	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	
Plan Premium	$0		$53		$194		$0	
Part B premium reduction	Not Available		Not Available		Not Available		CNC will reduce your Monthly Part B premium by $10	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Out-Of-Pocket Maximum	$4,200	$8,950	$3,800	$8,950	$3,500	$5,450	$2,500	$5,100
DOCTOR OFFICE VISITS								
Primary Care Physician (PCP) Visits	$0 copay	$25 copay	$0 copay	$20 copay	$0 copay	30% of the cost	$0 copay	$20 copay
Specialist Visits	$35 copay	$70 copay	$25 copay	$50 copay	$0 copay	30% of the cost	$10 copay	$20 copay
PODIATRY	$35 copay	$60 copay	$20 copay	$40 copay	$0 copay	30% of the cost	$20 copay	$50 copay
INPATIENT HOSPITAL CARE	Days 1-5: $250 copay per day. Days 6 and beyond $0 copay	35% of the cost	Days 1-5: $250 copay per day Days 6 and beyond $0 copay	30% of the cost	$0 copay	30% of the cost	Days 1-5: $50 copay per day Days 6 and beyond $0 copay per day	10% of the cost
SKILLED NURSING FACILITY (SNF)	Days 1-20: $0 copay Days 21-50: $16750 copay per day Days 51-100 $0 copay	35% of the cost	Days 1-20: $0 copay Days 21-50: $184 copay per day Days 51-100 $0 copay	30% of the cost	Days 1 -100 $0 copay	30% of the cost	Days 1-5: $0 copay per day Days 6-20: $10 copay per day Days 21-100: $100 copay per day	10% of the cost
TELEHEALTH SERVICES · Primary Care Physician Services · Mental Health Specialty Services · Specialty Services	$0 Copay $25 Copay $35 Copay	Not covered	$0 Copay $25 Copay $25 Copay	Not covered	$0 Copay $0 Copay $0 Copay	Not covered	$0 Copay $25 Copay $10 Copay	Not covered
OUTPATIENT REHABILITATION SERVICES								
Occupational Therapy Visit	$40 copay	$60 copay	$15 copay	$30 copay	$0 copay	30% of the cost	$10 copay	$20 copay
Physical / Speech / Language Visits	$15 copay	$60 copay	$15 copay	$45 copay	$0 copay	30% of the cost	$10 copay	$20 copay
HOME HEALTH SERVICES	$0 copay	$30 copay	$0 copay	$40 copay	$0 copay	30% of the cost	$15 copay	$40 copay
AMBULANCE · Ground Ambulance · Air Ambulance	$275 copay 20% of the cost		$275 copay 20% of the cost		$0 copay	35% of the cost	$275 copay 20% of the cost	
EMERGENCY CARE	$100 copay		$100 copay		$0 copay		$100 copay	
URGENTLY NEEDED SERVICES	$25 copay		$25 copay		$0 copay		$25 copay	
OUTPATIENT SURGERY								
Ambulatory Surgical Center	$150 copay	$275 copay	$150 copay	$275 copay	$0 copay	30% of the cost	$50 copay	$50 copay
Outpatient Hospital Facility	$275 copay	$350 copay	$275 copay	$350 copay	$0 copay	30% of the cost	$100 copay	$225 copay
DIAGNOSTIC TESTS & LAB SERVICES								
Basic Diagnostic Tests and Procedures	$0-$50 copay	$0-$75 copay	$0-$50 copay	$0-$175 copay	$0 copay	30% of the cost	$0-$50 copay	$10-$150 copay
Lab Services	$0-$10 copay	$25 copay	$0-$10 copay	$15-$25 copay	$0 copay	30% of the cost	$0-$5 copay	$10-$25 copay
OUTPATIENT X-RAYS	$10 copay	$25 copay	$5 copay	$30 copay	$0 copay	30% of the cost	$0 copay	$10-$25 copay
THERAPEUTIC RADIOLOGY SERVICES (such as radiation treatment for cancer)	20% of the cost	30% of the cost	20% of the cost	30% of the cost	$0 copay	30% of the cost	20% of the cost	30% of the cost
DURABLE MEDICAL EQUIPMENT	20% of the cost	30% of the cost	20% of the cost	30% of the cost	$0 copay	30% of the cost	20% of the cost	30% of the cost

