care n care
Insurance Company, Inc.

2023

Summary of Benefits HMO

CARE N' CARE CLASSIC (HMO) H2171-001

SOUTHWESTERN HEALTH SELECT (HMO) H2171-003

January 1, 2023 - December 31, 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.

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.

To join Southwestern Health Select (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, Dallas, Denton, Tarrant, Rockwall.** 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, 8 a.m. to 8pm, CST, seven days a week or April 1 - September 30, 8 a.m. to 8pm, CST, Monday through Friday or, visit us at cnchealthplan.com.

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

Premiums and Benefits	Care N' Care Classic (HMO) H2171-001
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
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).

Southwestern Health Select H2171-003

Premiums and Benefits	Southwestern Health Select (HMO) H2171-003
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[1]	Day 1-5: $275 copay per day Days 6 and beyond: $0 copay per day
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $250 copay You pay a $150 copay
Doctor Visits[1] • Primary • Specialist	 You pay a $0 copay You pay a $15 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 • MRI, CAT 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 $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
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 Available with additional premium under Optional supplemental benfits
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 $15 copay

[1]Services may require prior authorization [2]Prior Authorization is required for Non-Emergency transportation

Premiums and Benefits	Southwestern Health Select (HMO) H2171-003
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 $15 copay You pay a $15 copay
Skilled Nursing Facility[1]	Days 1-20: $0 copay per day Days 21-60: $196 copay per day Days 61 -100: $0 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: $275 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 $15 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	$10 copay	$20 copay	$0 copay	$0 copay
Tier 3: Preferred Brands	$40 copay	$80 copay	$40 copay	$80 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.

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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**

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2023

Summary of Benefits PPO

CARE N' CARE CHOICE (PPO) H6328-003

CARE N' CARE CHOICE PLUS (PPO) H6328-002

CARE N' CARE CHOICE PREMIUM (PPO) H6328-001

CARE N' CARE CHOICE MA-ONLY (PPO) H6328-005

January 1, 2023 - December 31, 2023
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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.

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Care N' Care Choice PPO H6328-003

Premiums and Benefits	Care N' Care Choice (PPO) H6328-003	
	In-Network	Out-Of-Network
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 $4,200 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[1]	Days 1-5: $250 per day Days 6 and beyond: $0 per day	You pay 35% of the cost
Outpatient Surgery[1] • 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 $35 copay	 You pay a $25 copay You pay a $70 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.

Premiums and Benefits	Care N' Care Choice (PPO) H6328-003	
	In-Network	Out-Of-Network
Urgently Needed Services	You pay a $25 copay per visit	You pay a $25 copay per visit
Diagnostic Services/Labs/Imaging[1] • Basic diagnostic tests and procedures • Sleep Study • Lab Services • MRI • CAT Scan • X-Rays	 Physician Office or Stand Alone Lab - $10 copay, Outpatient Facility - $25 copay You pay $0 copay for home based and $25 copay for other locations Physician Office or Stand Alone Lab - $0 copay, Outpatient Facility - $10 copay You pay a $200 You pay a $175 You pay a $10 copay	 Physician Office or Stand Alone Lab -$15 copay, Outpatient Facility - $30 copay You pay a $75 copay You pay a $25 copay You pay a $250 copay You pay a $250 copay You pay a $25 copay
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. Plan maximum benefit of $100.	You pay a $50 copay. You pay a $25 copay with a maximum benefit amount of $100
Mental Health Services[1] • Outpatient group therapy/individual therapy visit	You pay a $25 copay	You pay a $60 copay
Telehealth Services • Primary Care Physician Services • Mental Health Specialty • 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 $35 copay	Not covered
Nursing Hotline	You pay a $0 copay	You pay a $0 copay, must use preferred vendor for this benefit.
Home Health Services	You pay a $0 copay	You pay a $30 copay

[1]Services may require prior authorization [2]Prior Authorization is required for Non-Emergency transportation

Premiums and Benefits	Care N' Care Choice (PPO) H6328-003	
	In-Network	Out-Of-Network
	Days 1-5: $250 copay Days 6 and beyond: $0 copay	You pay 35% of the cost
Texas Health Care at Home	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).	
Skilled Nursing Facility[1]	Days 1-20: $0 copay Days 21-50: $167.50 copay per day Days 51-100: $0 copay	You pay 35% of the cost
Physical Therapy	You pay a $15 copay	You pay a $60 copay
Ambulance[2] • 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[1]	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 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. Must Use Preferred Vendor for this benefit	
Meal Benefit Post Discharge[1]	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 $20 copay	You pay a $40 copay
Acupuncture Services	You pay a $15 copay	You pay a $70 copay
Medicare Part B Drugs[1]	You pay 20% of the cost	You pay 30% of the cost

Outpatient Prescription Drug	
Pharmacy 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	$4 copay	$8 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").

