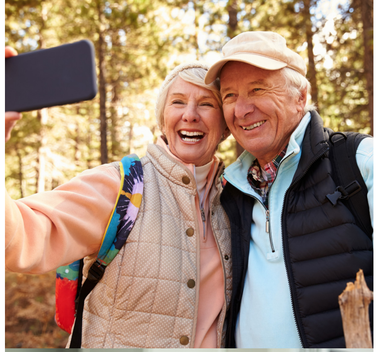
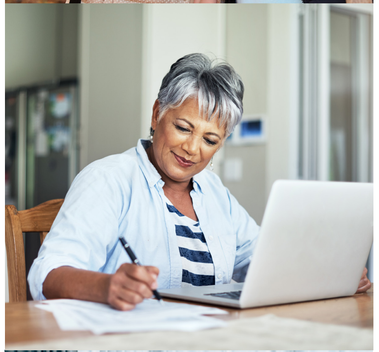
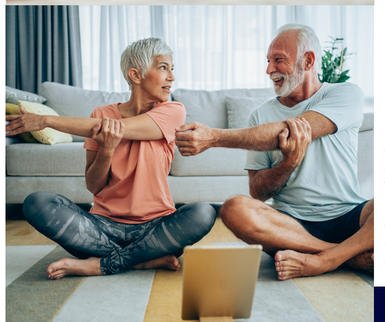
	Care N' Care Choice (PPO)		Care N' Care Choice Plus (PPO)		Care N' Care Choice Premium (PPO)		Care N' Care Choice MA-Only (PPO)	
Plan Premium	$0		$55		$200		$0	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Out-Of-Pocket Maximum	$3,900	$7,500	$3,500	$7,000	$3,500	$10,000	$2,500	$5,100
DOCTOR OFFICE VISITS								
Primary Care Physician (PCP) Visits	$0 copay	$25 copay	$10 copay	$40 copay	$0 copay	30% of the cost	$0 copay	$20 copay
Specialist Visits	$35 copay	$70 copay	$25 copay	$50 copay	$0 copay	30% of the cost	$10 copay	$20 copay
PODIATRY	$35 copay	$60 copay	$20 copay	$40 copay	$0 copay	30% of the cost	$20 copay	$50 copay
INPATIENT HOSPITAL CARE	Day 1: $250 copay per day Days 2-6: $150 copay per day. Days 7 and beyond: $0	35% of the cost	Days 1-6: $250 copay per day. Days 7 and beyond: $0	25% of the cost	$0 copay	30% of the cost	Days 1-6: $50 copay per day. Days 7 and beyond: $0	10% of the cost
SKILLED NURSING FACILITY (SNF)	Days 1-20: $0 copay per day. Days 21-100: $167.50 copay per day	40% of the cost	Days 1-20: $0 copay per day. Days 21-100: $184 copay per day	35% of the cost	$0 copay	30% of the cost	Days 1-5: $0 copay per day. Days 6-20: $10 copay per day. Days 21 - 100: $100 copay per day	10% of the cost
TELEHEALTH SERVICES · Primary Care Physician Services · Mental Health Specialty Services	$0 Copay $40 Copay	$25 Copay $60 Copay	$10 Copay $40 Copay	$40 Copay $55 Copay	$0 Copay $0 Copay	30% of the cost 30% of the cost	$0 Copay $35 Copay	$20 Copay $50 Copay
OUTPATIENT REHABILITATION SERVICES								
Occupational Therapy Visit	$40 copay	$60 copay	$15 copay	$30 copay	$0 copay	30% of the cost	$10 copay	$20 copay
Physical / Speech / Language Visits	$40 copay	$60 copay	$25 copay	$45 copay	$0 copay	30% of the cost	$10 copay	$20 copay
HOME HEALTH SERVICES	$0 copay	$30 copay	$0 copay	$40 copay	$0 copay	30% of the cost	$15 copay	$40 copay
AMBULANCE · Ground Ambulance · Air Ambulance	$200 copay 20% of the cost		$225 copay 20% of the cost		$0 copay	35% of the cost	$225 copay 20% of the cost	
EMERGENCY CARE	$90 copay		$90 copay		$0 copay		$100 copay	
OUTPATIENT SURGERY								
Ambulatory Surgical Center	$200 copay	$275 copay	$175 copay	$275 copay	$0 copay	35% of the cost	$50 copay	$50 copay
Outpatient Hospital Facility	$250 copay	$350 copay	$200 copay	$350 copay	$0 copay	30% of the cost	$100 copay	$225 copay
DIAGNOSTIC TESTS & LAB SERVICES								
Basic Diagnostic Tests and Procedures	$10 copay	$25 copay	$5-$10 copay	$15-$25 copay	$0 copay	30% of the cost	$0-$6 copay	$10-$25 copay
Lab Services	$10 copay	$25 copay	$5-$10 copay	$15-$25 copay	$0 copay	30% of the cost	$0-$5 copay	$10-$25 copay
OUTPATIENT X-RAYS	$10 copay	$25 copay	$5 copay	$30 copay	$0 copay	30% of the cost	$0 copay	$10-$25 copay
THERAPEUTIC RADIOLOGY SERVICES (such as radiation treatment for cancer)	20% of the cost	30% of the cost	20% of the cost	30% of the cost	$0 copay	30% of the cost	20% of the cost	30% of the cost
DURABLE MEDICAL EQUIPMENT	20% of the cost	30% of the cost	20% of the cost	30% of the cost	$0 copay	35% of the cost	20% of the cost	20% of the cost
Additional Benefits								
FITNESS BENEFIT	Unlimited number of visits to a SilverSneakers® participating fitness facility.		Unlimited number of visits to a SilverSneakers® participating fitness facility.		Unlimited number of visits to a SilverSneakers® participating fitness facility.		Unlimited number of visits to a SilverSneakers® participating fitness facility.	







