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

Medicare Advantage Plans

Summary of Benefits 2020

This is a summary of drug and health services covered by ConnectiCare Inc.,
January 1, 2020 – December 31, 2020

ConnectiCare

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2020 – December 31, 2020

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. 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?

ConnectiCare Choice Plan 1 (HMO) and ConnectiCare Choice Plan 3 (HMO) have a network of doctors, hospitals, pharmacies and other providers. Except in emergency or urgent care situations, if you use providers that are not in our network, we may not pay for these services.

ConnectiCare Choice Plan 1 and ConnectiCare 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.

ConnectiCare 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.

ConnectiCare 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 711.

From October 1st to March 31st, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. EST. From April 1st to September 30th, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. EST.

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	**ConnectiCare Choice Plan 1 (HMO)**	**ConnectiCare Choice Plan 2 (HMO)**
Monthly Plan Premium: (*For all counties in Connecticut*)	$182	$0
Medical Deductible	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
Outpatient Hospital Coverage: Outpatient Hospital Services *(including observation services)* Ambulatory Surgery Centers	 $200 copay $100 copay	 $200 copay $100 copay

ConnectiCare Choice Plan 3 (HMO)	**What you should know about ConnectiCare Choice Plan 1, Choice Plan 2 & Choice Plan 3**
$0	In addition, you must continue to pay your Medicare Part B premium. Premiums may be reduced based on Low-Income Subsidy (LIS) level or Extra Help.
$250 plan deductible	Choice Plan 1 and Choice Plan 2 DO NOT have a deductible for medical benefits. Choice Plan 3 DOES have a deductible for medical benefits. The deductible applies only to the following services: • Inpatient Hospital – Acute • Inpatient Hospital – Psychiatric • Skilled Nursing Facility • Outpatient Hospital Services • Outpatient Observation Services • Dialysis Services • 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.
$479 copay per day for days 1 through 3 per stay after you pay your plan deductible You pay nothing per day for days 4 and beyond per stay	The cost-sharing applies each time you are admitted to a hospital. Prior Authorization is required for each inpatient stay.
$350 copay after you pay your plan deductible $300 copay	Prior Authorization required for some services Prior Authorization required for some services

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	**ConnectiCare Choice Plan 1 (HMO)**	**ConnectiCare Choice Plan 2 (HMO)**
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 Services	$30 copay per visit within the United States	$10 copay per visit within the United States
Diagnostic Services/Labs/Imaging:		
• Diagnostic radiology service *(e.g., MRI)*	$200 copay	$175 copay
• Lab Services	$10 copay	$10 copay
• Diagnostic Tests and Procedures	$25 copay	$25 copay
• Outpatient x-rays	$35 copay	$35 copay
Hearing Services:		
• Hearing exam	$30 copay per visit	$10 copay per visit

ConnectiCare Choice Plan 3 (HMO)	**What you should know about ConnectiCare Choice Plan 1, Choice Plan 2 & Choice Plan 3**
You pay nothing $45 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 1 day, you do not have to pay your share of the cost for emergency care.
$45 copay per visit within the United States	If you are admitted to the hospital within 1 day, you have to pay your share of the cost for urgently needed care.
$275 copay $15 copay $25 copay $45 copay after you pay your plan deductible	Prior Authorization required Prior Authorization required for some services Prior Authorization required for some services Prior Authorization required for some services
$45 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, 2020 – December 31, 2020

Premiums and Benefits	ConnectiCare Choice Plan 1 (HMO)	ConnectiCare Choice Plan 2 (HMO)
Dental Services:		
Medicare-covered dental services	$30 copay per visit	$10 copay per visit
Preventive and Diagnostic Dental Services: Includes oral exams, cleanings, bitewing x-rays, and panorex x-rays or complete series	Not covered. You can purchase preventive dental services along with comprehensive dental services as an Optional Supplemental Benefit (see below)	You pay nothing Covers up to one oral exam and one cleaning every 6 months Covers bitewing x-rays, one every 6 months and one complete series (panorex x-rays) every 36 months You can purchase comprehensive dental services as an Optional Supplemental Benefit
Optional Supplemental Benefit	**Preventive and comprehensive dental services:**	**Comprehensive dental services:**
	$39 monthly premium	$29 monthly premium
	$100 calendar year deductible (Preventive services are not subject to the calendar year deductible)	$100 calendar year deductible
	$2,000 annual benefit maximum	$2,000 annual benefit maximum
Preventive Dental Services: (For Choice Plan 1)	You pay nothing for oral exams, cleanings and x-rays (limitations apply)	Included as plan benefit (see above)
Comprehensive Dental Services:		
Basic Services • Restorative services	20% of the cost after the $100 calendar year deductible is met	20% of the cost after the $100 calendar year deductible is met
Major Dental Services: • Endodontics, Periodontics, Extractions • Prosthodontics, other oral/ maxillofacial surgery, other services	50% of the cost after the $100 calendar year deductible is met	50% of the cost after the $100 calendar year deductible is met

