care n care
Insurance Company, Inc.

2021

Care N' Care Choice Plus (PPO)

	IN-NETWORK	OUT-OF-NETWORK
Plan Premium	**$55**	
Out-Of-Pocket Maximum	$3,500	$7,000
DOCTOR OFFICE VISITS		
Primary Care Physician (PCP) Visits	$10 copay	$40 copay
Specialist Visits	$25 copay	$50 copay
PODIATRY	$20 copay	$40 copay
INPATIENT HOSPITAL CARE	Days 1-6: $250 copay per day. Days 7 and beyond: $0	25% of the cost
SKILLED NURSING FACILITY (SNF)	Days 1-20: $0 copay per day. Days 21-100: $184 copay per day	35% of the cost
OUTPATIENT REHABILITATION SERVICES		
Occupational Therapy Visit	$15 copay	$30 copay
Physical / Speech / Language Visits	$25 copay	$45 copay
HOME HEALTH SERVICES	$0 copay	$40 copay
AMBULANCE • Ground Ambulance • Air Ambulance	$225 copay 20% of the cost	
EMERGENCY CARE	$90 copay	
OUTPATIENT SURGERY		
Ambulatory Surgical Center	$175 copay	$275 copay
Outpatient Hospital Facility	$200 copay	$350 copay
DIAGNOSTIC TESTS & LAB SERVICES		
Basic Diagnostic Tests and Procedures	$5-$10 copay	$15-$25 copay
Lab Services	$5-$10 copay	$15-$25 copay
OUTPATIENT X-RAYS	$5 copay	$30 copay
ADDITIONAL BENEFITS		
FITNESS BENEFIT	Unlimited number of visits to a SilverSneakers® participating fitness facility.	
OVER-THE-COUNTER (OTC)	$30 Every quarter (3 months) to spend on Plan-approved OTC items.	

DENTAL COVERAGE		
Preventive Dental Services Include: • Cleaning • Dental X-Ray(s) • Oral Exam • Fluoride	$0 copay	$0 copay
Limited Medicare Covered Services	$0 copay	$40 copay
VISION COVERAGE		
Routine Eye Exam (1 every year, includes refraction)	$25 copay	$40 copay
Eyeglasses or contact lenses after cataract surgery	$0 copay	$30 copay
Non-Medicare Prescription eyewear allowance	$100 every year	$100 every year
HEARING COVERAGE		
Exam to diagnose and treat hearing and balance issues	$25 copay	$45 copay
Routine Hearing Exam (for up to 1 every year)	$45 copay	$45 copay
Hearing Aid	Advanced Aids: $699 copay Premium Aids: $999 copay	

PRESCRIPTION DRUG BENEFIT	INITIAL COVERAGE PERIOD		
In-Network Retail	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 - Preferred Generics	$2 copay	$4 copay	$4 copay
Tier 2 - Generics	$12 copay	$24 copay	$24 copay
Tier 3 - Preferred Brand	$45 copay	$90 copay	$90 copay
Tier 4 - Non-Preferred Drugs	$90 copay	$180 copay	$180 copay
Tier 5 - Specialty Drugs	33% of the cost	33% of the cost	33% of the cost

Optional Supplemental Coverage:

DENTAL RIDER	
Monthly Premium	**$20**

For more information about Care N' Care HMO or PPO plan benefits, call 1-877-905-9208 (TTY 711) October 1 - March 31, 8am to 8pm, CST, seven days a week or April 1 - September 30, 8am to 5pm, CST, Monday through Friday.

Care N' Care Insurance is an HMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal. This information is not a complete description of benefits. Call 1-877-905-9208 (TTY 711) October 1 - March 31, 8am to 8pm, CST, seven days a week or April 1 - September 30, 8am to 5pm, CST, Monday through Friday for more information. Out-of-Network/non-contracted providers are under no obligation to treat Care N' Care members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Y0107_H6328_21_583_M