

# Benefit Highlights

## Care N' Care Choice Plus (PPO) H6328-002

Premiums and Benefits	Care N' Care Choice Plus (PPO) H6328-002	
	In-Network	Out-Of-Network
Monthly Plan Premium	You pay \$53 You must continue to pay your Medicare part B Premium	
Deductible	No Deductible	
Maximum Out-of-Pocket	You pay no more than \$3,800 annually for in-network services unless specifically excluded.	You pay no more than \$8,950 annually for combined in and out-of-network services unless specifically excluded.
Inpatient Hospital <sup>1</sup>	Days 1-5: \$250 per day Days 6 and beyond: \$0 per day	You pay 30% of the cost
Outpatient Surgery <sup>1</sup> • Outpatient Hospital • Ambulatory Surgical Center	You pay a \$275 copay You pay a \$150 copay	You pay a \$350 copay You pay a \$275 copay
Doctor Visits • Primary • Specialist	You pay a \$0 copay You pay a \$25 copay	You pay a \$20 copay You pay a \$50 copay
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings) Medicare-covered Zero Dollar Preventive Services COVID-19 Vaccine	You pay a \$0 copay You pay a \$0 copay You pay a \$0 copay	You pay a \$30 copay You pay a \$30 copay You pay a \$0 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 \$25 copay per visit	You pay a \$25 copay per visit
Diagnostic Services/Labs/ Imaging <sup>1</sup> • Basic diagnostic tests and procedures Sleep Study • Lab Services • MRI • CAT Scan • X-Rays	You pay a \$5 copay at a Dr. Office You pay a \$25 copay at an outpatient facility. You pay \$0 copay for home based and \$25 copay for other locations. You pay a \$0 copay at a Dr. Office or a stand-alone lab facility. You pay a \$10 copay at an outpatient facility. You pay a \$175 copay You pay a \$150 copay You pay a \$5 copay	You pay a \$10 copay at a Dr. Office You pay a \$30 copay at an outpatient facility. You pay \$175 copay You pay a \$15 copay at a Dr. Office or a stand-alone lab facility. You pay a \$25 copay at an outpatient facility. You pay a \$200 copay You pay a \$200 copay You pay a \$30 copay

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	In-Network	Out-Of-Network
Hearing Services • Routine hearing exam • Hearing aid	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 • Oral exam & Cleaning • X-Ray • Fluoride Treatments • Comprehensive Services	You pay a \$0 copay You pay a \$0 copay You pay a \$0 copay Covered with additional Premium, see Optional Supplemental Benefits.	You pay a \$0 copay You pay a \$0 copay You pay a \$0 copay Covered with additional Premium, see Optional Supplemental Benefits.
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 \$100.	You pay a \$40 copay. You pay a \$30 copay with a maximum benefit amount of \$100
Mental Health Services <sup>1</sup> • Outpatient group therapy/individual therapy visit	You pay a \$25 copay	You pay a \$55 copay
Telehealth Services • Primary Care Physician Services • Mental Health Specialty Services • Allergy & Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gynecology, OB/GYN, Infectious Diseases, Nephrology, Neurology, Ophthalmology	You pay a \$0 copay You pay a \$25 copay You pay a \$25 copay	Not Covered
Nursing Hotline	You pay a \$0 copay	\$0 copay, must use preferred vendors for this benefit
Home Health Services	You pay a \$0 copay	You pay a \$40 copay
Texas Health Care at Home	Days 1-5: \$250 copay Days 6 and beyond: \$0 copay	You pay 30% of the cost
	Hospital services in the home allows for certain health care services to be provided outside of a traditional hospital setting and within your home. Care begins after you're evaluated, determined to be eligible, and a hospitalist refers you. The hospitalist will consider your eligibility criteria including your medical conditions and your geographic location.  If you are approved by the hospitalist, the Intake Employee will conduct a Safety Screening with you to ensure your home is safe for yourself and for providers who deliver patient care in your home. The Safety Screening assesses for safety issues such as presence of a caregiver in the home, potential fall risks, running water, reliable cell phone coverage, etc. If you pass the Safety Screening, you can be admitted into the program contingent on the patient providing consent.  You will receive treatment and monitoring at home from a team of providers. Conditions which are eligible to be treated with this benefit can include: asthma, bronchitis, and other respiratory systems diagnosis; heart failure and shock; simple pneumonia and pleurisy; chronic obstructive pulmonary disease (COPD); cellulitis; kidney and urinary tract infections (UTI).	

