	Care N' Care Choice	(DDA) H6228 A02	Care N' Care Choice Plu	us (DDA) <u>H6228 A02</u>	Caro N' Caro Choice Dr	remium (PPO) H6328-00	1 Care N' Care Choice MA-O	nhy (DDA) 46228 005		Cano N' Cano Classic (IIMO) II9171 -001	Southwestern Health Select (HMO) H9171-009
Plan Premium	Solution Care Choice		stare N Care Choice Pil			5194	so	my (110) 110328-003		Care N' Care Classic (HMO) H2171-001	Southwestern Health Select (HMO) H2171-003
Plan Premium Part B premium reduction	Not Ava		Not Avail			Available	CNC will reduce your Monthly		Plan Premium	\$0	\$0
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	Out-Of-Pocket Maximum	\$3,900	\$3,200
Out-Of-Pocket Maximum	\$4,200	\$8,950	\$3,800	\$8,950	\$3,500	\$5,450	\$2,500	\$5,100	DOCTOR OFFICE VISITS		
DOCTOR OFFICE VISITS									Primary Care Physician (PCP) Visits	\$0 Copay	\$0 Copay
Primary Care Physician (PCP) Visits	\$0 copay	\$25 copay	\$0 сорау	\$20 copay	\$0 copay	30% of the cost	\$0 сорау	\$20 copay	Specialist Visits	\$35 Copay	\$15 Copay
Specialist Visits	\$35 сорау	\$70 сорау	\$25 сорау	\$50 copay	\$0 сорау	30% of the cost	\$10 сорау	\$20 сорау	PODIATRY		
PODIATRY	\$35 copay	\$60 copay	\$20 copay	\$40 copay	\$0 сорау	30% of the cost	\$20 сорау	\$50 сорау		\$35 Copay	\$15 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	10% of the cost	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
	Days 1-20: \$0 copay		Days 1-20: \$0 copay				per day Days 1-5: \$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
SKILLED NURSING FACILITY (SNF)	Days 21-50: \$167.50 copay per day Days 51-100 \$0 copay	35% of the cost	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 6-20: \$10 copay per day Days 21-100: \$100 copay per day	10% of the cost	<ul> <li>TELEHEALTH SERVICES</li> <li>Primary Care Physician Services</li> <li>Mental Health Specialty Services</li> </ul>	\$0 Сорау \$25 Сорау	\$0 Сорау \$15 Сорау
<ul><li>TELEHEALTH SERVICES</li><li>Primary Care Physician Services</li></ul>	\$0 Сорау		\$0 Copay		\$0 Copay		\$0 Сорау		Specialty Services	\$25 Copay	\$15 Copay \$15 Copay
Mental Health Specialty Services	\$0 Copdy \$25 Copay \$35 Copay	Not covered	\$25 Copay \$25 Copay \$25 Copay	Not covered	\$0 Copay	Not covered	\$25 Copay \$10 Copay	Not covered	OUTPATIENT REHABILITATION SERVICES		
Specialty Services	\$35 Copay		\$25 Copdy		\$0 Copay		\$10 Copay		Occupational Therapy Visit	\$25 Copay	\$15 Copay
OUTPATIENT REHABILITATION SERVICES									Physical / Speech / Language Visits	\$15 Сорау	\$15 Copay
Occupational Therapy Visit	\$40 copay	\$60 сорау	\$15 copay	\$30 сорау	\$0 сорау	30% of the cost	\$10 copay	\$20 сорау	HOME HEALTH SERVICES	\$0 Сорау	\$0 Сорау
Physical / Speech / Language Visits	\$15 copay	\$60 copay	\$15 сорау	\$45 copay	\$0 сорау	30% of the cost	\$10 copay	\$20 copay	AMBULANCE • Ground Ambulance	\$275 Copay	\$275 Copay
HOME HEALTH SERVICES	\$0 сорау	\$30 сорау	\$0 сорау	\$40 copay	\$0 сорау	30% of the cost	\$15 сорау	\$40 сорау	Air Ambulance	20% of the cost	20% of the cost
AMBULANCE • Ground Ambulance			\$275 co		\$0 сорау	35% of the cost	\$275 cop		EMERGENCY CARE	\$100 Copay	\$100 Copay
• Air Ambulance	20% of th	he cost	20% of the	e cost			20% of the	e cost	URGENTLY NEEDED SERVICES	\$30 copay	\$30 copay