For more information on Care N' Care (HMO/PPO), please call **877-905-9208** (TTY 711) October 1 - March 31, 8am to 8pm, CST, seven days a week or April 1 - September 30, 8am to 8pm, 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 1-877-665-2622 more information. 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.

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	Care N' Care Choice (PPO)		Care N' Care Choice Plus (PPO)		Care N' Care Choice Premium (PPO)		Care N' Care Choice MA-ONLY (PPO)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Over-The-Counter (OTC)	$30 Every quarter (3 months) to spend on Plan-approved OTC items.		$30 Every quarter (3 months) to spend on Plan-approved OTC items.		$30 Every quarter (3 months) to spend on Plan-approved OTC items.		$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	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Limited Medicare Covered Services	$0 copay	30% of the cost	$0 copay	30% of the cost	$0 copay	30% of the cost	$0 copay	$35 copay
VISION COVERAGE								
Routine Eye Exam (1 every year, includes refraction)	$0 copay	$50 copay	$0 copay	$40 copay	$0 copay	$35 copay	$0 copay	$35 copay
Eyeglasses or contact lenses after cataract surgery	$0 copay	$25 copay	$0 copay	$30 copay	$0 copay	30% of the cost	$0 copay	$30 copay
Non-Medicare Prescription eyewear allowance	$100 every year	$100 every year	$100 every year	$100 every year	$150 every year	$150 every year	$150 every year	$150 every year
HEARING COVERAGE								
Exam to diagnose and treat hearing and balance issues	$20 copay	$45 copay	$25 copay	$45 copay	$0 copay	30% of the cost	$20 copay	$45 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
Hearing Aid	Advanced Aids:$699 copay Premium Aids:$999 copay		Advanced Aids:$699 copay Premium Aids:$999 copay		Advanced Aids:$699 copay Premium Aids:$999 copay		Advanced Aids:$699 copay Premium Aids:$999 copay	

PRESCRIPTION DRUG BENEFIT	Care N' Care Choice (PPO)				Care N' Care Choice Plus (PPO)				Care N' Care Choice Premium (PPO)				Care N' Care Choice MA-ONLY (PPO)
Pharmacy Deductible	No Deductible				No Deductible				No Deductible				Not Covered
INITIAL COVERAGE PERIOD In-Network Pharmacy	Retail 30-day Supply	Retail 90-day Supply	Mail Order 30-day Supply	Mail Order 90-day Supply	Retail 30-day Supply	Retail 90-day Supply	Mail Order 30-day Supply	Mail Order 90-day Supply	Retail 30-day Supply	Retail 90-day Supply	Mail Order 30-day Supply	Mail Order 90-day Supply	
• Tier 1 - Preferred Generics	$4 copay	$8 copay	$0 copay	$0 copay	$2 copay	$4 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	
• Tier 2 - Generics	$14 copay	$28 copay	$14 copay	$28 copay	$12 copay	$24 copay	$12 copay	$24 copay	$10 copay	$20 copay	$10 copay	$20 copay	
• Tier 3 - Preferred Brand - *Select Insulins**	$47 copay *$35 copay*	$94 copay *$70 copay*	$47 copay *$35 copay*	$94 copy *$70 copay*	$45 copay *$35 copay*	$90 copay *$70 copay*	$45 copay *$35 copay*	$90 copay *$70 copay*	$40 copay *$35 copay*	$80copay *$70 copay*	$40 copay *$35 copay*	$80copay *$70 copay*	
• Tier 4 - Non-Preferred Drugs	$100 copay	$200 copay	$100 copay	$200 copay	$95 copay	$190 copay	$95 copay	$190 copay	$90 copay	$180 copay	$90 copay	$180 copay	
• Tier 5 - Specialty Drugs	33% of cost	33% of cost	33% of cost	33% of cost	33% of cost	33% of cost	33% of cost	33% of cost	33% of cost	33% of cost	33% of cost	33% of cost	
Gap Coverage*	T1 drugs; Partial gap coverage for Select T2 and T3 drugs				T1 drugs; Partial gap coverage for Select T2 and T3 drugs				T1 drugs; Partial gap coverage for Select T2 and T3 drugs				

*For further coverage details please review the Comprehensive Formulary (Drug List) we provided electronically on our website at www.cnchealthplan.com.

Optional Supplemental Coverage:

DENTAL RIDER				
Monthly Premium	**$26**	**$26**	**$26**	**$26**

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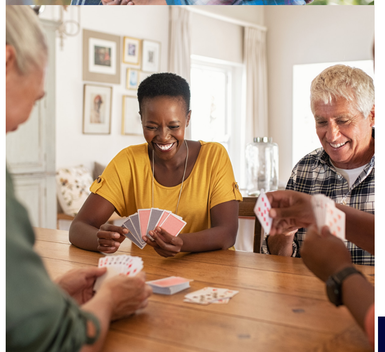

2022 Plan Benefit Highlights

CARE N' CARE CHOICE (PPO)

CARE N' CARE CHOICE PLUS (PPO)

CARE N' CARE CHOICE PREMIUM (PPO)

CARE N' CARE CHOICE MA-ONLY (PPO)

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Insurance Company, Inc.

Southwestern Health Resources
Texas Health Resources
UTSouthwestern Medical Center