ConnectiCare Medicare Advantage

Flex Plan 1 (HMO-POS)
Flex Plan 2 (HMO-POS)
Flex Plan 3 (HMO-POS)

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 a.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, 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 may change on January 1, 2020.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

ConnectiCare

H3528_C19109901_M Accepted 09/03/2018 CCIMEDADV_FLEXSB 1018

Summary of Benefits – ConnectiCare Flex 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 Flex Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

> **For Flex Plan 1 (HMO-POS) and Flex Plan 3 (HMO-POS):** Our service area includes the following counties in Connecticut: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham.
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> **For Flex Plan 2 (HMO-POS):** 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**.

Which doctors, hospitals and pharmacies can I use?

ConnectiCare Flex Plans have a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers, who are enrolled in Medicare, that are not in our network. Out-of-network/non-contracted providers are under no obligation to treat ConnectiCare, Inc. members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including cost-sharing that applies to out-of-network services. If you receive care from an out-of-network/non-contracted provider, we will pay for the same services we cover in-network, as long as the services are medically necessary. For a decision about whether we will cover an out-of-network service, you or your provider can ask us for a pre-service organization determination before you receive the service. Our customer service number is 1-800-224-2273 (TTY: 1-800-842-9710), seven days a week from 8 a.m. to 8 p.m. Eastern.

We cover Part D drugs. In addition, we 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.

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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-224-2273 (TTY: 1-800-842-9710).

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Flex Plan 1 (HMO-POS)**	**Flex Plan 2 (HMO-POS)**
Monthly Plan Premium:		
For Medicare beneficiaries who live in Hartford, Litchfield, Middlesex and Tolland counties	$237	$120
For Medicare beneficiaries who live in New Haven, New London and Windham counties	$237	$140
For Medicare beneficiaries who live in Fairfield county	$237	**NOT AVAILABLE**
Deductible - Medical	You pay nothing	You pay nothing
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	In-Network: $5,300 annually Out-of-Network: $10,000 annually	In-Network: $6,000 annually Out-of-Network: $10,000 annually
Inpatient Hospital Coverage	In-Network: $285 copay per day for days 1 through 6 per stay You pay nothing per day for days 7 and beyond per stay Out-of-Network: $450 copay per day for days 1 through 6 per stay You pay nothing per day for days 7 and beyond per stay	In-Network: $375 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 and beyond per stay Out-of-Network: 30% of the cost per day
Outpatient Hospital Coverage:		
• Outpatient Hospital Services *(including observation services)*	In-Network: $200 copay Out-of-Network: 20% of the cost	In-Network: $250 copay Out-of-Network: 40% of the cost
• Ambulatory Surgical Centers	In-Network: $100 copay Out-of-Network: $250 copay	In-Network: $150 copay Out-of-Network: 40% of the cost

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Flex Plan 3 (HMO-POS)	What you should know about Flex Plan 1, Flex Plan 2 & Flex Plan 3
$46	In addition, you must continue to pay your Medicare Part B premium.
$66	In addition, you must continue to pay your Medicare Part B premium.
$66	In addition, you must continue to pay your Medicare Part B premium.
You pay nothing	These plans do not have a deductible for medical benefits.
In-Network: $6,700 annually Out-of-Network: $10,000 annually	This is the most you pay for copays, coinsurance and other costs for medical services for the year.
In-Network: $465 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 and beyond per stay Out-of-Network: 50% of the cost per day	The cost-sharing applies each time you are admitted to a hospital. Prior Authorization is required for each inpatient stay.
In-Network: $325 copay Out-of-Network: 50% of the cost	Prior Authorization required for some services
In-Network: $200 copay Out-of-Network: 50% of the cost	Prior Authorization required for some services