EMERGENCY CARE	\$15 copay       \$60 copay         \$0 copay       \$30 copay         \$275 copay       \$20% of the cost         \$100 copay       \$         \$25 copay       \$		\$100 copay \$100 copay		\$0 сорау		\$100 copay		OUTPATIENT SURGERY		
URGENTLY NEEDED SERVICES	\$25 co	орау	\$25 cop	bay	\$0	сорау	\$25 cop	ау	Ambulatory Surgical Center	\$175 Copay	\$150 Сорау
OUTPATIENT SURGERY									Outpatient Hospital Facility	\$300 Сорау	\$250 Сорау
Ambulatory Surgical Center	\$150 copay	\$275 copay	\$150 copay	\$275 copay	\$0 сорау	30% of the cost	\$50 сорау	\$50 copay	DIAGNOSTIC TESTS & LAB SERVICES		
Outpatient Hospital Facility	\$275 copay	\$350 copay	\$275 сорау	\$350 copay	\$0 сорау	30% of the cost	\$100 сорау	\$225 copay	Basic Diagnostic Tests and Procedures	\$0-\$50 Сорау	\$0-\$50 Сорау
DIAGNOSTIC TESTS & LAB SERVICES									Lab Services	\$0-\$10 Сорау	\$0-\$10 Сорау
Basic Diagnostic Tests and Procedures	\$0-\$50 сорау	\$0-\$75 copay	\$0-\$50 copay	\$0-\$175 copay	\$0 сорау	30% of the cost	\$0-\$50 сорау	\$10-\$150 copay	OUTPATIENT X-RAYS	\$0 Сорау	\$0 Сорау
Lab Services	\$0-\$10 сорау	\$25 сорау	\$0-\$10 copay	\$15-\$25 сорау	\$0 сорау	30% of the cost	\$0-\$5 сорау	\$10-\$25 copay	THERAPEUTIC RADIOLOGY SERVICES	20% of the cost	20% of the cost
OUTPATIENT X-RAYS	\$10 copay	\$25 copay	\$5 copay	\$30 copay	\$0 сорау	30% of the cost	\$0 сорау	\$10-\$25 copay	(such as radiation treatment for cancer)		
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	20% 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			
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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' Ca			are N' Care Choice Premium (PPO) H6328-001			Care N' Care Choice MA-ONLY (PPO) H6328-005		
	IN-NE	TWORK	OUT-OF-	NETWORK	IN-NE	TWORK	OUT-OF-I	NETWORK	IN-NE	TWORK	OUT-OF-	NETWORK	IN-NETWORK	OUT-OF-NETWORK	
FITNESS BENEFIT	Unlimited number of visits to a SilverSneakers <sup>®</sup> participating fitness facility. OON must use preferred vendor			Unlimited number of visits to a SilverSneakers <sup>®</sup> participating fitness facility. OON must use preferred vendor			Unlimited number of visits to a SilverSneakers <sup>®</sup> participating fitness facility. OON must use preferred vendor				Unlimited number of visits to a SilverSneakers <sup>®</sup> 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 сорау		\$0 0	copay	\$0 сорау		\$0 сорау		\$0 сорау		\$0 сорау		\$0 copay	\$0 сорау	
VISION COVERAGE															
Routine Eye Exam (1 every year, includes refraction)	\$0 сорау		\$50 copay		\$0 сорау \$40 сорау		copay	\$0 сорау \$35 сорау		сорау	\$0 copay	\$35 copay			
Eyeglasses or contact lenses after cataract surgery	glasses or contact lenses after cataract surgery \$0 cop		орау \$30 сорау		\$0 сорау \$30 сорау		\$0 copay 30% of the cost		\$0 сорау	\$30 copay					
Non-Medicare Prescription eyewear allowance	on-Medicare Prescription eyewear allowance \$100 every ye		\$100 every year		\$100 every year \$100 every year		ery year	\$150 every year \$150 every year		\$150 every year	\$150 every year				
HEARING COVERAGE			1				1								
Exam to diagnose and treat hearing and balance issues	\$20	\$20 copay		сорау	\$25 copay		\$45 copay		\$0 copay 30% of		f the cost	\$20 copay	\$45 copay		
Routine Hearing Exam (for up to 1 every year)	\$45	\$45 сорау		сорау	\$45	\$45 сорау \$45 сорау		\$45 copay \$45 copay		сорау	\$45 copay	\$45 copay			