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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.

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 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).

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	

Premiums and Benefits	Care N' Care Choice Plus (PPO) H6328-002	
	In-Network	Out-Of-Network
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[1]	Days 1-5: $250 per day Days 6 and beyond: $0 per day	You pay 30% of the cost
Outpatient Surgery[1] • 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[1] • 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 for home based and for other locations. 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
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

Premiums and Benefits	Care N' Care Choice Plus (PPO) H6328-002	
	In-Network	Out-Of-Network
Mental Health Services[1] • 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).	
Skilled Nursing Facility[1]	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[2] • 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[1]	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 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. Must Use Preferred Vendor for this benefit	

Meal Benefit Post Discharge[1]	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[1]	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 **$4,660**, 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
- *Select Insulins**	*$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

*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 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. 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).

Care N' Care Choice Premium (PPO) H6328-001

Premiums and Benefits	Care N' Care Choice Premium (PPO) H6328-001	
	In-Network	**Out-Of-Network**
Monthly Plan Premium	You pay $194 You must continue to pay your Medicare part B Premium	
Deductible	No Deductible	
Maximum Out-of-Pocket	You pay no more than $3,500 annually for in-network services unless specifically excluded.	You pay no more than $5,450 annually for combined in and out-of-network services unless specifically excluded.
Inpatient Hospital[1]	You pay a $0 copay	You pay 30% of the cost
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $0 copay You pay a $0 copay	 You pay 30% of the cost You pay 30% of the cost
Doctor Visits • Primary • Specialist	 You pay a $0 copay You pay a $0 copay	 You pay 30% of the cost You pay 30% of the cost
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 30% of the cost You pay 30% of the cost You pay a $30 copay
Emergency Care	You pay a $0 copay Emergency copay is waived if you are admitted to the hospital within 3 days due to the same condition.	You pay a $0 copay 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 $0 copay	You pay a $0 copay
Diagnostic Services/Labs/Imaging[1] • Basic Diagnostic tests and procedures • Sleep Study • Lab Services • MRI, CAT Scan • X-Rays	 You pay a $0 copay You pay a $0 copay You pay a $0 copay You pay a $0 copay You pay a $0 copay	 You pay 30% of the cost You pay 30% of the cost You pay 30% of the cost You pay 30% of the cost You pay 30% of the cost
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 0% of the cost You pay 0% of the cost You pay 0% of the cost 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	 You pay a $35 copay. You pay a $30 copay with a maximum benefit amount of $150
Mental Health Services[1] • Outpatient group therapy/individual therapy visit	You pay a $0 copay	You pay 30% of the cost
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 $0 copay You pay a $0 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 30% of the cost
Texas Health Care at Home	You pay a $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).	
Skilled Nursing Facility[1]	Days 1-100: $0 copay	You pay 30% of the cost
Physical Therapy	You pay a $0 copay	You pay 30% of the cost
Ambulance[2] • Ground Ambulance • Air Ambulance	 You pay a $0 copay You pay a $0 copay	 You pay 35% of the cost You pay 35% of the cost
Transportation	Not Covered	Not Covered
Over-the counter	You pay a $0 copay Maximum benefit amount $60 every three months	Must use preferred vendor for this benefit

Meal Benefit for Chronic Illness[1]	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 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. Must Use Preferred Vendor for this benefit	
Meal Benefit Post Discharge[1]	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 $0 copay	You pay 30% of the cost
Acupuncture Services	You pay a $0 copay	You pay 30% of the cost
Medicare Part B Drugs[1]	$0 copay	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 **$4,660**, 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	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generics	$8 copay	$16 copay	$8 copay	$16 copay
Tier 3: Preferred Brands	$43 copay	$86 copay	$43 copay	$86 copay
- *Select Insulins**	*$35 copay*	*$70 copay*	*$35 copay*	*$70 copay*
Tier 4: Non-Preferred Drugs	$92 copay	$184 copay	$92 copay	$184 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 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. 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).

