a $200 copay You pay a $10 copay at a Dr. Office You pay a $25 copay at an outpatient hospital facility.
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 • Denture Adjustments • Comprehensive Services	$0 Copay	You pay a $10 copay You pay a $10 copay You pay a $10 copay Covered with additional Premium, see Optional Supplemental Benefits.

Premiums and Benefits	Care N' Care Choice Premium (PPO)	
	In-Network	Out-Of-Network
Vision Services • Routine Eye Exam	You pay a $0 copay	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.
• Glasses, Lenses and Frames	You pay a $0 copay with a maximum benefit amount of $150	You pay a $30 copay and you will be reimbursed up to a maximum amount of $75 for frames, lenses/glasses with submission of paid receipt and completed reimbursement form.
Mental Health Services • Outpatient group therapy/individual therapy visit	$0 Copay	You pay a $50 copay
Skilled Nursing Facility	$0 Copay	You pay 30% of the cost
Physical Therapy	$0 Copay	You pay a $30 copay
Ambulance • Ground Ambulance • Air Ambulance	$0 Copay	You pay a $225 copay You pay 20% of the cost
Transportation	Not Covered	Not Covered
Medicare Part B Drugs	$0 Copay	You pay 30% of the cost

Outpatient Prescription Drugs			
Deductible	You pay $0		
Initial Coverage	Retail Rx 30-day supply	Retail or Mail Order 90-day Supply	
Tier 1: Preferred Generics Tier 2: Generics Tier 3: Preferred Brands Tier 4: Non-Preferred Drugs Tier 5: Specialty Drugs	$0 copay $10 copay $40 copay $85 copay 33% of the cost	$0 copay $20 copay $80 copay $170 copay 33% of the cost	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
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 $6,350. This amount and rules for counting costs toward this amount have been set by Medicare.
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, 2020). 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 $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs).

CARE N' CARE CHOICE MA-ONLY (PPO)

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 $3,000 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	Days 1-6: $175 per day Days 7 and beyond: $0 per day	You pay 35% of the cost
Outpatient Surgery • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $100 copay You pay a $75 copay	 You pay a $225 copay You pay a $175 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 nothing. There are some covered services that have a cost.	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

Premiums and Benefits	Care N' Care Choice MA-Only (PPO)	
	In-Network	Out-Of-Network
Diagnostic Services/ Labs/Imaging		
• Diagnostic tests and procedures	You pay a $0 copay at a Dr. Office. You pay a $5 copay at an outpatient hospital facility.	You pay a $10 copay at a Dr. Office. You pay a $25 copay at an outpatient hospital facility.
• Sleep Study	You pay a $100 copay	You pay a $150 copay
• Lab Services	You pay a $0 copay at a Dr. Office. You pay a $5 copay at an outpatient hospital facility.	You pay a $10 copay at a Dr. Office. You pay a $25 copay at an outpatient hospital facility.
• MRI, CAT Scan	You pay a $150	You pay a $200 copay
• X-Rays	You pay a $0 copay	You pay a $10 copay at a Dr. Office. You pay a $25 copay at an outpatient hospital facility.
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 $10 copay	You pay a $10 copay
• X-Ray	You pay a $10 copay	You pay a $10 copay
• Denture Adjustments	You pay a $10 copay	You pay a $10 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 $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.
• Glasses, Lenses and Frames	You pay a $0 copay with a maximum benefit amount of $150	You pay a $30 copay and you will be reimbursed up to a maximum amount of $75 for frames, lenses/glasses with submission of paid receipt and completed reimbursement form.
Mental Health Services		
• Outpatient group therapy/individual therapy visit	You pay a $35 copay	You pay a $50 copay

Premiums and Benefits	Care N' Care Choice MA-Only (PPO)	
	In-Network	Out-Of-Network
Skilled Nursing Facility	Days 1-5: $0 copay Days 6-20: $20 copay per day Days 21-100: $160 copay per day	You pay 35% of the cost
Physical Therapy	You pay a $10 copay	You pay a $20 copay
Ambulance • 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	You pay 20% of the cost	You pay 30% of the cost

Optional Supplemental Benefits	
Comprehensive Services	$18 Premium

Restorative (Up to 4 total fillings per year)

Code	Description	Frequency	Member Co-Pay
D2140	Amalgam Filling - one surface		$35.00
D2150	Amalgam Filling - two surfaces		$45.00
D2160	Amalgam Filling - three surfaces		$55.00
D2330	Resin-Based Composite - one surface, anterior		$50.00
D2331	Resin-Based Composite - two surfaces, anterior		$65.00
D2332	Resin-Based Composite - three surfaces, anterior		$80.00

