ConnectiCare Medicare Advantage

Choice Plan 1 (HMO)
Choice Plan 2 (HMO)
Choice Plan 3 (HMO)

Summary of Benefits 2019

This is a summary of drug and health services covered by ConnectiCare, Inc., January 1, 2019 – December 31, 2019

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 customer service representative at 1-877-224-8220 (TTY: 1-800-842-9710), 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **connecticare.com/medicare** or call 1-877-224-8220 (TTY: 1-800-842-9710) 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.
- ☐ 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, it means you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ 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/co-insurance many change on January 1, 2020.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

ConnectiCare

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Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

ConnectiCare, Inc. is a Medicare Advantage HMO/HMO-POS plan with a Medicare contract. Enrollment in the Plan depends on contract renewal. The benefit information provided is a summary of what we cover and what you pay for. It does not list every service that we cover or list every limitation or exclusion. Some services may require prior authorization. To get a complete list of services we cover, including those that require prior authorization, please request the "Evidence of Coverage." You can find this document on our website at **connecticare.com/medicare**, or call us at the phone number(s) below and we'll send you a copy.

Who can join?

To join a ConnectiCare Choice Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

> **For Choice Plan 1 (HMO):** Our service area includes the following counties in Connecticut: Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham.
> **This plan is not offered in Fairfield County.**
>
> **For Choice Plan 2 (HMO) and Choice Plan 3 (HMO):** Our service area includes the following counties in Connecticut: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham.

Which doctors, hospitals and pharmacies can I use?

Choice Plan 1 (HMO) and Choice Plan 3 (HMO) have a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services.

Choice Plan 1 and Choice Plan 3 cover Part D drugs. In addition they cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **connecticare.com/medicare**. Or, call us and we'll send you a copy.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost sharing. You may pay less if you use these pharmacies. You can see our plan's provider and pharmacy directory on our website at **connecticare.com/medicare**. Or, call us and we'll send you a copy.

Choice Plan 2 (HMO) has a network of doctors, hospitals and other providers. If you use providers that are not in our network, the plan may not pay for these services. You can see our plan's provider directory on our website at **connecticare.com/medicare**. Or, call us and we'll send you a copy.

Choice Plan 2 **DOES NOT cover Part D drugs**. This plan does cover Part B drugs such as chemotherapy and some drugs administered by your provider.

How to reach us:

For more information, please call us at the phone number below or visit us at **connecticare.com/medicare**.

Toll-free 1-877-224-8220, TTY users should call 1-800-842-9710.

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern.

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Choice Plan 1 (HMO)**	**Choice Plan 2 (HMO)**
Monthly Plan Premium:		
For Medicare beneficiaries who live in Hartford, Litchfield, Middlesex and Tolland counties	$186	$0
For Medicare beneficiaries who live in New Haven, New London and Windham counties	$172	$0
For Medicare beneficiaries who live in Fairfield county	**NOT AVAILABLE**	$0
Deductible - Medical	You pay nothing	You pay nothing
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$3,400 annually	$6,000 annually
Inpatient Hospital Coverage	$345 copay per day for days 1 through 5 per stay You pay nothing per day for days 6 and beyond per stay	$295 copay per day for days 1 through 6 per stay You pay nothing per day for days 7 and beyond per stay

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Choice Plan 3 (HMO)	What you should know about Choice Plan 1, Choice Plan 2 & Choice Plan 3
$0	In addition, you must continue to pay your Medicare Part B premium.
$0	In addition, you must continue to pay your Medicare Part B premium.
$0	In addition, you must continue to pay your Medicare Part B premium.
$1,000 plan deductible	Choice Plan 1 and Choice Plan 2 DO NOT have a deductible for medical benefits. Choice Plan 3 DOES have a medical deductible. The deductible applies only to the following services: • Ambulance • Ambulatory Surgical Centers • Cardiac Rehabilitation Therapy • Diagnostic Radiology • Dialysis Services • Kidney Disease Education • Occupational, Speech and Language Therapy • Outpatient Hospital Services (including observation services) • Physical Therapy • Pulmonary Rehabilitation Therapy • Skilled Nursing Facility • Therapeutic Radiology • X-rays
$6,700 annually	This is the most you pay for copays, coinsurance and other costs for medical services for the year.
$465 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 and beyond per stay	The cost-sharing applies each time you are admitted to a hospital. Prior Authorization is required for each inpatient stay.

