

## Summary of Benefits

### CARE N' CARE CLASSIC (HMO)

January 1, 2021 - December 31, 2021

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 Care N' Care Classic (HMO), 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 emergency situations, if you use the providers that are not in our network, we may not pay for these services.

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 5pm, CST, Monday through Friday or, visit us at [cnchealthplan.com](http://cnchealthplan.com).

<sup>1</sup>Services may require prior authorization

Premiums and Benefits	Care N' Care Classic (HMO)
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 \$3,200 Annually Includes copays and other costs for medical services for the year unless specifically excluded.
Inpatient Hospital <sup>1</sup>	Day 1: \$250 per day Days 2-5: \$100 per day Days 6 and beyond: \$0 per day
Outpatient Surgery <sup>1</sup> <ul style="list-style-type: none"> <li>Outpatient Hospital</li> <li>Ambulatory Surgical Center</li> </ul>	You pay a \$200 copay You pay a \$180 copay
Doctor Visits <ul style="list-style-type: none"> <li>Primary</li> <li>Specialist</li> </ul>	You pay a \$0 copay You pay a \$25 copay. Referral is required for specialist visits.
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings)	You pay nothing. There are some covered services that have a cost.

<sup>1</sup>Services may require prior authorization <sup>2</sup>Prior Authorization is required for Non-Emergency transportation

Premiums and Benefits		Care N' Care Classic (HMO)	
Emergency Care	You pay \$120 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		
Diagnostic Services/Labs/Imaging <sup>1</sup>	<ul style="list-style-type: none"> <li>• Basic Diagnostic tests and Procedures You pay a \$0 copay</li> <li>• Sleep Study You pay a \$100 copay</li> <li>• Lab Services You pay a \$0 copay</li> <li>• MRI, CAT Scan You pay a \$200 copay</li> <li>• X-Rays You pay a \$0 copay</li> </ul>		
Hearing Services	<ul style="list-style-type: none"> <li>• Routine hearing exam You pay a \$45 copay*</li> <li>• Hearing aid You pay a \$599 copayment per aid for Advanced Aids* You pay a \$899 copayment per aid for Premium Aids* *Does not count towards Maximum Out-of-Pocket</li> </ul>		
Dental Services	<ul style="list-style-type: none"> <li>• Oral exam &amp; Cleaning You pay a \$0 copay</li> <li>• X-Ray You pay a \$0 copay</li> <li>• Fluoride Treatments You pay a \$0 copay</li> <li>• Comprehensive Services Covered with additional Premium, see Optional Supplemental Benefits.</li> </ul>		
Vision Services	<ul style="list-style-type: none"> <li>• Routine Eye Exam You pay a \$0 copay</li> <li>• Glasses, Lenses and Frames You pay a \$0 copay with a maximum benefit amount of \$150</li> </ul>		
Mental Health Services <sup>1</sup>	<ul style="list-style-type: none"> <li>• Outpatient group therapy/ individual therapy visit You pay a \$40 copay</li> </ul>		
Skilled Nursing Facility <sup>1</sup>	Days 1-20: \$0 copay Days 21-100: \$184 copay per day		
Physical Therapy	You pay a \$20 copay		
Ambulance <sup>2</sup>	<ul style="list-style-type: none"> <li>• Ground Ambulance You pay a \$275 copay</li> <li>• Air Ambulance You pay 20% of the cost</li> </ul>		
Transportation	Not Covered		
Medicare Part B Drugs <sup>1</sup>	You pay 20% 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	\$95 copay	\$190 copay	
Tier 5: Specialty Drugs	33% of the cost	33% of the cost	

Outpatient Prescription Drugs			
Retail Rx 30-day supply	Retail Rx 30-day supply	Retail or Mail Order 90-day Supply	
Select Insulins:	\$35 copay	\$70 copay	This cost-sharing applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help")
<p>During the initial coverage stage, your out-of-pocket costs for select insulins will be no more than \$35 for a retail 30-day supply or \$70 for a retail or mail order 90-day supply. Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help"). To find out which drugs are select insulins, review the most recent Drug List we provided electronically.</p> <p>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.</p>			
Coverage Gap			
<p>During the Coverage Gap stage, your out-of-pocket costs for select insulins will be no more than \$35 for a retail 30-day supply or \$70 for a retail or mail order 90-day supply. Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help"). To find out which drugs are select insulins, review the most recent Drug List we provided electronically.</p> <p>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 \$6,550. This amount and rules for counting costs toward this amount have been set by Medicare.</p>			
Catastrophic Coverage			
<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2021). 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 \$3.70 for a generic drug or a drug that is treated like a generic and \$9.20 for all other drugs).</p>			
Supplemental Dental Rider			
<p>Members who choose to add the Supplemental Dental Rider to their plan will receive comprehensive dental services for an additional \$20 monthly premium. The rider provides coverage on dental services that require a preauthorization and coinsurance for each dental service.</p>			
Additional Benefits Include*:			
<ul style="list-style-type: none"> <li>• Fillings</li> <li>• Extractions</li> <li>• Root Canals</li> <li>• Dentures (full and partial) and denture adjustments</li> <li>• Crowns</li> <li>• Oral Surgery</li> <li>• Implants</li> </ul>			

\*For full benefit detail, refer to the Evidence of Coverage. Detailed dental codes can also be found on the Care N' Care website, at [cnhealthplan.com/our-plans-2021/our-benefits-2021/](http://cnhealthplan.com/our-plans-2021/our-benefits-2021/)

# 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 1-877-905-9210 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.
- 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

- 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, 2021.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

## 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 1-877-905-9210 (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 20211, 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 1-877-905-9210 (TTY:711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-905-9210 (TTY:711)

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-905-9210(ATS: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-905-9210(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 1-877-905-9210 (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。1-877-905-9210 (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 1-877-905-9210 (TTY:711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-905-9210(TTY: 711).

عربي (Arabic):

مقرب لصتا. ناجملاب كل رفاوتت ةيوجللا ةدعاسلما تامدخ نإف، ةغلللا ركذا ثدحتت تنك اذا: ةظوحلم  
1-877-905-9210.(711:TTY)

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-905-9210(TTY: 711).

سامت یسراف (Persian): یم مهارف امش یارب ناگیار تروصب ینابز تلایهست ،دینک یم وگتفگ یسراف نابز هب رگا :هجوت اب .دشاب 1-877-905-9210 (TTY: 711). دیریگب

ह दी (Hindi): ध्यान दें: यदद आप ह दी बोलते हैं तो आपके ललए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-905-9210(TTY: 711) पर कॉल करें।

وُدرًا (Urdu):

یہ ہایتسد یم تفم تامدخ یم ددم یم نابز وک پآ وت ،ہیہ ےتلوب ودرًا  
1-877-905-9210(TTY: 711). لاک یرک

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-905-9210(TTY: 711).

ພາສາລາວ (Laotian/Lao):

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີອັມໃຫ້ທ່ານ. ໂທສ 1-877-905-9210(TTY: 711).