### Benefit Summary

**In-Network**

**Out-Of-Pocket Maximum**

- **Care N' Care Choice (PPO)**: $3,200
- **Care N' Care Choice Premium (PPO)**: $3,500
- **Care N' Care Choice MA-Only (PPO)**: $3,500

**Primary Care Physician (PCP) Visits**

- **Care N' Care Choice (PPO)**: $0 copay
- **Care N' Care Choice MA-Only (PPO)**: $0 copay

**Specialist Visits**

- **Care N' Care Choice (PPO)**: $15 copay
- **Care N' Care Choice MA-Only (PPO)**: $15 copay

**In-Hospital Surgery**

- **Care N' Care Choice (PPO)**: Day 1: $10 copay per day
- **Care N' Care Choice MA-Only (PPO)**: Day 1: $10 copay per day

**Emergency Care**

- **Care N' Care Choice (PPO)**: Days 1-20: $0 copay per day
- **Care N' Care Choice MA-Only (PPO)**: Days 1-20: $0 copay per day

**Additional Benefits**

- **Fitness Benefit**
  - Unlimited number of visits to a SilverSneakers® participating fitness facility

### Plan Details

**Care N' Care Choice Classic (HMO)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist Visits</td>
<td>$15 copay</td>
<td>$70 copay</td>
</tr>
</tbody>
</table>

**Care N' Care Choice Plus (PPO)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical / Speech / Language Visits</td>
<td>$40 copay</td>
<td>$45 copay</td>
</tr>
</tbody>
</table>

**Care N' Care Choice Premium (PPO)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy Visit</td>
<td>$45 copay</td>
<td>$50 copay</td>
</tr>
</tbody>
</table>

**Care N' Care Choice MA-Only (PPO)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical / Speech / Language Visits</td>
<td>$45 copay</td>
<td>$50 copay</td>
</tr>
</tbody>
</table>

### Additional Notes

- **Outpatient Rehabilitation Services**
  - **Ambulance**
    - **Ground Ambulance**
      - $275 copay
      - 20% of the cost
    - **Air Ambulance**
      - $200 copay
      - 20% of the cost
  - **Inpatient Hospital Care**
    - **Primary Care Physician (PCP) Visits**
      - $10 copay
    - **Specialist Visits**
      - $15 copay
    - **In-Network**
      - Days 1-20: $0 copay per day
      - Days 21-100: $0 copay per day
      - Days 1-20: $0 copay per day
      - Days 21-100: $0 copay per day

### Contact Information

For more information on Care N' Care (HMO/PPO) Health Plans, please call 877-905-9208 (TTY 711).

October 1 - March 31, 8am to 8pm, CST, seven days a week
April 1 - September 30, 8am to 8pm, CST, Monday through Friday.

**Health Plans, please call 877-905-9208 (TTY 711). Care N' Care Classic (HMO) Health Plans are compliant with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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). Care N' Care Classic (HMO) Health Plans do not exclude people who speak languages other than English and who are limited in their ability to read, write, understand, or speak English.
DENTAL COVERAGE

Preventive Dental Services Include:
• Cleaning
• Dental X-Ray(s)
• Oral Exam

IN-NETWORK
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay

LIMITED MEDICARE COVERED SERVICES
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay
$0 copay

VISION COVERAGE

Routine Eye Exam (1 every year, includes refraction)
$0 copay
$35 copay
$50 copay
$25 copay
$40 copay
$0 copay
$35 copay
$45 copay
$35 copay

Non-Medicare Prescription eyewear allowance
$150 every year
$0 copay
$0 copay
$30 copay
$0 copay
$30 copay
$0 copay
$30 copay
$30 copay

HEARING COVERAGE

Exam to diagnose and treat hearing and balance issues
$35 copay
$20 copay
$45 copay
$25 copay
$45 copay
$0 copay
$30 copay
$20 copay
$30 copay

Routine Hearing Exam (for up to 1 every year)
$45 copay
$45 copay
$45 copay
$45 copay
$45 copay
$45 copay
$45 copay
$45 copay
$45 copay

Hearing Aid
Advanced Aids: $599 copay
Premium Aids: $899 copay
Premium Aids: $599 copay
Premium Aids: $899 copay
Advanced Aids: $599 copay
Premium Aids: $899 copay
Advanced Aids: $599 copay
Premium Aids: $899 copay
Premium Aids: $899 copay

PRESCRIPTION DRUG BENEFIT

INITIAL COVERAGE PERIOD

In-Network Retail

One-Month Supply
Two-Month Supply
Three-Month Supply
One-Month Supply
Two-Month Supply
Three-Month Supply
One-Month Supply
Two-Month Supply
Three-Month Supply

Tier 1 - Preferred Generic
$0 copay
$0 copay
$0 copay
$10 copay
$10 copay
$10 copay
$2 copay
$4 copay
$4 copay
$0 copay
$0 copay
$0 copay

Tier 2 - Generics
$10 copay
$20 copay
$30 copay
$15 copay
$30 copay
$50 copay
$22 copay
$44 copay
$44 copay
$10 copay
$20 copay
$20 copay

Tier 3 - Preferred Brand
$40 copay
$60 copay
$80 copay
$47 copay
$94 copay
$188 copay
$45 copay
$90 copay
$90 copay
$40 copay
$80 copay
$80 copay

Tier 4 - Non-Preferred Drugs
$95 copay
$190 copay
$380 copay
$100 copay
$200 copay
$300 copay
$90 copay
$180 copay
$180 copay
$85 copay
$170 copay
$170 copay

Tier 5 - Specialty Drugs
33% of the cost
33% of the cost
33% of the cost
33% of the cost
33% of the cost
33% of the cost
33% of the cost
33% of the cost
33% of the cost
33% of the cost
33% of the cost
33% of the cost

Optional Supplemental Coverage:

DENTAL RIDER

Monthly Premium
$20
$20
$20
$20

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