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Choice Plan 1 (HMO)**	**Choice Plan 2 (HMO)**
Outpatient Hospital Coverage:		
Outpatient Hospital Services *(including observation services)*	$200 copay	$200 copay
Ambulatory Surgical Centers	$100 copay	$100 copay
Doctor Visits:		
• Primary Care Provider (PCP)	At a Sanitas Medical Center: You pay nothing For all other Primary Care Providers: $10 copay per visit	You pay nothing
• Specialist	$30 copay per visit	$10 copay per visit
Preventive Care	You pay nothing	You pay nothing
Emergency Care	$90 copay per visit within the United States	$90 copay per visit within the United States
Urgently Needed Care	$30 copay per visit within the United States	$10 copay per visit within the United States
Worldwide Emergent/Urgent Care *(coverage outside the United States)*	$90 copay	$90 copay
Diagnostic Services/Labs/Imaging:		
• Diagnostic radiology service *(e.g., MRI)*	$200 copay	$175 copay
• Lab Services	$10 copay	$10 copay
• Diagnostic Tests and Procedures	10% of the cost	10% of the cost
• Outpatient x-rays	$35 copay	$35 copay
Hearing Services:		
• Hearing exam	$30 copay per visit	$10 copay per visit

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Choice Plan 3 (HMO)	What you should know about Choice Plan 1, Choice Plan 2 & Choice Plan 3
$350 copay after you pay your plan deductible	Prior Authorization required for some services
$200 copay after you pay your plan deductible	Prior Authorization required for some services
At a Sanitas Medical Center: You pay nothing For all other Primary Care Providers: $10 copay per visit	
$50 copay per visit	No referrals are needed to see specialists.
You pay nothing	Includes your annual physical exam, influenza vaccine, colorectal cancer screening, screening mammography, and all other Medicare-approved preventive care.
$90 copay per visit within the United States	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
$50 copay per visit within the United States	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed care.
$90 copay	There is a combined $50,000 annual limit for emergency care, urgent care and emergent ambulance services outside of the United States. See page 8 for additional cost-sharing information for ambulance services.
$275 copay after you pay your plan deductible	Prior Authorization required
$20 copay	Prior Authorization required for some services
20% of the cost	Prior Authorization required for some services
$45 copay after you pay your plan deductible	Prior Authorization required for some services
$50 copay per visit	You are covered for 1 routine hearing exam each year and for exams to diagnose and treat hearing and balance issues.

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Choice Plan 1 (HMO)**	**Choice Plan 2 (HMO)**
Dental Services: Preventive Preventive and Diagnostic Services: Includes oral exams, cleanings, bitewing x-rays, and panorex x-rays or complete series Covers up to two oral exams and cleanings every calendar year	Not covered	You pay nothing
Dental Services: Basic and Comprehensive	Not covered	Not covered
Dental Services: Medicare-covered	$30 copay per visit	$10 copay per visit
Vision Services:		
• Vision Exam	$30 copay per visit	$10 copay per visit
• Eyeglasses or contact lenses after cataract surgery	You pay nothing	You pay nothing
Mental Health Services:		
• Inpatient visit	$400 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 through 90 per stay	$400 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 through 90 per stay
• Outpatient visits	$30 copay per visit	$10 copay per visit
Skilled Nursing Facility (SNF)	You pay nothing per day for days 1 through 20 per benefit period $172 copay per day for days 21 through 100 per benefit period	You pay nothing per day for days 1 through 20 per benefit period $172 copay per day for days 21 through 100 per benefit period
Physical Therapy	$30 copay per visit	$10 copay per visit

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Choice Plan 3 (HMO)	What you should know about Choice Plan 1, Choice Plan 2 & Choice Plan 3
You pay nothing	For Choice Plan 1, you may purchase a separate optional dental plan for preventive, basic and comprehensive dental services. (see page 13) For Choice Plan 2 and Choice Plan 3, preventive and diagnostic dental services are included. You may purchase a separate optional dental plan for additional preventive services and basic and comprehensive dental services. (see page 13)
Not covered	You may purchase a separate optional dental plan for preventive, basic and comprehensive dental services. (see page 13)
$50 copay per visit	Medicare-covered services only
$50 copay per visit You pay nothing	You are covered for 1 routine eye exam each year and for exams to diagnose and treat diseases and conditions of the eye. Eyewear must be obtained within 12 months of surgery.
$400 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 through 90 per stay $40 copay per visit	The cost-sharing applies each time you are admitted inpatient to a Psychiatric Facility. Prior Authorization required Prior Authorization required
After you pay your plan deductible you pay: Nothing per day for days 1 through 20 per benefit period $172 copay per day for days 21 through 100 per benefit period	Our plan covers up to 100 days in a SNF per benefit period. Prior Authorization required A benefit period begins the day you're admitted into a SNF. The benefit period ends when you haven't gotten any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.
$40 copay per visit after you pay your plan deductible	