	Care N' Care Classic (HMO) H2171-001	Southwestern Health Select (HMO) H2171-003
Plan Premium	$0	$0
Out-Of-Pocket Maximum	$3,900	$3,200
DOCTOR OFFICE VISITS		
Primary Care Physician (PCP) Visits	$0 Copay	$0 Copay
Specialist Visits	$35 Copay	$15 Copay
PODIATRY	$35 Copay	$15 Copay
INPATIENT HOSPITAL CARE	Days 1-5: $300 copay per day Days 6 and beyond $0 copay per day	Days 1-5: $275 copay per day Days 6 and beyond $0 copay per day
SKILLED NURSING FACILITY (SNF)	Days 1-20: $0 copay per day Days 21 -100: $196 copay per day	Days 1-20: $0 copay per day Days 21-60: $196 copay per day Days 61 -100: $0 copay per day
TELEHEALTH SERVICES · Primary Care Physician Services · Mental Health Specialty Services · Specialty Services	$0 Copay $25 Copay $25 Copay	$0 Copay $15 Copay $15 Copay
OUTPATIENT REHABILITATION SERVICES		
Occupational Therapy Visit	$25 Copay	$15 Copay
Physical / Speech / Language Visits	$15 Copay	$15 Copay
HOME HEALTH SERVICES	$0 Copay	$0 Copay
AMBULANCE · Ground Ambulance · Air Ambulance	$275 Copay 20% of the cost	$275 Copay 20% of the cost
EMERGENCY CARE	$100 Copay	$100 Copay
URGENTLY NEEDED SERVICES	$30 copay	$30 copay
OUTPATIENT SURGERY		
Ambulatory Surgical Center	$175 Copay	$150 Copay
Outpatient Hospital Facility	$300 Copay	$250 Copay
DIAGNOSTIC TESTS & LAB SERVICES		
Basic Diagnostic Tests and Procedures	$0-$50 Copay	$0-$50 Copay
Lab Services	$0-$10 Copay	$0-$10 Copay
OUTPATIENT X-RAYS	$0 Copay	$0 Copay
THERAPEUTIC RADIOLOGY SERVICES (such as radiation treatment for cancer)	20% of the cost	20% of the cost
DURABLE MEDICAL EQUIPMENT	20% of the cost	20% of the cost

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

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. **This information is not a complete description of benefits.** Call 1-877-665-2622 more information. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Y0107_23_056_M

	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	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
FITNESS BENEFIT	Unlimited number of visits to a SilverSneakers® participating fitness facility. OON must use preferred vendor		Unlimited number of visits to a SilverSneakers® participating fitness facility. OON must use preferred vendor		Unlimited number of visits to a SilverSneakers® participating fitness facility. OON must use preferred vendor		Unlimited number of visits to a SilverSneakers® participating fitness facility. OON must use preferred vendor	
Over-The-Counter (OTC)	$60 Every quarter (3 months) to spend on Plan-approved OTC items. OON must use preferred vendor		$60 Every quarter (3 months) to spend on Plan-approved OTC items. OON must use preferred vendor		$60 Every quarter (3 months) to spend on Plan-approved OTC items. OON must use preferred vendor		$40 Every quarter (3 months) to spend on Plan-approved OTC items. OON must use preferred vendor	
DENTAL COVERAGE								
Preventive Dental Services Include: • Cleaning • Dental X-Ray(s) • Oral Exam	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
VISION COVERAGE								
Routine Eye Exam (1 every year, includes refraction)	$0 copay	$50 copay	$0 copay	$40 copay	$0 copay	$35 copay	$0 copay	$35 copay
Eyeglasses or contact lenses after cataract surgery	$0 copay	$30 copay	$0 copay	$30 copay	$0 copay	30% of the cost	$0 copay	$30 copay
Non-Medicare Prescription eyewear allowance	$100 every year	$100 every year	$100 every year	$100 every year	$150 every year	$150 every year	$150 every year	$150 every year
HEARING COVERAGE								
Exam to diagnose and treat hearing and balance issues	$20 copay	$45 copay	$25 copay	$45 copay	$0 copay	30% of the cost	$20 copay	$45 copay
Routine Hearing Exam (for up to 1 every year)	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay
Hearing Aid	Advanced Aids:$699 copay Premium Aids:$999 copay		Advanced Aids:$699 copay Premium Aids:$999 copay		Advanced Aids:$699 copay Premium Aids:$999 copay		Advanced Aids:$699 copay Premium Aids:$999 copay	