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2020 – December 31, 2020

ConnectiCare Choice Plan 3 (HMO)	What you should know about ConnectiCare Choice Plan 1, Choice Plan 2 & Choice Plan 3
$45 copay per visit You pay nothing Covers up to one oral exam and one cleaning every 6 months Covers bitewing x-rays, one every 6 months and one complete series (panorex x-rays) every 36 months You can purchase comprehensive dental services as an Optional Supplemental Benefit	Medicare-covered services only
Comprehensive dental services: $29 monthly premium $100 calendar year deductible $2,000 annual benefit maximum Included as plan benefit (see above)	Choice Plan 2 and Choice Plan 3 include preventive dental services as a plan benefit.
20% of the cost after the $100 calendar year deductible is met	Covers: Restorations (fillings)
50% of the cost after the $100 calendar year deductible is met	Major services include: Crowns; Fixed Bridgework; Partial and Full Dentures; Denture Adjustments; Repairs to Fixed Bridges and Partial and Full Dentures; Recement of Fixed Bridges, Crowns and Inlays; Extractions and Oral Surgery; Root Canal Therapy; Implants; Periodontal Scaling and Planing, Periodontal Surgery and Maintenance

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	**ConnectiCare Choice Plan 1 (HMO)**	**ConnectiCare Choice Plan 2 (HMO)**
Vision Services:		
• Vision Exam	$30 copay per visit	$10 copay per visit
• Eyewear - routine	Not covered	Not covered
• Eyeglasses or contact lenses after cataract surgery	You pay nothing	You pay nothing
Mental Health Services:		
• Inpatient visit	$1,763 per admission	$1,763 per admission
• 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 $178 copay per day for days 21 through 100 per benefit period	You pay nothing per day for days 1 through 20 per benefit period $178 copay per day for days 21 through 100 per benefit period
Physical Therapy	$30 copay per visit	$10 copay per visit
Ambulance (may require approval; not waived if admitted)		
• Ground	$200 copay	$50 copay
• Air	20% of the cost	20% of the cost
Transportation	Not covered	Not covered
Medicare Part B Drugs	10% of the cost for Medicare-covered Part B drugs **in the home** 20% of the cost for Medicare-covered Part B drugs **dispensed at a retail pharmacy, mail order pharmacy, physician office and outpatient facility**	10% of the cost for Medicare-covered Part B drugs **in the home** 20% of the cost for Medicare-covered Part B drugs **dispensed at a retail pharmacy, mail order pharmacy, physician office and outpatient facility**

ConnectiCare Choice Plan 3 (HMO)	**What you should know about ConnectiCare Choice Plan 1, Choice Plan 2 & Choice Plan 3**
$45 copay per visit $200 allowance every two years 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.
$1,763 per admission after you pay your plan deductible $40 copay per visit	The cost-sharing applies each time you are admitted inpatient to a Psychiatric Facility. Prior Authorization required
After you pay your plan deductible you pay: Nothing per day for days 1 through 20 per benefit period $178 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	
$385 copay 20% of the cost	You are covered for ground ambulance services worldwide. There is a combined $50,000 annual limit for emergency care, urgent care and ground emergent ambulance services outside of the United States. Prior Authorization required for non-emergent services You are not covered for air ambulance services outside of the United States.
Not covered	
10% of the cost for Medicare-covered Part B drugs **in the home** 20% of the cost for Medicare-covered Part B drugs **dispensed at a retail pharmacy, mail order pharmacy, physician office and outpatient facility**	We cover Part B drugs such as chemotherapy and some drugs administered by your doctor. Prior Authorization required for some Part B drugs

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2020 – December 31, 2020

Prescription Drugs for ConnectiCare Choice Plan 1 (HMO) and Choice Plan 3 (HMO)

Our plan groups each drug into one of five "tiers" (levels). You will need to use the formulary (list of covered drugs) to locate what tier a drug is on.

Four Stages of Drug Coverage

Deductible

The deductible is the amount you pay before your plan starts to pay. This deductible is for retail and home delivery. There is no deductible for Tier 1 (preferred generic) and Tier 2 (generic) drugs. There is a deductible for Tier 3 (preferred brand), Tier 4 (non-preferred drug) and Tier 5 (specialty tier) drugs.

Initial Coverage

After you've reached the deductible, you'll enter the initial coverage phase.

In this phase, you and the plan share the costs of some of the covered drugs until your total drug costs, including deductible, exceed $4,020. The total drug costs paid by both you and our Part D plan will help you reach the coverage gap.

