	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		$50		$195		$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	$4,300	$8,950	$3,900	$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	$45 copay	$20 copay	$25 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
Telehealth Services • Primary Care Physician or Urgent Care • Mental Health Specialty Services • Specialist 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
HOSPITAL, EMERGENCY, URGENT CARE								
Inpatient Hospital Care (there is a supplemental benefit covering any hospital stay beyond 90 days)	Days 1-5: $225 copay per day Days 6 and beyond $0 copay per day	35% of the cost	Days 1-5: $200 copay per day Days 6 and beyond $0 copay per day	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: $167.50 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
Ambulance • Ground Ambulance • Air Ambulance	$275 copay 20% of the cost	$275 copay 20% of the cost	$275 copay 20% of the cost	$275 copay 20% of the cost	$0 copay $0 copay	35% of the cost 35% of the cost	$275 copay 20% of the cost	$275 copay 20% of the cost
Emergency Care	$100 copay		$100 copay		$0 copay		$100 copay	
Urgently Needed Services	$30 copay		$25 copay		$0 copay		$25 copay	
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	$0 copay	$40 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	$200 copay	$350 copay	$200 copay	$350 copay	$0 copay	30% of the cost	$100 copay	$225 copay
DIAGNOSTIC TESTS AND LAB SERVICES								
Basic Diagnostic Procedures & Tests (Non-Radiologic) - examples allergy tests, EKGs, psychological tests	$0-$25 copay	$0-$75 copay	$0-$25 copay	$0-$175 copay	$0 copay	$0 copay-30% of the cost	$0-$25 copay	$0-$150 copay
Diagnostic Radiological Services - examples CT scans, MRI, Ultrasounds, Echocardiograms	$0-$200 copay	$75-$250 copay	$0-$175 copay	$75-$200 copay	$0 copay	30% of the cost	$0-$150 copay	$75-$200 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	$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
SUPPLIES AND EQUIPMENT								
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
Rewards and Incentives Program	N/A	Up to $750 for completing health and wellness activities
Flexible Spending Card (Supplemental dental, hearing, and vision out-of-pocket costs)	N/A	$800, distribution quarterly ($200 per quarter)
DOCTOR OFFICE VISITS		
Primary Care Physician (PCP) Visits	$0 copay	$0 copay
Specialist Visits	$0 copay	$0 copay
Podiatry	$35 copay	$15 copay
Telehealth Services • Primary Care Physician or Urgent Care • Mental Health Specialty Services • Specialist Services	$0 copay $25 copay $0 copay	$0 copay $15 copay $0 copay
HOSPITAL, EMERGENCY, URGENT CARE		
Inpatient Hospital Care (there is a supplemental benefit covering any hospital stay beyond 90 days at $0 copay)	Days 1-5: $210 copay per day Days 6 and beyond $0 copay per day	Days 1-5: $225 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
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 REHABILITATION SERVICES		
Occupational Therapy Visit	$25 copay	$15 copay
Physical / Speech / Language Visits	$15 copay	$15 copay
Home Health Services	$0 copay	$0 copay
OUTPATIENT SURGERY		
Ambulatory Surgical Center	$175 copay	$150 copay
Outpatient Hospital Facility	$190 copay	$190 copay
DIAGNOSTIC TESTS AND LAB SERVICES		
Basic Diagnostic Procedures & Tests (Non-Radiologic) - examples allergy tests, EKGs, psychological tests	$0-$50 copay	$0-$50 copay
Diagnostic Radiological Services - examples CT scans, MRI, Ultrasounds, Echocardiograms	$0-$225 copay	$0-$200 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
SUPPLIES AND EQUIPMENT		
Durable Medical Equipment	20% of the cost	20% of the cost

For prospective members

Call our Medicare Specialist for more information about Medicare Advantage plans at **1-877-905-9208** (TTY 711) from 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.

For members

Call or Email your Customer Experience Team with questions about your current Care N' Care plan at **1-877-374-7993** (TTY 711), yourteam@cnchealthplan.com, from October 1,– March 31, 8 a.m. – 8 p.m. CST seven days a week or April 1– September 30, 8 a.m. – 8 p.m. CST, Monday through Friday.

The benefit information provided is a highlight of what we cover and what you pay. It does not list every benefit or service that we cover or every limitation or exclusion. To get a complete list we cover, including which benefits or services require a prior authorization or referral, see the Evidence of Coverage on our website at cnchealthplan.com. You can also call us at the phone number listed on this page.

Care N' Care Insurance Company, Inc. (Care N' Care) is anHMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal.