Hearing Aid	Advanced Aids:\$699 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	e Choice (PPC	))	C	are N' Care C	hoice Plus (P	PO)	Care	e N' Care Cho	ice Premium	n (PPO)	Care N' Care Choice MA-ONLY (PPO)		
Pharmacy Deductible		No De	ductible			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			
• Tier 1 - Preferred Generics	\$4 copay	\$8 copay	\$0 сорау	\$0 сорау	\$2 copay	\$4 copay	\$0 сорау	\$0 сорау	\$0 copay	\$0 copay	\$0 сорау	\$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	Not Covered		
<ul> <li>Tier 3 - Preferred Brand</li> <li>Select Insulins*</li> </ul>	\$47 copay \$35 copay	\$94 сорау \$70 сорау	\$47 copay \$35 copay	\$94 сору \$70 сорау	\$45 copay \$35 copay	\$90 сорау \$70 сорау	\$45 copay \$35 copay	\$90 сорау \$70 сорау	\$43 copay \$35 copay	\$86 copay \$70 copay	\$43 copay \$35 copay	\$86 сорау \$70 сорау	-		
• Tier 4 - Non-Preferred Drugs	\$100 copay	\$200 copay	\$100 copay	\$200 сорау	\$97 copay	\$194 copay	\$97 сорау	\$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	red 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			TI 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					DENTAL RIDER           \$25         \$25	
Monthly Premium	\$25	\$25	\$25	\$25	\$25	

	Care N	' Care Classi	.c (HMO) H2	171-001	Southwestern Health Select (HMO) H2171-003					
FITNESS BENEFIT	Unlir		sits to a SilverSnea fitness facility.	ıkers <sup>®</sup>	Unlimited number of visits to a SilverSneakers <sup>®</sup> participating fitness facility.					
Over-The-Counter (OTC)	\$60		6 months) to spe ed OTC items.	nd on	\$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 C	opay		\$0 Сорау					
VISION COVERAGE										
Routine Eye Exam (1 every year, includes refraction)		\$0 C	Copay			\$0 C	opay			
Eyeglasses or contact lenses after cataract surgery		\$0 C	Copay			\$0 C	opay			
Non-Medicare Prescription eyewear allowance	_	\$150 Maxir	num Benefit		\$150 Maximum Benefit					
HEARING COVERAGE										
Exam to diagnose and treat hearing and balance issues		\$25 C	Copay		\$25 Сорау					
Routine Hearing Exam (for up to 1 every year)	_	\$45 (	Сорау		\$45 Copay					
Hearing Aid		Advanced Aic Premium Aids:	ls:\$599 copay \$899 copay		Advanced Aids:\$599 copay Premium Aids:\$899 copay					
PRESCRIPTION DRUG BENEFIT	C	are N' Care	Classic (HM	0)	Southwestern Health Select (HMO)					
Pharmacy Deductible		No Dec	ductible		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 сорау	\$0 copay	\$0 copay	\$0 copay	\$0 copay		
• Tier 2 - Generics	\$14 сорау	\$28 сорау	\$14 copay	\$28 сорау	\$10 сорау	\$20 сорау	\$0 сорау	\$0 copay		
<ul> <li>Tier 3 - Preferred Brand</li> <li>Select Insulins*</li> </ul>	\$47 сорау \$35 сорау	\$94 сорау <i>\$70 сорау</i>	\$47 copay <i>\$35 copay</i>	\$94 сорау <i>\$70 сорау</i>	\$40 copay \$35 copay	\$80 copay \$70 copay	\$40 copay \$ <i>35 copay</i>	\$80 сорау <i>\$70 сорау</i>		
<ul> <li>Tier 4 - Non-Preferred Drugs</li> </ul>	\$100 copay	\$200 copay	\$100 copay	\$200 copay	\$100 copay	\$200 сорау	\$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; P	artial gap coveraç	ge for Select T2 ar	nd T3 drugs	T1 drugs; Partial gap coverage for Select T2 and T3 drugs					

## Optional Supplemental Coverage:

## 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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