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Choice Plan 1 (HMO)**	**Choice Plan 2 (HMO)**
Ambulance (*air and ground, one-way trip*)	$200 copay	$50 copay
Transportation	Not covered	Not covered
Medicare Part B Drugs	20% of the cost	20% of the cost
Foot Care *(podiatry services)*:		
• Foot exams and treatment	$30 copay per visit	$10 copay per visit
Chiropractic Care	$20 copay per visit	$20 copay per visit
Occupational, Speech, and Language Therapy	$30 copay per visit	$10 copay per visit
Cardiac and Pulmonary Therapy	$30 copay per visit	$10 copay per visit
Home Health Care	You pay nothing	You pay nothing
Hospice	You pay nothing	You pay nothing
Medical Equipment/Supplies:		
• Durable Medical Equipment *(e.g., wheelchairs, oxygen)*	20% of the cost	You pay nothing
• Prosthetics *(e.g., braces, artificial limbs)*	20% of the cost	You pay nothing
Diabetic Supplies and Training:		
• Diabetic supplies *(includes monitoring supplies and therapeutic shoes or inserts)*	20% of the cost	You pay nothing
• Kidney disease education	You pay nothing	You pay nothing
Wellness Programs *(e.g., fitness)*	You pay nothing	You pay nothing

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Choice Plan 3 (HMO)	What you should know about Choice Plan 1, Choice Plan 2 & Choice Plan 3
$385 copay after you pay your plan deductible	You are covered for ambulance services worldwide. There is a combined $50,000 annual limit for emergency care, urgent care and emergent ambulance services outside of the United States. Prior Authorization required for non-emergent services
Not covered	
20% of the cost	We cover Part B drugs such as chemotherapy and some drugs administered by your doctor. Prior Authorization required for some Part B drugs
$50 copay per visit	Exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions
$20 copay per visit	Manipulation of the spine to correct a subluxation (when one or more of the bones in your spine move out of position)
$40 copay per visit after you pay your plan deductible	
$50 copay per visit after you pay your plan deductible	Prior Authorization required for pulmonary rehabilitation therapy
You pay nothing	Prior Authorization required
You pay nothing	You are covered for hospice care from a Medicare-certified hospice. Original Medicare, rather than our plan, will pay for hospice services. You may have to pay part of the cost for drugs and respite care.
20% of the cost 20% of the cost	Prior Authorization required for some services Prior Authorization required for some services
20% of the cost You pay nothing after you pay your plan deductible	
You pay nothing	Includes the SilverSneakers® fitness program

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Outpatient Prescription Drugs for Choice Plan 1 (HMO) Only			
The amount you pay for Part D prescription drugs depends on the drug's tier, what stage of the prescription drug benefit you are in and where you purchase your Part D prescription drugs. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may be required to pay the difference between what you pay at the out-of-network pharmacy and the cost that we would pay at an in-network pharmacy.			
Deductible	$0 for Tier 1 and Tier 2 drugs $300 for Tier 3, Tier 4 and Tier 5 drugs		
Stage 1: Initial Coverage You pay these amounts until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by you and our Part D plan.	**30-day supply Preferred Retail Pharmacy**	**30-day supply Standard Retail Pharmacy**	**90-day supply Mail Order Pharmacy**
Tier 1: Preferred Generic	$2 copay	$9 copay	You pay nothing
Tier 2: Generic	$10 copay	$20 copay	$30 copay
Tier 3: Preferred Brand	$42 copay	$47 copay	$126 copay
Tier 4: Non-preferred drug	$95 copay	$100 copay	$285 copay
Tier 5: Specialty drug	27% of the cost	27% of the cost	Long-term supply is not available
Stage 2: Coverage Gap You pay these amounts after the total yearly drug costs (including what your plan has paid and what you have paid) reach $3,820.	**30-day supply Preferred Retail Pharmacy**	**30-day supply Standard Retail Pharmacy**	**90-day supply Mail Order Pharmacy**
Tier 1: Preferred Generic	$2 copay	$9 copay	You pay nothing
Tier 2: Generic	$10 copay	$20 copay	$30 copay
Tier 3: Preferred Brand	25% of the cost	25% of the cost	25% of the cost
Tier 4: Non-preferred drug	37% of the cost for Non-preferred Generic Drugs 25% of the cost for Non-preferred Brand Drugs	37% of the cost for Non-preferred Generic Drugs 25% of the cost for Non-preferred Brand Drugs	37% of the cost for Non-preferred Generic Drugs 25% of the cost for Non-preferred Brand Drugs

