care n care
Insurance Company, Inc.

2023

# Benefit Highlights

## 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<br>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]<br>• Outpatient Hospital<br>• Ambulatory Surgical Center | You pay a $0 copay | You pay 30% of the cost<br>You pay 30% of the cost |
| Doctor Visits<br>• Primary<br>• Specialist | You pay a $0 copay | You pay 30% of the cost<br>You pay 30% of the cost |
| Preventive Care (e.g. Flu Vaccine, Diabetic Screenings<br>Medicare-covered Zero Dollar Preventive Services<br>COVID-19 Vaccine | You pay a $0 copay<br>You pay a $0 copay<br>You pay a $0 copay | You pay 30% of the cost<br>You pay 30% of the cost<br>You pay a $30 copay |
| Emergency Care | You pay a $0 copay<br>Emergency copay is waived if you are admitted to the hospital within 3 days due to the same condition. | You pay a $0 copay<br>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]<br>• Basic Diagnostic tests and procedures<br>• Sleep Study<br>• Lab Services<br>• MRI, CAT Scan<br>• X-Rays | You pay a $0 copay<br>You pay a $0 copay<br>You pay a $0 copay<br>You pay a $0 copay<br>You pay a $0 copay | You pay 30% of the cost<br>You pay 30% of the cost<br>You pay 30% of the cost<br>You pay 30% of the cost<br>You pay 30% of the cost |
| Hearing Services<br>• Routine hearing exam<br>• Hearing aid | You pay a $45 copay*<br>You pay a $699 copayment per aid for Advanced Aids*<br>You pay a $999 copayment per aid for Premium Aids*<br>*Does not count towards Maximum Out-of-Pocket | You pay a $45 copay*<br>You pay a $699 copayment per aid for Advanced Aids*<br>You pay a $999 copayment per aid for Premium Aids*<br>*Does not count towards Maximum Out-of-Pocket |

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| Dental Services<br>• Oral exam & Cleaning<br>• X-Ray<br>• Fluoride Treatments<br>• Comprehensive Services | <br>You pay a $0 copay<br>You pay a $0 copay<br>You pay a $0 copay<br>Covered with additional Premium, see Optional Supplemental Benefits. | <br>You pay 0% of the cost<br>You pay 0% of the cost<br>You pay 0% of the cost<br>Covered with additional Premium, see Optional Supplemental Benefits. |
| Vision Services<br>• Routine Eye Exam<br>• Glasses, Lenses and Frames | <br>You pay a $0 copay<br>You pay a $0 copay with a maximum benefit amount of $150 | <br>You pay a $35 copay.<br>You pay a $30 copay with a maximum benefit amount of $150 |
| Mental Health Services[1]<br>• Outpatient group therapy/individual therapy visit | You pay a $0 copay | You pay 30% of the cost |
| Telehealth Services<br>• Primary Care Physician Services<br>• Mental Health Specialty Services<br>• Allergy & Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gynecology, OB/GYN, Infectious Diseases, Nephrology, Neurology, Ophthalmology | <br>You pay a $0 copay<br>You pay a $0 copay<br>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.<br><br>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.<br><br>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]<br>• Ground Ambulance<br>• Air Ambulance | <br>You pay a $0 copay<br>You pay a $0 copay | <br>You pay 35% of the cost<br>You pay 35% of the cost |
| Transportation | Not Covered | Not Covered |
| Over-the counter | You pay a $0 copay<br>Maximum benefit amount $60 every three months | Must use preferred vendor for this benefit |

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| 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

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| 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 |
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| **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 |
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| 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**<br>· **Extractions**<br>· **Root Canals**<br>· **Dentures (full and partial) and denture adjustments**<br>· **Crowns**<br>· **Oral Surgery**<br>· **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.

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