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Flex Plan 1 (HMO-POS)**	**Flex Plan 2 (HMO-POS)**
Doctor Visits:		
• Primary Care Provider (PCP)	In-Network: At a Sanitas Medical Center: You pay nothing For all other Primary Care Providers: $15 copay per visit Out-of-Network: $40 copay per visit	In-Network: At a Sanitas Medical Center: You pay nothing For all other Primary Care Providers: $15 copay per visit Out-of-Network: $50 copay per visit
• Specialist	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $35 copay per visit Out-of-Network: $50 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	$35 copay per visit within the United States
Worldwide Emergent/Urgent Care *(coverage outside the United States)*	$90 copay per visit	$90 copay per visit
Diagnostic Services/Labs/Imaging:		
• Diagnostic radiology service *(e.g., MRI)*	In-Network: $200 copay Out-of-Network: 40% of the cost	In-Network: $250 copay Out-of-Network: 40% of the cost
• Lab Services	In-Network: $10 copay Out-of-Network: 20% of the cost	In-Network: $15 copay Out-of-Network: 40% of the cost
• Diagnostic Tests and Procedures	In-Network: 10% of the cost Out-of-Network: 20% of the cost	In-Network: 20% of the cost Out-of-Network: 40% of the cost

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Flex Plan 3 (HMO-POS)	What you should know about Flex Plan 1, Flex Plan 2 & Flex Plan 3
In-Network: At a Sanitas Medical Center: You pay nothing For all other Primary Care Providers: $20 copay per visit Out-of-Network: 50% of the cost per visit	
In-Network: $50 copay per visit Out-of-Network: 50% of the cost 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 per visit	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.
In-Network: $275 copay Out-of-Network: 50% of the cost	Prior Authorization required
In-Network: $20 copay Out-of-Network: 50% of the cost	Prior Authorization required for some services
In-Network: 20% of the cost Out-of-Network: 50% of the cost	Prior Authorization required for some services

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Flex Plan 1 (HMO-POS)**	**Flex Plan 2 (HMO-POS)**
Diagnostic Services/Labs/Imaging (cont'd):		
• Outpatient x-rays	In-Network: $35 copay Out-of-Network: 20% of the cost	In-Network: $40 copay Out-of-Network: 40% of the cost
Hearing Services:		
• Hearing exam	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $35 copay per visit Out-of-Network: $50 copay per visit
Dental Services	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $35 copay per visit Out-of-Network: $50 copay per visit
Vision Services:		
• Vision exam	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $35 copay per visit Out-of-Network: $50 copay per visit
• Eyeglasses or contact lenses after cataract surgery	In-Network: You pay nothing Out-of-Network: $40 copay	In-Network: You pay nothing Out-of-Network: 30% of the cost
Mental Health Services		
• Inpatient visit	In-Network: $400 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 through 90 per stay Out-of-Network: 40% of the cost	In-Network: $400 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 through 90 per stay Out-of-Network: 40% of the cost

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Flex Plan 3 (HMO-POS)	What you should know about Flex Plan 1, Flex Plan 2 & Flex Plan 3
In-Network: $45 copay Out-of-Network: 50% of the cost	Prior Authorization required for some services
In-Network: $50 copay per visit Out-of-Network: 50% of the cost per visit	You are covered for 1 routine hearing exam each year and for exams to diagnose and treat hearing and balance issues.
In-Network: $50 copay per visit Out-of-Network: 50% of the cost per visit	Medicare-covered services only. For preventive and comprehensive dental services, see page 14.
In-Network: $50 copay per visit Out-of-Network: 50% of the cost per visit In-Network: You pay nothing Out-of-Network: 50% of the cost	You are covered for 1 routine eye exam each year and for exams to diagnose and treat diseases and conditions of the eye. Refractions are not covered. Eyewear must be obtained within 12 months of surgery.
In-Network: $400 copay per day for days 1 through 4 per stay You pay nothing per day for days 5 through 90 per stay Out-of-Network: 50% of the cost	The cost-sharing applies each time you are admitted inpatient to a Psychiatric Facility. Prior Authorization required

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Flex Plan 1 (HMO-POS)**	**Flex Plan 2 (HMO-POS)**
Mental Health Services (cont'd) • Outpatient visits	In-Network: $30 copay per visit Out-of-Network: 40% of the cost per visit	In-Network: $35 copay per visit Out-of-Network: 40% of the cost per visit
Skilled Nursing Facility (SNF)	In-Network: 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 Out-of-Network: 40% of the cost per day for days 1 through 100 per benefit period	In-Network: 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 Out-of-Network: 40% of the cost per day for days 1 through 100 per benefit period
Physical Therapy	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $35 copay per visit Out-of-Network: $50 copay per visit
Ambulance *(air and ground, one-way trip)*	In-Network: $200 copay Out-of-Network: $200 copay	In-Network: $300 copay Out-of-Network: $300 copay
Transportation	Not covered	Not covered
Medicare Part B Drugs	In-Network: 20% of the cost Out-of-Network: 40% of the cost	In-Network: 20% of the cost Out-of-Network: 40% of the cost
Foot Care (podiatry services) • Foot exams and treatment	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $35 copay per visit Out-of-Network: $50 copay per visit
Chiropractic Care	In-Network: $20 copay per visit Out-of-Network: $40 copay per visit	In-Network: $20 copay per visit Out-of-Network: $50 copay per visit