Retail Cost Sharing

ConnectiCare Choice Plan 1 and ConnectiCare Choice Plan 3 30-Day Supply of Drugs							
Tier	**Deductible**		**Initial Coverage $0-$4,020:**		**Coverage Gap $4,021-$6,350**		**Catastrophic Over $6,350**
	In Choice Plan 1 You Pay	**In Choice Plan 3 You Pay**	**Preferred Pharmacy**	**Standard Pharmacy**	**In Choice Plan 1 You Pay**	**In Choice Plan 3 You Pay**	**You Pay the greater of:**
Tier 1: Preferred Generic	$0	$0	$2	$9	$2/$9*	25%	5% or $3.60
Tier 2: Generic	$0	$0	$10	$20	$10/$20*	25%	5% or $3.60
Tier 3: Preferred Brand	$300	$435	$42	$47	25%	25%	5% or $8.95
Tier 4: Non-Preferred Drug			$95	$100	25%	25%	5% or $8.95
Tier 5: Specialty Tier			27% for Choice Plan 1 25% for Choice Plan 3	27% for Choice Plan 1 25% for Choice Plan 3	25%	25%	5% or $3.60 for generic specialty drugs 5% or $8.95 for brand specialty drugs

*Cost share at a Preferred Pharmacy/Standard Pharmacy

Mail Order Cost Sharing

ConnectiCare Choice Plan 1 and ConnectiCare Choice Plan 3		
Tier	**Initial Coverage $0-$4,020**	
	30-day supply	**90-day supply**
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$10	$25
Tier 3: Preferred Brand	$42	$126
Tier 4: Non-Preferred Drug	$95	$285
Tier 5: Specialty Tier	27% for Choice Plan 1 25% for Choice Plan 3	Not available in a long-term supply

If you live in a long-term care facility, you pay the same as at a retail pharmacy.

Coverage Gap

The coverage gap (also called the "donut hole") starts after the total yearly drug cost (along with what our plan has paid and what you have paid) exceeds $4,020.

While in the coverage gap in 2020:

- For Choice Plan 1, you will continue to pay your set copayments for Tier 1 and Tier 2 drugs, and 25% of the plan's cost for Tier 3, Tier 4 and Tier 5 drugs.
- For Choice Plan 3, you will pay 25% of the plan's cost for all drugs.

You enter the catastrophic coverage phase once your yearly true out-of-pocket costs (TrOOP) exceed $6,350. The costs paid by you, and the manufacturer discount payment for brand-name drugs count toward your true out-of-pocket costs and help you get out of the coverage gap. **Not everyone will reach the coverage gap.**

Catastrophic Coverage

After your yearly true out-of-pocket drug costs exceed **$6,350**, you pay the greater of: 5% of the cost or you pay **$3.60** for generic drugs (including brand-name drugs treated as generic) and **$8.95** for all other drugs.

Qualifying for Extra Help, Low Income Subsidy (LIS)

If you qualify for Extra Help for your Medicare prescription drug plan costs, the amount you pay for insurance every month and cost at the pharmacy will be lower.

The amount of Extra Help, Low Income Subsidy (LIS) level, will decide the amount you pay for insurance every month as a member of our plan.

To learn more about available Medicare Part D subsidies (the money granted by the government to help pay for Part D drugs), please call:

- ConnectiCare at 1-877-224-8220 (TTY: 711), 8:00 a.m. to 8:00 p.m. 7 days a week from October 1st to March 31st and 8:00 a.m. to 8:00 p.m., Monday – Friday from April 1st to September 30th.
- Social Security at 800-772-1213 (TTY: 800-325-0778), Monday through Friday, 7:00 a.m. to 7:00 p.m. Or visit **ssa.gov**. Social Security can also provide you with an application.

Summary of Benefits – ConnectiCare Choice Plans

January 1, 2020 – December 31, 2020

Other Benefits	ConnectiCare Choice Plan 1 (HMO)	ConnectiCare Choice Plan 2 (HMO)
Foot Care *(podiatry services)*:		
• Foot exams and treatment (Routine exams not covered)	$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 Therapy	$30 copay per visit	$10 copay per visit
Intensive Cardiac Therapy	$100 copay per visit	$100 copay per visit
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:		
• Fitness	You pay nothing	You pay nothing
• Teladoc®	$45 copay per visit	$45 copay per visit
Worldwide Emergent/Urgent Care *(coverage outside the United States)*	$90 copay	$90 copay

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 Choice Plan 3 (HMO)	What you should know about ConnectiCare Choice Plan 1, Choice Plan 2 & Choice Plan 3
$45 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	
$45 copay per visit $100 copay per visit $30 copay per visit	Prior Authorization required
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	
You pay nothing $45 copay per visit	Includes the SilverSneakers® fitness program
$90 copay	There is a combined $50,000 annual limit for emergency care, urgent care and ground emergent ambulance services outside of the United States. You are not covered for air ambulance services outside the United States. See page I-9 for additional cost-sharing information for ambulance services.

ConnectiCare, Inc. is an HMO/HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal. For more information, contact the plan. This information is not a complete description of benefits. Call 1-877-224-8220 (TTY: 711) 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. Other providers are available in our network. SilverSneakers® is a registered trademark of Tivity Health, Inc. ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call 1-800-224-2273 (TTY: 711).

2020 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 customer service representative at 1-877-224-8220 (TTY: 711). From October 1st to March 31st, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. EST. From April 1st to September 30th, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. EST.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **connecticare.com/medicare** or call 1-877-224-8220 (TTY: 711) 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 medicine 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 co-payments/co-insurance may change on January 1, 2021.
- ☐ 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