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SUPPLEMENTAL BENEFIT	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.	Not Available	Unlimited number of visits to a SilverSneakers® participating fitness facility.	Not Available	Unlimited number of visits to a SilverSneakers® participating fitness facility.	Not Available	Unlimited number of visits to a SilverSneakers® participating fitness facility.	Not Available
Over-The-Counter (OTC) through Medline (Benefit does not carry over to the next quarter)	$90 Every quarter (3 months) to spend on Plan-approved OTC items.	Not Available	$90 Every quarter (3 months) to spend on Plan-approved OTC items.	Not Available	$130 Every quarter (3 months) to spend on Plan-approved OTC items.	Not Available	$75 Every quarter (3 months) to spend on Plan-approved OTC items.	Not Available
DENTAL COVERAGE through DentaQuest								
Comprehensive and Preventive Dental Services includes but is not limited to the following: • Cleaning • Dental X-Ray(s) • Oral Exam • Fillings • Dentures • Extractions • Implants	$0 copay up to $3000 benefit maximum	$0 copay for the in-network allowed amount up to the benefit maximum PLUS Difference between the out-of-network submitted amount and the in-network allowed amount.	$0 copay up to $3000 benefit maximum	$0 copay for the in-network allowed amount up to the benefit maximum PLUS Difference between the out-of-network submitted amount and the in-network allowed amount.	$0 copay up to $3000 benefit maximum	$0 copay for the in-network allowed amount up to the benefit maximum PLUS Difference between the out-of-network submitted amount and the in-network allowed amount.	$0 copay up to benefit $1000 maximum	$0 copay for the in-network allowed amount up to the benefit maximum PLUS Difference between the out-of-network submitted amount and the in-network allowed amount.
VISION COVERAGE through EyeMed								
Eye Exam (1 every year, includes refraction)	$0 copay	Up to $50 reimbursement for the exam visit	$0 copay	Up to $50 reimbursement for the exam visit	$0 copay	Up to $50 reimbursement for the exam visit	$0 copay	Up to $50 reimbursement for the exam visit
Prescription eyewear allowance (every year) eye glasses (frames and lenses) or contact lenses (conventional or disposable)	up to $150 allowance toward purchase	up to $150 reimbursement	Up to $150 allowance toward purchase	up to $150 reimbursement	up to$150 allowance toward purchase	up to $150 reimbursement	up to$150 allowance toward purchase	up to $150 reimbursement
HEARING COVERAGE through TruHearing								
Routine Hearing Exam (1 every year- must be with TruHearing provider)	$0 copay	Not Available Must use a TruHearing provider	$0 copay	Not Available Must use a TruHearing provider	$0 copay	Not Available Must use a TruHearing provider	$0 copay	Not Available Must use a TruHearing provider
Hearing Aids (Up to two TruHearing-branded aids every year (one per ear per year))	Standard Aids: $499 copay per aid Advanced Aids: $699 copay per aid Premium Aids: $999 copay per aid		Standard Aids: $499 copay per aid Advanced Aids: $699 copay per aid Premium Aids: $999 copay per aid		Standard Aids: $499 copay per aid Advanced Aids: $699 copay per aid Premium Aids: $999 copay per aid		Standard Aids: $499 copay per aid Advanced Aids: $699 copay per aid Premium Aids: $999 copay per aid	

PRESCRIPTION DRUG BENEFIT	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
Pharmacy Deductible	No Deductible				No Deductible				No Deductible				Not Covered
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	Retail 30-day Supply	Retail 100-day Supply	Mail Order 30-day Supply	Mail Order 100-day Supply	
• 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	$12 copay	$24 copay	$12 copay	$24 copay	$12 copay	$24 copay	$12 copay	$24 copay	$8 copay	$16 copay	$8 copay	$16 copay	
• Tier 3 - Preferred Brand - *Formulary 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*	Tier 1 drugs; Partial gap coverage for Select Tier2 and Tier 3 drugs				Tier 1 drugs; Partial gap coverage for Select Tier2 and Tier 3 drugs				Tier 1 drugs; Partial gap coverage for Select Tier2 and Tier 3 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.

SUPPLEMENTAL BENEFITS	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) through Medline (Benefit does not carry over to the next quarter)	$75 Every quarter (3 months) to spend on Plan-approved OTC items.	$100 Every quarter (3 months) to spend on Plan-approved OTC items.
DENTAL COVERAGE through DentaQuest		
Comprehensive and Preventive Dental Services includes but is not limited to the following: • Cleaning • Dental X-Ray(s) • Oral Exam • Fillings • Dentures • Extractions • Implants	$0 copay up to $3000 benefit maximum	$0 copay up to $3000 benefit maximum
VISION COVERAGE through EyeMed		
Eye Exam (1 every year, includes refraction – must be with EyeMed provider)	$0 copay	$0 copay
Prescription eyewear allowance (every year) eye glasses (frames & lenses) or contact lenses (conventional or disposable)	Up to $150 allowance toward purchase	Up to $150 allowance toward purchase
HEARING COVERAGE through TruHearing		
Routine Hearing Exam (1 every year- must be with TruHearing provider)	$0 copay	$0 copay
Hearing Aids (Up to two TruHearing-branded aids every year (one per ear per year))	Standard Aids: $399 copay per aid Advanced Aids: $599 copay per aid Premium Aids: $899 copay per aid	Standard Aids: $399 copay per aid Advanced Aids: $599 copay per aid Premium Aids: $899 copay per aid

PRESCRIPTION DRUG BENEFIT	Care N' Care Classic (HMO) H2171-001				Southwestern Health Select (HMO) H2171-003			
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	$10 copay	$20 copay	$10 copay	$20 copay	$10 copay	$20 copay	$0 copay	$0 copay
• Tier 3 - Preferred Brand - *Formulary 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*	Tier 1 drugs; Partial gap coverage for Select Tier2 and Tier 3 drugs				Tier 1 drugs; Partial gap coverage for Select Tier2 and Tier 3 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.

care@care
Insurance Company, Inc.

2024 Plan Benefit Highlights

CARE N' CARE CLASSIC (HMO) H2171-001
SOUTHWESTERN HEALTH SELECT (HMO) H2171-003
CARE N' CARE CHOICE PREMIUM (PPO) H6328-001
CARE N' CARE CHOICE PLUS (PPO) H6328-002
CARE N' CARE CHOICE (PPO) H6328-003
CARE N' CARE CHOICE MA-ONLY (PPO) H6328-005

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Southwestern Health Resources
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