care n care
Insurance Company, Inc.

2024

Summary Of Benefits
Care N' Care Choice Premium (PPO) H6328-001

January 1, 2024 - December 31, 2024

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 is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage." You can also see the Evidence of Coverage on our website, cnchealthplan.com.

To join a Care N' Care Choice Premium (PPO) plan, 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, Ellis, Erath, Hood, Johnson, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise.** Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at 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 8 p.m. CST, seven days a week or April 1 - September 30, 8 a.m. to 8 p.m. CST, Monday through Friday or, visit us at cnchealthplan.com.

Premiums and Benefits	Care N' Care Choice Premium (PPO) H6328-001	
Monthly Plan Premium	You pay a $195 monthly premium. You must continue to pay your Medicare Part B premium.	
Deductible	Medical Deductible: $0 Prescription Drug Deductible: $0	
Maximum Out-of-Pocket - The most you pay for copays, coinsurance and other costs for covered medical services for the year.	Your yearly limit(s) in this plan: $3,500 for services you receive from in-network providers. $5,450 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	
	In-Network	**Out-Of-Network**
Inpatient Hospital	$0 copay per day Services require prior authorization	30% of the cost per stay Services require prior authorization
Outpatient Hospital	$0 copay Services require prior authorization	30% of the cost per stay Services require prior authorization
Ambulatory Surgical Center	$0 copay Services require prior authorization	30% of the cost Services require prior authorization
Doctor's Office Visits	Primary care physician visit: $0 copay Specialist visit: $0 copay Telehealth Services: Primary Care Physician or Urgent Care: $0 copay Specialist visit: $0 copay	Primary care physician visit:30% of the cost Specialist visit: 30% of the cost Telehealth Services: Not available Must use in-network provider or our vendor MDLIVE for this benefit

Preventive Care (e.g. Flu Vaccine, Diabetic Screenings, Annual Wellness Visit, Bone mass measurement, Breast cancer screening, Cardiovascular disease (behavioral therapy) Cardiovascular screenings, Cervical and vaginal cancer screening	$0 copay for all preventive services covered under Original Medicare Any additional preventive services approved by Medicare during the contract year will be covered.	30% of the cost Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$0 copay per visit Worldwide Emergency: $0 copay Note: Coverage limited to $100,000 per year for worldwide emergency/urgent services outside the United States	$0 copay per visit Worldwide Emergency: $0 copay Note: Coverage limited to $100,000 per year for worldwide emergency/urgent services outside the United States
Urgently Needed Services	$0 copay per visit Worldwide Urgently Needed Service: $0 copay Note: Coverage limited to $100,000 per year for worldwide emergency/urgent services outside the United States	$0 copay per visit Worldwide Urgently Needed Service: $0 copay Note: Coverage limited to $100,000 per year for worldwide emergency/urgent services outside the United States
Diagnostic Services/Labs/ Imaging	Diagnostic colonoscopy: $0 copay Diagnostic tests and procedures: $0 copay Lab services: $0 copay Diagnostic radiology: $0 copay Diagnostic mammogram: $0 copay Outpatient x-rays: $0 copay Radiation therapy: $0 copay Services may require prior authorization	Diagnostic colonoscopy: 30% of the cost Diagnostic tests and procedures: $0 copay-30% of the cost Lab services: 30% of the cost Diagnostic radiology: 30% of the cost Diagnostic mammogram: 30% of the cost Outpatient x-rays: 30% of the cost Radiation therapy: 30% of the cost Services may require prior authorization
Hearing Services	Medicare-covered exam to diagnose and treat hearing and balance issues: $0 copay Routine hearing exam (1 visit every year - benefit through TruHearing): $0 copay Hearing Aid (1 hearing aid per ear per year - benefit through TruHearing): $499 - $999 copay per aid.	Medicare-covered exam to diagnose and treat hearing and balance issues: 30% of the cost Routine hearing exam (1 visit every year - benefit through TruHearing): Not Available, must use a TruHearing provider Hearing Aid (1 hearing aid per ear per year - benefit through TruHearing): Not Available, must use a TruHearing provider
Dental Services Comprehensive and Preventive Services includes but is not limited to the following: (up to $3,000) • Cleaning • Dental X-Ray(s) • Oral Exam • Fillings • Dentures • Extractions	$0 copay up to $3 ,000 benefit maximum Note: Once benefit max is reached: you pay 100% of the claim cost (Benefit through DentaQuest) Your provider may need to obtain prior authorization for routine dental benefits	$0 copay for the in-network allowed amount up to the benefit maximum PLUS the difference between the out-of-network submitted amount and the in-network allowed amount Note: Once benefit max is reached: you pay 100% of the claim cost (Benefit through DentaQuest) Your provider may need to obtain prior authorization for routine dental benefits
Vision Services	Medicare-covered Diagnosis/Treatment of illness/injury of eye: $0 copay Medicare-covered Glaucoma Screening: $0 copay Medicare-covered diabetic retinopathy screen (1x/yr): $0 copay Medicare covered standard glasses or contacts after cataract surgery: $0 copay Routine eye exam with dilation as necessary: $0 copay (benefit through EyeMed) Prescription eyewear (eye glasses (frames and lenses) or contact lenses, conventional or disposable): up to $150 allowance toward purchase (benefit through EyeMed) Medically Necessary Contact Lenses: $0 copay (benefit through EyeMed)	Medicare-covered Diagnosis/Treatment of illness/injury of eye: 30% of the cost Medicare-covered Glaucoma Screening: 30% of the cost Medicare-covered diabetic retinopathy screen (1x/yr): 30% of the cost Medicare-covered standard glasses or contacts after cataract surgery: 30% of the cost Routine eye exam with dilation as necessary: $50 reimbursment max (benefit through EyeMed) Prescription eyewear (eye glasses (frames and lenses) or contact lenses, conventional or disposable): up to $150 reimbursement max (benefit through EyeMed) Medically Necessary Contact Lenses: $210 reimbursement max (benefit through EyeMed)