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	In-Network		Out-Of-Network	
Skilled Nursing Facility <sup>1</sup>	Days 1-20: \$0 copay per day Days 21-50: \$184 copay per day Days 51-100: \$0 copay per day		You pay 30% of the cost	
Physical Therapy	You pay a \$15 copay		You pay a \$45 copay	
Ambulance <sup>2</sup> • Ground Ambulance • Air Ambulance	You pay a \$275 copay You pay 20% of the cost		You pay a \$275 copay You pay 20% of the cost	
Transportation	Not Covered		Not Covered	
Over-the counter	You pay a \$0 copay Maximum benefit amount \$60 every three months		You pay a \$0 copay, must use preferred vendor for this benefit.	
Meal Benefit for Chronic Illness <sup>1</sup>	You pay a \$0 copay		You pay a \$0 copay	
	Members under Care Management with eligible chronic conditions include AIDS, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure, coronary artery disease, diabetes, hypertension, and chronic kidney disease (CKD); Beneficiaries may receive a maximum of 3 healthy meals per day for up to 2 weeks per year per condition. Must Use Preferred Vendor for this benefit			
Meal Benefit Post Discharge <sup>1</sup>	You pay a \$0 copay		You pay a \$0 copay	
	Immediately following surgery or inpatient hospitalization; beneficiaries may receive 3 meals per day for up to 2 weeks, up to 2 discharges per year. Must Use Preferred Vendor for this benefit			
Chiropractic services	You pay a \$15 copay		You pay a \$30 copay	
Acupuncture Services	You pay a \$15 copay		You pay \$40 copay	
Medicare Part B Drugs <sup>1</sup>	You pay 20% of the cost		You pay 30% of the cost	
Outpatient Prescription Drugs				
Deductible	You pay \$0			
Initial Coverage Stage				
During this stage you pay a flat fee (copay) or a percentage of a drug's total cost (coinsurance) for each prescription you fill and the plan pays the rest. Once your total drug costs (amount paid by the plan and by you or others on your behalf) reach <b>\$4,660</b> , you move to the Coverage Gap Stage.				
In-Network Pharmacy	Retail 30-day supply	Retail 90-day Supply	Mail Order 30-day supply	Mail Order 90-day supply
Tier 1: Preferred Generics	\$2 copay	\$4 copay	\$0 copay	\$0 copay
Tier 2: Generics	\$12 copay	\$24 copay	\$12 copay	\$24 copay
Tier 3: Preferred Brands	\$45 copay	\$90 copay	\$45 copay	\$90 copay
- <i>Select Insulins*</i>	\$35 copay	\$70 copay	\$35 copay	\$70 copay
Tier 4: Non-Preferred Drugs	\$97 copay	\$194 copay	\$97 copay	\$194 copay
Tier 5: Specialty Drugs	33% of the cost	Not covered	33% of the cost	Not covered
<p>*To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically on our website at <a href="http://www.cnhealthplan.com">www.cnhealthplan.com</a>. You can identify Select Insulins by the abbreviation "SSM" found in the "Requirements/Limits" column in the Drug List.</p> <p><b>Note:</b> This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help"). If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.</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> <p><b>Important Message About What You Pay for Vaccines</b> – Our plan covers most Part D vaccines at no cost to you. Call your Customer Experience Team for more information.</p> <p><b>Important Message About What You Pay for Insulin</b> – You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.</p>				

## Outpatient Prescription Drugs

### Coverage Gap

During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be no more than \$35 for a retail or mail order 30-day supply or \$70 for a retail or mail order 90-day supply. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically on our website at [www.cnchealthplan.com](http://www.cnchealthplan.com). You can identify Select Insulins by the abbreviation "SSM" found in the "Requirements/Limits" column in the Drug List.

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 \$7,400. This amount and rules for counting costs toward this amount have been set by Medicare.

If you reside in a long-term health care facility, you pay the same as a standard retail pharmacy.

Note: This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

## Outpatient Prescription Drugs

### 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, 2023). 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 \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs).

## Supplemental Dental Rider

Members who choose to add the Supplemental Dental Rider to their plan will receive comprehensive dental services for an additional \$25 monthly premium. The rider provides coverage on dental services most often used without the need for a referral or preauthorization. HMO Supplemental Dental Rider In-Network coverage only.

### Additional Benefits Include\*:

- Fillings
- Extractions
- Root Canals
- Dentures (full and partial) and denture adjustments
- Crowns
- Oral Surgery
- Implants

Care N' Care Insurance Company, Inc. (Care N' Care) is an HMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal.