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

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 Flex 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 Flex 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 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 member services number is 1-800-224-2273 (TTY: 711), 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 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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-224-2273 (TTY: 711).

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	**ConnectiCare Flex Plan 1 (HMO-POS)**	**ConnectiCare Flex Plan 2 (HMO-POS)**
Monthly Plan Premium:		
For Medicare beneficiaries who live in Hartford, Litchfield, Middlesex and Tolland counties	$240	$133
For Medicare beneficiaries who live in Fairfield, New Haven, New London and Windham counties	$240	$133
Medical Deductible	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

ConnectiCare Flex Plan 3 (HMO-POS)	What you should know about ConnectiCare Flex Plan 1, Flex Plan 2 & Flex Plan 3
$49	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.
$69	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.
You pay nothing	These plans do not have a deductible for medical benefits.
In-Network: $5,500 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.

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	**ConnectiCare Flex Plan 1 (HMO-POS)**	**ConnectiCare Flex Plan 2 (HMO-POS)**
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 Surgery Centers	In-Network: $100 copay Out-of-Network: $250 copay	In-Network: $150 copay Out-of-Network: 40% of the cost
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

ConnectiCare Flex Plan 3 (HMO-POS)	**What you should know about ConnectiCare Flex Plan 1, Flex Plan 2 & Flex Plan 3**
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
In-Network: At a Sanitas Medical Center: You pay nothing For all other Primary Care Providers: $5 copay per visit Out-of-Network: 50% of the cost per visit	No referrals are needed to see specialists.
In-Network: $50 copay per visit Out-of-Network: 50% of the cost per visit	
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.

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	**ConnectiCare Flex Plan 1 (HMO-POS)**	**ConnectiCare Flex Plan 2 (HMO-POS)**
Urgently Needed Services	$30 copay per visit within the United States	$35 copay per visit within the United States
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: $25 copay Out-of-Network: 20% of the cost	In-Network: $25 copay Out-of-Network: 40% of the cost
• 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

ConnectiCare Flex Plan 3 (HMO-POS)	**What you should know about ConnectiCare Flex Plan 1, Flex Plan 2 & Flex Plan 3**
$50 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.
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: $25 copay Out-of-Network: 50% of the cost	Prior Authorization required for some services
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.

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	ConnectiCare Flex Plan 1 (HMO-POS)	ConnectiCare Flex Plan 2 (HMO-POS)
Dental Services:		
Medicare-covered 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
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)	Not covered You can purchase preventive dental services along with comprehensive dental services as an Optional Supplemental Benefit (see below)
Optional Supplemental Benefit	**Preventive and comprehensive dental services:** $39 monthly premium $100 calendar year deductible (Preventive services are not subject to the calendar year deductible) $2,000 annual benefit maximum	**Preventive and comprehensive dental services:** $39 monthly premium $100 calendar year deductible (Preventive services are not subject to the calendar year deductible) $2,000 annual benefit maximum
Preventive Dental Services (For Flex Plan 1 and Flex Plan 2)	You pay nothing for oral exams, cleanings and x-rays (limitations apply)	You pay nothing for oral exams, cleanings and x-rays (limitations apply)
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 Flex Plans

January 1, 2020 – December 31, 2020

ConnectiCare Flex Plan 3 (HMO-POS)	What you should know about ConnectiCare Flex Plan 1, Flex Plan 2 & Flex Plan 3
In-Network: $50 copay per visit Out-of-Network: 50% of the cost You pay nothing Covers up to one oral exam and one cleaning every 6 months Covers one standard x-ray every 6 months and one complete series (panorex x-rays) every 36 months You can purchase comprehensive dental services as an Optional Supplemental Benefit (see below)	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)	Flex Plan 3 includes 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 Flex Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	ConnectiCare Flex Plan 1 (HMO-POS)	ConnectiCare Flex Plan 2 (HMO-POS)
Vision Services:		
Vision exam	In-Network: $30 copay per visit Out-of-Network: Not covered	In-Network: $35 copay per visit Out-of-Network: Not covered
Eyewear - routine	Not covered	Not covered
Eyeglasses or contact lenses after cataract surgery	In-Network: You pay nothing Out-of-Network: Not covered	In-Network: You pay nothing Out-of-Network: Not covered
Mental Health Services		
• Inpatient visit	In-Network: $1,763 per admission Out-of-Network: 40% of the cost	In-Network: $1,763 per admission Out-of-Network: 40% of the cost
• 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 $178 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 $178 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

ConnectiCare Flex Plan 3 (HMO-POS)	What you should know about ConnectiCare Flex Plan 1, Flex Plan 2 & Flex Plan 3
In-Network: $50 copay per visit Out-of-Network: Not covered In-Network: $300 allowance per calendar year Out-of-Network: Not covered In-Network: You pay nothing Out-of-Network: Not covered	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.
In-Network: $1,763 per admission Out-of-Network: 50% of the cost In-Network: $40 copay per visit Out-of-Network: 50% of the cost per visit	The cost-sharing applies each time you are admitted inpatient to a Psychiatric Facility. Prior Authorization required Prior Authorization required
In-Network: 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 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.

