care n care
Insurance Company, Inc.

2023

Benefit Highlights

Care N' Care Classic (HMO) H2171-001

[1]Services may require prior authorization

Premiums and Benefits	Care N' Care Classic (HMO) H2171-001
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 $3,900 Annually Includes copays and other costs for medical services for the year unless specifically excluded.
Inpatient Hospital[1]	Day 1-5 $300 copay per day Days 6 and beyond: $0 copay per day
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $300 copay You pay a $175 copay
Doctor Visits • Primary • Specialist	 You pay a $0 copay You pay a $35 copay. Referral is required for specialist visits.
Preventive Care (e.g. Flu Vaccine, Diabetic Screenings, COVID-19 Vaccine) Medicare-covered Zero Dollar Preventive Services	You pay nothing You pay nothing
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.
Urgently Needed Services	You pay a $30 copay per visit
Diagnostic Services/Labs/ Imaging[1] • Basic Diagnostic tests and Procedures • Sleep Study • Lab Services • CAT Scan • MRI, MRA, PET Scan • X-Rays	 You pay a $0-$50 copay You pay $0 copay for home based and $50 copay for other locations Physician Office or Stand Alone Lab - $0 copay, Outpatient Facility - $10 copay You pay a $200 copay You pay a $225 copay You pay a $0 copay
Hearing Services • Routine hearing exam • Hearing aid	 You pay a $45 copay* 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
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.
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 $150

Premiums and Benefits	Care N' Care Classic (HMO) H2171-001
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 $150
Mental Health Services[1] • Outpatient group therapy/ individual therapy visit	You pay a $25 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
Skilled Nursing Facility[1]	Days 1-20: $0 copay per day Days 21-100: $196 copay per day
Nursing Hotline	You pay a $0 copay
Home Health Services	You pay a $0 copay
Texas Health Care at Home	Days 1-5: $300 copay Days 6 and beyond: $0 copay 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).
Physical Therapy	You pay a $15 copay
Ambulance[2] • Ground Ambulance • Air Ambulance	 You pay a $275 copay You pay 20% of the cost
Transportation	Not Covered
Over-the counter	You pay a $0 copay Maximum benefit amount $60 every three months
Meal Benefit for Chronic Illness[1]	You pay a $0 copay Members under Care Management with eligible chronic conditions include AIDS, asthma, chronic obstructive pulmonary disease (COPD), congestive health 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.
Meal Benefit Post Discharge[1]	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
Chiropractic services	You pay a $20 copay
Acupuncture Services	You pay a $15 copay
Medicare Part B Drugs[1]	You pay 20% 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 **$4,660**, you move to the Coverage Gap Stage.

In-Network Pharmacy	Retail 30-day supply	Retail 100-day Supply	Mail Order 30-day supply	Mail Order 100-day supply
Tier 1: Preferred Generics	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generics	$14 copay	$28 copay	$14 copay	$28 copay
Tier 3: Preferred Brands	$47 copay	$94 copay	$47 copay	$94 copay
- *Select Insulins**	*$35 copay*	*$70 copay*	*$35 copay*	*$70 copay*
Tier 4: Non-Preferred Drugs	$100 copay	$200 copay	$100 copay	$200 copay
Tier 5: Specialty Drugs	33% of the cost	Not covered	33% of the cost	Not covered

*To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically on our website at www.cnchealthplan.com. You can identify Select Insulins by the abbreviation "SSM" found in the "Requirements/Limits" column in the Drug List.
Note: 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.
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.
Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call your Customer Experience Team for more information.
Important Message About What You Pay for Insulin – 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.

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 100-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. 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").

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

*For full benefit detail, refer to the Evidence of Coverage. Detailed dental codes can also be found on the Care N' Care website, at cnchealthplan.com/our-plans-2023/our-benefits-2023/

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.