Care N' Care Choice MA-Only (PPO) H6328-005

Premiums and Benefits	Care N' Care Choice MA-Only (PPO) H6328-005	
	In-Network	**Out-Of-Network**
Monthly Plan Premium	You pay $0 You must continue to pay your Medicare part B Premium	
Part B premium reduction	CNC will reduce your Monthly Part B premium by $10	
Deductible	No Deductible	
Maximum Out-of-Pocket	You pay no more than $2,500 annually for in-network services unless specifically excluded.	You pay no more than $5,100 annually for combined in and out-of-network services unless specifically excluded.
Inpatient Hospital[1]	Days 1-5: $50 per day Days 6 and beyond: $0 per day	You pay 10% of the cost
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $100 copay You pay a $50 copay	 You pay a $225 copay You pay a $50 copay
Doctor Visits • Primary • Specialist	 You pay a $0 copay You pay a $10 copay	 You pay a $20 copay You pay a $20 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[1] • Basic diagnostic tests and procedures • Sleep Study • Lab Services • MRI, CAT Scan • X-Rays	 You pay a $0 copay at a Dr. Office You pay a $5 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 $5 copay at an outpatient facility. You pay a $150 You pay a $0 copay	 You pay a $10 copay at a Dr. Office You pay a $25 copay at an outpatient facility. You pay $150 copay You pay a $10 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 $10 copay at a Dr. Office or a stand-alone lab facility. You pay a $25 copay at an outpatient facility.

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 $150.	You pay a $35 copay You pay a $30 copay with a maximum benefit amount of $150
Mental Health Services[1] • Outpatient group therapy/individual therapy visit	You pay a $25 copay	You pay a $50 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 $10 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 $15 copay	You pay a $40 copay
Texas Health Care at Home	Days 1-5: $50 copay Days 6 and beyond: $0 copay per day	You pay 10% 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).	
Skilled Nursing Facility[1]	Days 1-5: $0 copay Days 6-20: $10 copay per day Days 21-100: $100 copay per day	You pay 10% of the cost
Physical Therapy	You pay a $10 copay	You pay a $20 copay

Ambulance[2] • 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 $40 every three months	You pay a $0 copay, must use preferred vendor for this benefit
Meal Benefit for Chronic Illness[1]	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 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. Must Use Preferred Vendor for this benefit	
Meal Benefit Post Discharge[1]	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 $20 copay	You pay a $40 copay
Acupuncture Services	You pay a $15 copay	You pay $40 copay
Medicare Part B Drugs[1]	You pay 20% of the cost	You pay 30% of the cost

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/

Pre-Enrollment Checklist

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 1-877-905-9210.

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 cnchealthplan.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, or pay a higher share of the cost.
- ☐ 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

- ☐ If you select a plan with a monthly premium then in addition to your monthly plan premium 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, 2024.
- ☐ For PPO plans, you do not need to get a referral or approval in advance when you get care from out-of-network providers. However, it is strongly recommended that you provide notification to Care N' Care before you get some services from non-plan providers. If you do not provide this notification, you may be responsible for the providers' charges, if Care N' Care determines the services are not covered benefits or are not medically necessary. If you provide notification before obtaining services, you will not run the risk of Care N' Care (PPO) determining that the services are not covered.
- ☐ For HMO plan, you must use network providers except in emergency or urgent care situations or for out-of-area renal dialysis or other services. If you obtain routine care from out of network providers, neither Medicare nor Care N' Care will be responsible for the cost.

care n care
Insurance Company, Inc.

2023

Discrimination is Against the Law

Care N' Care (HMO/PPO) 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 1-877-665-2622 (TTY: 711), 8 a.m. to 8 p.m., CST seven days a week from October 1 – March 31, or 8 a.m. to 8 p.m., CST, Monday through Friday April 1 – September 30

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, 1603 Lyndon B. Johnson Freeway, Suite 300, Farmers Branch, TX 75234 , 1-877-665-2622 (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 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs. gov/ocr/office/file/index.html

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-374-7993 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-374-7993 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我┌提供免┌的翻┌服┌, ┌助┌解答┌于健康或┌物保┌的任何疑 ┌。如果┌需要此翻┌服┌, ┌致┌ 1-877-374-7993 (TTY: 711) 。我┌的中文工作人┌很┌意┌助┌。 ┌是一┌免┌服┌。

Chinese Cantonese: ┌對我們的健康或藥物保險可能存有疑問, ┌此我們提供免費的翻譯 服務。如需翻譯服務, 請致電 1-877-374-7993 (TTY: 711) 。我們講中文的人員將樂意┌┌提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-374-7993 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-374-7993 (TTY : 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-374-7993 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-374-7993 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-374-7993 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-374-7993 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديك. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-374-7993 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-374-7993 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-374-7993 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-374-7993 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-374-7993 (TTY : 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-374-7993 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: ┌社の健康 健康保┌と┌品 ┌方┌プランに┌するご質問にお答えするため に、無料の通┌サ┌ビスがありますございます。通┌をご用命になるには、1-877-374-7993 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサ┌ ビスです。

Y0107_23_025_M Accepted