Benefit Highlights

CARE N' CARE CHOICE PPO

[1]Services may require prior authorization

Premiums and Benefits	Care N' Care Choice (PPO)	
	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 $3,900 annually for in-network services unless specifically excluded.	You pay no more than $7,500 annually for combined in and out-of-network services unless specifically excluded.
Inpatient Hospital[1]	Day 1: $250 per day Days 2-6: $150 per day Days 7 and beyond: $0 per day	You pay 35% of the cost
Outpatient Surgery[1] • Outpatient Hospital • Ambulatory Surgical Center	 You pay a $250 copay You pay a $200 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)	You pay nothing	You pay nothing
Emergency Care	You pay $90 per visit Emergency copay is waived if you are admitted to the hospital within 3 days due to the same condition.	You pay $90 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	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 $10 copay You pay a $150 copay You pay a $10 copay You pay a $200 You pay a $10 copay	 You pay a $25 copay You pay a $200 copay You pay a $25 copay You pay a $200 copay You pay a $25 copay

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

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 will be reimbursed up to a maximum amount of $30 for a routine eye exam with submission of paid receipt and completed reimbursement form. You pay a $25 copay. Plan maximum benefit of $100.
Telehealth Services • Primary Care Physician Services • Mental Health Specialty Services	$0 Copay $40 Copay	$25 Copay $60 Copay
Mental Health Services[1] • Outpatient group therapy/individual therapy visit	You pay a $40 copay	You pay a $60 copay
Skilled Nursing Facility[1]	Days 1-20: $0 copay Days 21-100: $167.50 copay per day	You pay 40% of the cost
Physical Therapy	You pay a $40 copay	You pay a $60 copay
Ambulance[2] • Ground Ambulance • Air Ambulance	You pay a $200 copay You pay 20% of the cost	You pay a $200 copay You pay 20% of the cost

Premiums and Benefits	Care N' Care Choice (PPO)	
	In-Network	Out-Of-Network
Transportation	Not Covered	Not Covered
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

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	$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	33% of the cost	33% of the cost	33% of the cost

*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.

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 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 $7,050. 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, 2022). 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 $3.95 for a generic drug or a drug that is treated like a generic and $9.85 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 $26 monthly premium. The rider provides coverage on dental services that require a preauthorization and coinsurance for each dental service.

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 cn-chealthplan.com/our-plans-2022/our-benefits-2022/

Questions? Call Care N' Care!

Toll-free at 1-877-665-2622 (TTY 711) October 1 - March 31, 8am to 8pm, CST, seven days a week or April 1 - September 30, 8am to 8pm, Monday through Friday.