Outpatient Prescription Drugs For Choice Plan 1 (HMO) Only (cont'd)			
Stage 2: Coverage Gap (cont'd)	**30-day supply Preferred Retail Pharmacy**	**30-day supply Standard Retail Pharmacy**	**90-day supply Mail Order Pharmacy**
Tier 5: Specialty drug	37% of the cost for Generic Specialty Drugs 25% of the cost for Brand Specialty Drugs	37% of the cost for Generic Specialty Drugs 25% of the cost for Brand Specialty Drugs	Long-term supply is not available Long-term supply is not available
Stage 3: Catastrophic Coverage Once your yearly out-of-pocket drug costs reach $5,100, you pay the greater of these amounts.	• 5% of the cost, or • $3.40 copay for generic drugs and a $8.50 copay for all other drugs		

Outpatient Prescription Drugs for Choice Plan 3 (HMO) Only			
The amount you pay for Part D prescription drugs depends on the drug's tier, what stage of the prescription drug benefit you are in and where you purchase your Part D prescription drugs. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may be required to pay the difference between what you pay at the out-of-network pharmacy and the cost that we would pay at an in-network pharmacy.			
Deductible	$0 for Tier 1 and Tier 2 drugs $300 for Tier 3, Tier 4 and Tier 5 drugs		
Stage 1: Initial Coverage You pay these amounts until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by you and our Part D plan.	**30-day supply Preferred Retail Pharmacy**	**30-day supply Standard Retail Pharmacy**	**90-day supply Mail Order Pharmacy**
Tier 1: Preferred Generic	$2 copay	$9 copay	You pay nothing
Tier 2: Generic	$10 copay	$20 copay	$30 copay
Tier 3: Preferred Brand	$42 copay	$47 copay	$126 copay
Tier 4: Non-preferred drug	$95 copay	$100 copay	$285 copay

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Outpatient Prescription Drugs for Choice Plan 3 (HMO) Only (cont'd)			
Stage 1: Initial Coverage (cont'd)	**30-day supply Preferred Retail Pharmacy**	**30-day supply Standard Retail Pharmacy**	**90-day supply Mail Order Pharmacy**
Tier 5: Specialty drug	27% of the cost	27% of the cost	Long-term supply is not available
Stage 2: Coverage Gap You pay these amounts after the total yearly drug costs (including what your plan has paid and what you have paid) reach $3,820.	**30-day supply Preferred Retail Pharmacy**	**30-day supply Standard Retail Pharmacy**	**90-day supply Mail Order Pharmacy**
Tier 1: Preferred Generic	37% of the cost	37% of the cost	37% of the cost
Tier 2: Generic	37% of the cost	37% of the cost	37% of the cost
Tier 3: Preferred Brand	25% of the cost	25% of the cost	25% of the cost
Tier 4: Non-preferred drug	37% of the cost for Non-preferred Generic Drugs 25% of the cost for Non-preferred Brand Drugs	37% of the cost for Non-preferred Generic Drugs 25% of the cost for Non-preferred Brand Drugs	37% of the cost for Non-preferred Generic Drugs 25% of the cost for Non-preferred Brand Drugs
Tier 5: Specialty drug	37% of the cost for Generic Specialty Drugs 25% of the cost for Brand Specialty Drugs	37% of the cost for Generic Specialty Drugs 25% of the cost for Brand Specialty Drugs	Long-term supply is not available Long-term supply is not available
Stage 3: Catastrophic Coverage Once your yearly out-of-pocket drug costs reach $5,100, you pay the greater of these amounts.	• 5% of the cost, or • $3.40 copay for generic drugs and a $8.50 copay for all other drugs		

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2019 – December 31, 2019

Optional Supplemental Benefits

Dental – Preventive and Comprehensive Services

- Monthly Premium.....You pay $34 per month.
- Deductible.....$100 per year
- Calendar Year Benefit Maximum.....$1,000 every year

You pay the $34 monthly premium in addition to your Medicare Part B premium and your ConnectiCare Choice Plan monthly premium.

Our plan has additional coverage limits for certain benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at **http://www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.