

# Summary of Benefits

CARE N’ CARE CHOICE (PPO)  
 CARE N’ CARE CHOICE PLUS (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-

CARE N’ CARE CHOICE PREMIUM (PPO)  
 CARE N’ CARE CHOICE MA-ONLY (PPO)

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](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 1-877-665-2622 (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 5pm, CST, Monday through Friday. or visit us at [cnchealthplan.com](http://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 <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Sleep Study</li> <li>• Lab Services</li> <li>• MRI, CAT Scan</li> <li>• X-Rays</li> </ul>	<p>You pay a \$10 copay</p> <p>You pay a \$150 copay</p> <p>You pay a \$10 copay</p> <p>You pay a \$200</p> <p>You pay a \$10 copay</p>	<p>You pay a \$25 copay</p> <p>You pay a \$200 copay</p> <p>You pay a \$25 copay</p> <p>You pay a \$250 copay</p> <p>You pay a \$25 copay</p>
Hearing Services <ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Hearing aid</li> </ul>	<p>You pay a \$45 copay*</p> <p>You pay a \$699 copayment per aid for Advanced Aids*</p> <p>You pay a \$999 copayment per aid for Premium Aids*</p> <p>*Does not count towards Maximum Out-of-Pocket</p>	<p>You pay a \$45 copay*</p> <p>You pay a \$699 copayment per aid for Advanced Aids*</p> <p>You pay a \$999 copayment per aid for Premium Aids*</p> <p>*Does not count towards Maximum Out-of-Pocket</p>
Dental Services <ul style="list-style-type: none"> <li>• Oral exam &amp; Cleaning</li> <li>• X-Ray</li> <li>• Denture Adjustments</li> <li>• Comprehensive Services</li> </ul>	<p>You pay a \$25 copay</p> <p>You pay a \$25 copay</p> <p>You pay a \$25 copay</p> <p>Covered with additional Premium, see Optional Supplemental Benefits.</p>	<p>You pay a \$25 copay</p> <p>You pay a \$25 copay</p> <p>You pay a \$25 copay</p> <p>Covered with additional Premium, see Optional Supplemental Benefits.</p>
Vision Services <ul style="list-style-type: none"> <li>• Routine Eye Exam</li> <li>• Glasses, Lenses and Frames</li> </ul>	<p>You pay a \$0 copay</p> <p>You pay a \$0 copay with a maximum benefit amount of \$100</p>	<p>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.</p> <p>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.</p>

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	\$5 copay	\$10 copay	If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.
Tier 2: Generics	\$15 copay	\$30 copay	
Tier 3: Preferred Brands	\$47 copay	\$94 copay	
Tier 4: Non-Preferred Drugs	\$100 copay	\$200 copay	
Tier 5: Specialty Drugs	33% of the cost	33% of the cost	
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 <ul style="list-style-type: none"> <li>• Outpatient Hospital</li> <li>• Ambulatory Surgical Center</li> </ul>	You pay a \$200 copay You pay a \$150 copay	You pay a \$325 copay You pay a \$225 copay
Doctor Visits <ul style="list-style-type: none"> <li>• Primary</li> <li>• Specialist</li> </ul>	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 <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Sleep Study</li> <li>• Lab Services</li> <li>• MRI, CAT Scan</li> <li>• X-Rays</li> </ul>	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
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Hearing aid</li> </ul>	<p>You pay a \$45 copay*</p> <p>You pay a \$699 copayment per aid for Advanced Aids*</p> <p>You pay a \$999 copayment per aid for Premium Aids*</p> <p>*Does not count towards Maximum Out-of-Pocket</p>	<p>You pay a \$45 copay*</p> <p>You pay a \$699 copayment per aid for Advanced Aids*</p> <p>You pay a \$999 copayment per aid for Premium Aids*</p> <p>*Does not count towards Maximum Out-of-Pocket</p>
<b>Dental Services</b> <ul style="list-style-type: none"> <li>• Oral exam &amp; Cleaning</li> <li>• X-Ray</li> <li>• Denture Adjustments</li> <li>• Comprehensive Services</li> </ul>	<p>You pay a \$20 copay</p> <p>You pay a \$20 copay</p> <p>You pay a \$20 copay</p> <p>Covered with additional Premium, see Optional Supplemental Benefits.</p>	<p>You pay a \$20 copay</p> <p>You pay a \$20 copay</p> <p>You pay a \$20 copay</p> <p>Covered with additional Premium, see Optional Supplemental Benefits.</p>
<b>Vision Services</b> <ul style="list-style-type: none"> <li>• Routine Eye Exam</li> <li>• Glasses, Lenses and Frames</li> </ul>	<p>You pay a \$0 copay</p> <p>You pay a \$0 copay with a maximum benefit amount of \$100</p>	<p>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</p> <p>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.</p>
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>• Outpatient group therapy/individual therapy visit</li> </ul>	<p>You pay a \$40 copay</p>	<p>You pay a \$55 copay</p>
<b>Skilled Nursing Facility</b>	<p>Days 1-20: \$20 copay per day</p> <p>Days 21-100: \$160 copay per day</p>	<p>You pay 35% of the cost</p>
<b>Physical Therapy</b>	<p>You pay a \$25 copay</p>	<p>You pay a \$45 copay</p>
<b>Ambulance</b> <ul style="list-style-type: none"> <li>• Ground Ambulance</li> <li>• Air Ambulance</li> </ul>	<p>You pay a \$225 copay</p> <p>You pay 20% of the cost</p>	<p>You pay a \$225 copay</p> <p>You pay 20% of the cost</p>
<b>Transportation</b>	<p>Not Covered</p>	<p>Not Covered</p>
<b>Medicare Part B Drugs</b>	<p>You pay 20% of the cost</p>	<p>You pay 30% of the cost</p>