Crowns (Total of 2 per year – 6 month waiting period)

Code	Description	Frequency	Member Co-Pay
D2740	Crown - Porcelain/Ceramic Substrate		$295.00
D2750	Crown - Porcelain Fused to High Noble Metal		$275.00
D2751	Crown - Porcelain Fused to Predominantly Base Metal		$305.00
D2752	Crown - Porcelain Fused to Noble Metal		$320.00
D2791	Crown - Full Cast Base Metal		$307.00
D2792	Crown - Full Cast Noble Metal		$305.00

Scaling & Root Planing (Total of 2 per year)

Code	Description	Frequency	Member Co-Pay
D4341	Scaling & Root Planing (per quadrant)	1/12 months	$53.00
D4342	Periodontal Scaling and Root Planing, 1-3 teeth	1/12 months	$30.00
D4355	Full Mouth Debridement	1/12 months	$32.00

Prosthodontics - Removable (6 month waiting period)			
Code	Description	Frequency	Member Co-Pay
D5110	Complete denture - maxillary	1/60 months	$206.00
D5120	Complete denture - mandibular	1/60 months	$206.00
D5130	Immediate denture - maxillary (in lieu of D5110)	1/60 months	$213.75
D5140	Immediate denture - mandibular (in lieu of D5120)	1/60 months	$213.75
Partial Dentures (Including Routine Post-Delivery Care)			
Code	Description	Frequency	Member Co-Pay
D5213	Maxillary partial denture - cast metal framework	1/60 months	$217.75
D5214	Mandibular partial denture - cast metal framework	1/60 months	$217.75
Denture Adjustments (Up to 2 per year)			
Code	Description	Frequency	Member Co-Pay
D5410	Adjust Complete Denture - maxillary		$0.00
D5411	Adjust Complete Denture - mandibular		$0.00
D5421	Adjust partial denture - maxillary		$0.00
D5422	Adjust partial denture - mandibular		$0.00
Repairs to complete dentures			
Code	Description	Frequency	Member Co-Pay
D5510	Repair broken complete denture base		$39.00
D5520	Replace missing/broken teeth, complete denture		$31.00
Repairs to Partial Dentures			
Code	Description	Frequency	Member Co-Pay
D5610	Repair resin denture base		$45.00
D5640	Replace broken teeth, per tooth		$30.00
Extractions (Up to 2 per year)			
Code	Description	Frequency	Member Co-Pay
D7140	Extraction, Erupted Tooth		$40.00
D7210	Extraction, Surgical		$75.00

**Lab fees are the member's responsibility.*

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 1-877-665-2622

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 1-877-665-2622 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, 2020.

- ☐ 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.

care@care
Insurance Company, Inc.

2020

Discrimination is Against the Law

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 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Care N' Care:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Care N' Care at 1-877-665-2622 (TTY: 711) October 1 - March 31, 8AM - 8PM (CST), 7 days a week; April 1 - September 30, 8AM - 5PM (CST), Monday through Friday.

If you believe that Care N' Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Care N' Care, Attn: Appeals and Grievances, 1701 River Run, Suite 402, Fort Worth, TX 76107, 1- 877-374-7993, (TTY 711), or via fax at 817-810-5214. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department is available to help you.

You can also file a civil rights 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 SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-665-2622 (TTY:711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-665-2622 (TTY:711)

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-665-2622 (ATS: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-665-2622 (телетайп: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電
1-877-665-2622 (TTY:711).。

繁體中文(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-877-665-2622 (TTY:711).まで、お電話にてご連絡ください 。

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1- 877-374-7993 (TTY: 711). 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-877-665-2622 (TTY:711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-665-2622 (TTY: 711).

ةيبرعل(Arabic):

مقرب لصتا .ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ :ةظوحلم 1-877-665-2622 .
(TTY:711)

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleis-tungen zur Verfügung. Rufnummer: 1-877-665-2622 (TTY: 711).

سامت یسراف :(Persian) ی مهارف امش یارب ناگيار تروصب ینابز تلايهست ،دينک یم وگتفگ یسراف نابز هب
رگا :هجوت اب .دشاب <1-877-665-2622> :TTY) .711)دیریگب

ह दिी (Hindi): ध्यान दें: यदद आप ह दिी बोलते हैं तो आपके ललए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-877-665-2622 (TTY: 711) पर कॉल करें।

وُدرُا(Urdu):

ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو ،ہیں بولتے اردو
کال کریں. (TTY: 711) <1-877-665-2622>

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવાઓ
તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-665-2622 (TTY: 711).

ພາສາລາວ (Laotian/Lao):
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-665-2622 (TTY: 711).