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2020 – December 31, 2020

Premiums and Benefits	**ConnectiCare Flex Plan 1 (HMO-POS)**	**ConnectiCare Flex Plan 2 (HMO-POS)**
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 (may require approval; not waived if admitted) • Ground • Air	 In-Network: $200 copay Out-of-Network: $200 copay In-Network: 20% of the cost Out-of-Network: 20% of the cost	 In-Network: $300 copay Out-of-Network: $300 copay In-Network: 20% of the cost Out-of-Network: 20% of the cost
Transportation	Not covered	Not covered
Medicare Part B Drugs	In-Network: 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** Out-of-Network: 40% of the cost	In-Network: 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** Out-of-Network: 40% of the cost

ConnectiCare Flex Plan 3 (HMO-POS)	**What you should know about ConnectiCare 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: $325 copay Out-of-Network: $325 copay In-Network: 20% of the cost Out-of-Network: 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 emergent ground ambulance services outside of the United States. Prior Authorization required for non-emergent services Air ambulance services outside the United States are not covered.
Not covered	
In-Network: 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** 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

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2020 – December 31, 2020

Prescription Drugs for ConnectiCare Flex Plan 1, Flex Plan 2 and Flex Plan 3 (HMO-POS)

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 Flex Plan 1, Flex Plan 2 and Flex Plan 3 30-Day Supply of Drugs						
Tier	**Deductible**	**Initial Coverage $0-$4,020:**		**Coverage Gap $4,021-$6,350**		**Catastrophic Over $6,350**
	You Pay	**Preferred Pharmacy**	**Standard Pharmacy**	**In Flex Plan 1 You Pay**	**In Flex Plan 2 and 3 You Pay**	**You Pay the greater of:**
Tier 1: Preferred Generic	$0	$2	$9	$2/$9*	25%	5% or $3.60
Tier 2: Generic	$0	$10	$20	$10/$20*	25%	5% or $3.60
Tier 3: Preferred Brand	$300	$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%	27%	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 Flex Plan 1, Flex Plan 2 and Flex Plan 3		
	Initial Coverage $0-$4,020	
Tier	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%	Not available in 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 Flex 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 Flex Plan 2 and Flex 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 Flex Plans

January 1, 2020 – December 31, 2020

Other Benefits	ConnectiCare Flex Plan 1 (HMO-POS)	ConnectiCare Flex Plan 2 (HMO-POS)
Foot Care (podiatry services) • Foot exams and treatment (Routine exams not covered)	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
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 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
Intensive Cardiac Therapy	In-Network: $100 copay per visit Out-of-Network: 50% of the cost per visit	In-Network: $100 copay per visit Out-of-Network: 50% of the cost per visit
Pulmonary Therapy	In-Network: $30 copay per visit Out-of-Network: $40 copay per visit	In-Network: $30 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

ConnectiCare Flex Plan 3 (HMO-POS)	**What you should know about ConnectiCare Flex Plan 1, Flex Plan 2 & Flex Plan 3**
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)
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 In-Network: $100 copay per visit Out-of-Network: 50% of the cost per visit In-Network: $30 copay per visit Out-of-Network: 50% of the cost per visit	Prior Authorization required
In-Network: You pay nothing Out-of-Network: 50% of the cost	Prior Authorization required

Summary of Benefits – ConnectiCare Flex Plans

January 1, 2020 – December 31, 2020

Other Benefits	ConnectiCare Flex Plan 1 (HMO-POS)	ConnectiCare Flex Plan 2 (HMO-POS)
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:		
• Fitness	You pay nothing	You pay nothing
• Teladoc®	In-Network: $45 copay per visit Out-of-Network: Not covered	In-Network: $45 copay per visit Out-of-Network: Not covered
Worldwide Emergent/Urgent Care *(coverage outside the United States)*	$90 copay per visit	$90 copay per visit

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 Flex Plan 3 (HMO-POS)	**What you should know about ConnectiCare Flex Plan 1, Flex Plan 2 & Flex Plan 3**
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	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
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 In-Network: $45 copay per visit Out-of-Network: Not covered	Includes the SilverSneakers® fitness program
$90 copay per visit	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 of the United States. See page III-13 for additional cost-sharing information for ambulance services.

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.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in 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