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Flex Plan 3 (HMO-POS)	What you should know about Flex Plan 1, Flex Plan 2 & Flex Plan 3
In-Network: $40 copay per visit Out-of-Network: 50% of the cost per visit	Prior Authorization required
In-Network: 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 Out-of-Network: 50% of the cost per day for days 1 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.
In-Network: $40 copay per visit Out-of-Network: 50% of the cost per visit	
In-Network: $325 copay Out-of-Network: $325 copay	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	
In-Network: 20% of the cost Out-of-Network: 50% 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
In-Network: $50 copay per visit Out-of-Network: 50% of the cost per visit	Exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions
In-Network: $20 copay per visit Out-of-Network: 50% of the cost per visit	Manipulation of the spine to correct a subluxation (when one or more of the bones in your spine move out of position)

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Premiums and Benefits	**Flex Plan 1 (HMO-POS)**	**Flex Plan 2 (HMO-POS)**
Occupational, Speech and Language Therapy	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $35 copay per visit Out-of-Network: $50 copay per visit
Cardiac and Pulmonary Therapy	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $35 copay per visit Out-of-Network: $50 copay per visit
Home Health Care	In-Network: You pay nothing Out-of-Network: 40% of the cost	In-Network: You pay nothing Out-of-Network: 40% of the cost
Hospice	You pay nothing	You pay nothing
Medical Equipment/Supplies		
• Durable Medical Equipment *(e.g., wheelchairs, oxygen)*	In-Network: 20% of the cost Out-of-Network: 40% of the cost	In-Network: 20% of the cost Out-of-Network: 40% of the cost
• Prosthetics *(e.g., braces, artificial limbs)*	In-Network: 20% of the cost Out-of-Network: 40% of the cost	In-Network: 20% of the cost Out-of-Network: 40% of the cost
Diabetic Supplies and Training:		
• Diabetic supplies *(includes monitoring supplies and therapeutic shoes or inserts)*	In-Network: 20% of the cost Out-of-Network: 20% of the cost	In-Network: 20% of the cost Out-of-Network: 30% of the cost
• Kidney disease education	In-Network: You pay nothing Out-of-Network: 20% of the cost	In-Network: You pay nothing Out-of-Network: 20% of the cost
Wellness Programs *(e.g., fitness)*	You pay nothing	You pay nothing

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Flex Plan 3 (HMO-POS)	What you should know about Flex Plan 1, Flex Plan 2 & Flex Plan 3
In-Network: $40 copay per visit Out-of-Network: 50% of the cost per visit	
In-Network: $50 copay per visit Out-of-Network: 50% of the cost per visit	Prior Authorization required for pulmonary rehabilitation therapy
In-Network: You pay nothing Out-of-Network: 50% of the cost	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.
In-Network: 20% of the cost Out-of-Network: 50% of the cost In-Network: 20% of the cost Out-of-Network: 50% of the cost	Prior Authorization required for some services Prior Authorization required for some services
In-Network: 20% of the cost Out-of-Network: 50% of the cost In-Network: You pay nothing Out-of-Network: 50% of the cost	
You pay nothing	Includes the SilverSneakers® fitness program

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Outpatient Prescription Drugs

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.

Prescription Drug Benefits for Flex Plan 1

Annual 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

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Prescription Drugs Benefits for Flex Plan 1 (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	
Prescription Drug Benefits for Flex Plan 2 & Flex Plan 3			
Annual 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	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

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2019 – December 31, 2019

Prescription Drug Benefits for Flex Plan 2 & Flex Plan 3 (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 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		

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 Flex 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.

ConnectiCare, Inc. is an HMO/HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal. This information is not a complete description of benefits. Call 1-877-224-8220 (TTY: 1-800-842-9710) for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The Formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. Tivity Health, SilverSneakers and SilverSneakers FLEX are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.