Mental Health Care	Inpatient Services: $0 copay Outpatient Services: Individual and group therapy visit with a mental health specialist or psychiatrist: $0 copay Telehealth Services: Mental Health Specialty Services: $0 copay	Inpatient Services: 30% of the cost Outpatient Services: Individual and group therapy visit with a mental health specialist or psychiatrist: 30% of the cost Telehealth Services: Not available, must use in-network provider or our vendor MDLIVE for this benefit.
Skilled Nursing Facility (SNF)	Days 1-100: $0 copay Services require prior authorization	30% of the cost Services require prior authorization
Physical Therapy	$0 copay	30% of the cost
Ambulance	Ground Ambulance: $0 Air Ambulance: $0 copay Prior Authorization is required for Non-Emergency transportation	Ground Ambulance: 35% of the cost Air Ambulance: 35% of the cost Prior Authorization is required for Non-Emergency transportation
Transportation	Not Covered	Not Covered
Medicare Part B Drugs	Part B insulin: $35 copay per month All other Part B drugs: $0 (may require prior authorization)	Part B insulin: 30% of the cost All other Part B drugs: 30% of cost (may require prior authorization)
Acupuncture Services	$0 copay (Benefit through American Specialty Health)	You pay 30% of the cost
Chiropractic Services	$0 copay	You pay 30% of the cost
Home Health Services	$0 copay Servives require prior authorization	You pay 30% of the cost Services require prior authorization
Nurse Advice Line	$0 copay (Benefit through Carenet Health)	Not available, must use preferred vendor Carenet Healthfor this benefit
Occupational Therapy	$0 copay	30% of the cost
Over-the-Counter Products	$130 every quarter (3 months) to spend on plan-approved OTC items (Benefit through Medline)	Not available, must use preferred vendor Medline for this benefit
Podiatry Services	$0 copay	You pay 30% of the cost

Prescription Drug Benefits

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 **$5,030**, 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	$8 copay	$16 copay	$8 copay	$16 copay
Tier 3: Preferred Brands	$43 copay	$86 copay	$43 copay	$86 copay
- *Formulary 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

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 Formulary 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 Insulins are on our formulary, review the most recent Drug List we provided electronically on our website at www.cnchealthplan.com.

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 $8,000. This amount and rules for counting costs toward this amount have been set by Medicare.

Catastrophic Coverage

During this stage, you pay zero for each prescription you fill. The plan and Medicare pay the rest until the end of the calendar year.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-877-905-9210 (TTY: 711).
ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-877-905-9210 (TTY: 711).

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.
The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Care N' Care Insurance Company members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Experience Team number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

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

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. 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.
- ☐ Review the formulary to make sure your drugs are covered.
- ☐ Review enrollment decision and how enrollment will affect current coverage.

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/coinsurance may change on January 1, 2025.
- ☐ 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.

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