## Outpatient Prescription Drugs

Deductible	You pay \$0		
<b>Initial Coverage</b>	Retail Rx 30-day supply	Retail or Mail Order 90-day Supply	
Tier 1: Preferred Generics	\$2 copay	\$4 copay	If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.
Tier 2: Generics	\$12 copay	\$24 copay	
Tier 3: Preferred Brands	\$45 copay	\$90 copay	
Tier 4: Non-Preferred Drugs	\$90 copay	\$180 copay	
Tier 5: Specialty Drugs	33% of the cost	33% of the cost	

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 <ul style="list-style-type: none"> <li>• Outpatient Hospital</li> <li>• Ambulatory Surgical Center</li> </ul>	\$0 Copay	You pay a \$225 copay You pay a \$200 copay
Doctor Visits <ul style="list-style-type: none"> <li>• Primary</li> <li>• Specialist</li> </ul>	\$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 <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Sleep Study</li> <li>• Lab Services</li> <li>• MRI, CAT Scan</li> <li>• X-Rays</li> </ul>	\$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 <ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Hearing aid</li> </ul>	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 <ul style="list-style-type: none"> <li>• Oral exam &amp; Cleaning</li> <li>• X-Ray</li> <li>• Denture Adjustments</li> <li>• Comprehensive Services</li> </ul>	\$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  • 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 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	\$0 copay	\$0 copay	If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.
Tier 2: Generics	\$10 copay	\$20 copay	
Tier 3: Preferred Brands	\$40 copay	\$80 copay	
Tier 4: Non-Preferred Drugs	\$85 copay	\$170 copay	
Tier 5: Specialty Drugs	33% of the cost	33% of the cost	
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
<b>Diagnostic Services/ Labs/Imaging</b> <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Sleep Study</li> <li>• Lab Services</li> <li>• MRI, CAT Scan</li> <li>• X-Rays</li> </ul>	<p>You pay a \$0 copay at a Dr. Office. You pay a \$5 copay at an outpatient hospital facility.</p> <p>You pay a \$100 copay You pay a \$0 copay at a Dr. Office. You pay a \$5 copay at an outpatient hospital facility.</p> <p>You pay a \$150 You pay a \$0 copay</p>	<p>You pay a \$10 copay at a Dr. Office. You pay a \$25 copay at an outpatient hospital facility.</p> <p>You pay a \$150 copay You pay a \$10 copay at a Dr. Office. You pay a \$25 copay at an outpatient hospital facility.</p> <p>You pay a \$200 copay You pay a \$10 copay at a Dr. Office. You pay a \$25 copay at an outpatient hospital facility.</p>
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Hearing aid</li> </ul>	<p>You pay a \$45 copay*</p> <p>You pay a \$699 copayment per aid for Advanced Aids*</p> <p>You pay a \$999 copayment per aid for Premium Aids*</p> <p>*Does not count towards Maximum Out-of-Pocket</p>	<p>You pay a \$45 copay*</p> <p>You pay a \$699 copayment per aid for Advanced Aids*</p> <p>You pay a \$999 copayment per aid for Premium Aids*</p> <p>*Does not count towards Maximum Out-of-Pocket</p>
<b>Dental Services</b> <ul style="list-style-type: none"> <li>• Oral exam &amp; Cleaning</li> <li>• X-Ray</li> <li>• Denture Adjustments</li> <li>• Comprehensive Services</li> </ul>	<p>You pay a \$10 copay</p> <p>You pay a \$10 copay You pay a \$10 copay</p> <p>Covered with additional Premium, see Optional Supplemental Benefits.</p>	<p>You pay a \$10 copay</p> <p>You pay a \$10 copay You pay a \$10 copay</p> <p>Covered with additional Premium, see Optional Supplemental Benefits.</p>
<b>Vision Services</b> <ul style="list-style-type: none"> <li>• Routine Eye Exam</li> <li>• Glasses, Lenses and Frames</li> </ul>	<p>You pay a \$0 copay</p> <p>You pay a \$0 copay with a maximum benefit amount of \$150</p>	<p>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.</p> <p>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.</p>
<b>Mental Health Services</b> <ul style="list-style-type: none"> <li>• Outpatient group therapy/individual therapy visit</li> </ul>	<p>You pay a \$35 copay</p>	<p>You pay a \$50 copay</p>

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	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	You pay 20% of the cost	You pay 30% of the cost

### Optional Supplemental Benefits

Comprehensive Services	\$18 Premium
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### 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

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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 [cnhealthplan.com](http://cnhealthplan.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.