PRESCRIPTION DRUG BENEFIT	Care N' Care Choice (PPO)				Care N' Care Choice Plus (PPO)				Care N' Care Choice Premium (PPO)				Care N' Care Choice MA-ONLY (PPO)
Pharmacy Deductible	No Deductible				No Deductible				No Deductible				
INITIAL COVERAGE PERIOD In-Network Pharmacy	Retail 30-day Supply	Retail 100-day Supply	Mail Order 30-day Supply	Mail Order 100-day Supply	Retail 30-day Supply	Retail 90-day Supply	Mail Order 30-day Supply	Mail Order 90-day Supply	Retail 30-day Supply	Retail 90-day Supply	Mail Order 30-day Supply	Mail Order 90-day Supply	Not Covered
• Tier 1 - Preferred Generics	$4 copay	$8 copay	$0 copay	$0 copay	$2 copay	$4 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	
• Tier 2 - Generics	$14 copay	$28 copay	$14 copay	$28 copay	$12 copay	$24 copay	$12 copay	$24 copay	$8 copay	$16 copay	$8 copay	$16 copay	
• Tier 3 - Preferred Brand - *Select Insulins**	$47 copay *$35 copay*	$94 copay *$70 copay*	$47 copay *$35 copay*	$94 copay *$70 copay*	$45 copay *$35 copay*	$90 copay *$70 copay*	$45 copay *$35 copay*	$90 copay *$70 copay*	$43 copay *$35 copay*	$86 copay *$70 copay*	$43 copay *$35 copay*	$86 copay *$70 copay*	
• Tier 4 - Non-Preferred Drugs	$100 copay	$200 copay	$100 copay	$200 copay	$97 copay	$194 copay	$97 copay	$194 copay	$92 copay	$184 copay	$92 copay	$184 copay	
• Tier 5 - Specialty Drugs	33% of cost	Not covered	33% of cost	Not covered	33% of cost	Not covered	33% of cost	Not covered	33% of cost	Not covered	33% of cost	Not covered	
Gap Coverage*	T1 drugs; Partial gap coverage for Select T2 and T3 drugs				T1 drugs; Partial gap coverage for Select T2 and T3 drugs				T1 drugs; Partial gap coverage for Select T2 and T3 drugs				

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

Optional Supplemental Coverage:

DENTAL RIDER				
Monthly Premium	**$25**	**$25**	**$25**	**$25**

	Care N' Care Classic (HMO) H2171-001	Southwestern Health Select (HMO) H2171-003
FITNESS BENEFIT	Unlimited number of visits to a SilverSneakers® participating fitness facility.	Unlimited number of visits to a SilverSneakers® participating fitness facility.
Over-The-Counter (OTC)	$60 Every quarter (3 months) to spend on Plan-approved OTC items.	$60 Every quarter (3 months) to spend on Plan-approved OTC items.
DENTAL COVERAGE		
Preventive Dental Services Include: • Cleaning • Dental X-Ray(s) • Oral Exam	$0 Copay	$0 Copay
VISION COVERAGE		
Routine Eye Exam (1 every year, includes refraction)	$0 Copay	$0 Copay
Eyeglasses or contact lenses after cataract surgery	$0 Copay	$0 Copay
Non-Medicare Prescription eyewear allowance	$150 Maximum Benefit	$150 Maximum Benefit
HEARING COVERAGE		
Exam to diagnose and treat hearing and balance issues	$25 Copay	$25 Copay
Routine Hearing Exam (for up to 1 every year)	$45 Copay	$45 Copay
Hearing Aid	Advanced Aids:$599 copay Premium Aids:$899 copay	Advanced Aids:$599 copay Premium Aids:$899 copay

PRESCRIPTION DRUG BENEFIT	Care N' Care Classic (HMO)				Southwestern Health Select (HMO)			
Pharmacy Deductible	No Deductible				No Deductible			
INITIAL COVERAGE PERIOD In-Network Pharmacy	Retail 30-day Supply	Retail 100-day Supply	Mail Order 30-day Supply	Mail Order 100-day Supply	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	$0 copay	$0 copay	$0 copay	$0 copay
• Tier 2 - Generics	$14 copay	$28 copay	$14 copay	$28 copay	$10 copay	$20 copay	$0 copay	$0 copay
• Tier 3 - Preferred Brand - *Select Insulins**	$47 copay *$35 copay*	$94 copay *$70 copay*	$47 copay *$35 copay*	$94 copay *$70 copay*	$40 copay *$35 copay*	$80 copay *$70 copay*	$40 copay *$35 copay*	$80 copay *$70 copay*
• Tier 4 - Non-Preferred Drugs	$100 copay	$200 copay	$100 copay	$200 copay	$100 copay	$200 copay	$100 copay	$200 copay
• Tier 5 - Specialty Drugs	33% of cost	Not covered	33% of cost	Not covered	33% of cost	Not covered	33% of cost	Not covered
Gap Coverage*	T1 drugs; Partial gap coverage for Select T2 and T3 drugs				T1 drugs; Partial gap coverage for Select T2 and T3 drugs			

Optional Supplemental Coverage:

DENTAL RIDER			
$25	**$25**	**$25**	**$25**

care n care
Insurance Company, Inc.

2023 Plan Benefit Highlights

CARE N' CARE CLASSIC (HMO) H2171-001
SOUTHWESTERN HEALTH SELECT (HMO) H2171-003
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

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