2024 Summary of Benefits
ConnectiCare Flex Plan 3 (HMO-POS)

January 1, 2024 – December 31, 2024

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 and we'll send you a copy.

Who Can Join?

To join **ConnectiCare Flex Plan 3 (HMO-POS)**, 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 Plan 3 (HMO-POS) has 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 the ConnectiCare Medicare Connect Concierge 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 Medicare Connect Concierge number is **800-224-2273** (TTY: **711**). From Oct. 1 to March 31, you can call us seven days a week from 8 a.m. to 8 p.m. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 8 p.m.

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.

In most situations you must 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 directories on our website at **connecticare.com/medicare**. Or, call us and we'll send you a copy.

How To Reach Us

To find out more about ConnectiCare plans and to enroll, please call us at **877-224-8220** (TTY: **711**). From Oct. 1 to March 31, you can call us seven days a week from 8 a.m. to 8 p.m. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Or visit us, at our website **connecticare.com/medicare**.

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 **medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Premiums and Benefits	ConnectiCare Flex Plan 3 (HMO-POS)
Monthly Plan Premium	
For Medicare beneficiaries who live in Hartford, Litchfield, Middlesex, and Tolland counties.	$30 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.
For Medicare beneficiaries who live in Fairfield, New Haven, New London, and Windham counties.	$51 You must continue to pay your Medicare Part B premium. Premiums may be reduced based on Low-Income Subsidy (LIS) level or Extra Help.
Medical Deductible	You pay $0
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs.) This is the most you will pay out-of-pocket for your covered Part A and Part B Services.	In-network: $6,350 annually. Out-of-network: $10,000 annually. After you reach the maximum out-of-pocket limit, we will pay the full cost of covered Part A and Part B Services for the rest of the year.
Inpatient Hospital Coverage (May require approval.)	In-network: $495 copay per day for days one through four per admission. You pay nothing per day for days five and beyond per admission. Out-of-network: 35% of the cost per admission.
Outpatient Hospital Coverage (May require approval.)	
• Outpatient hospital services (including observation services):	In-network: $325 copay. Out-of-network: 35% of the cost.
• Ambulatory surgery centers:	In-network: $200 copay. Out-of-network: 35% of the cost.
Doctor Visits (in-office/virtual)	
• Primary care provider (PCP):	In-network: $5 copay per visit. Out-of-network: 35% of the cost. You pay nothing for annual physical exam.
• Specialist:	In-network: $50 copay per visit. Out-of-network: 35% of the cost.

Premiums and Benefits	ConnectiCare Flex Plan 3 (HMO-POS)
Preventive Care	You pay $0 – Bone mass measurement. – Breast cancer screening (mammogram). – Cardiovascular screening. – Cervical and vaginal cancer screening. – Colorectal cancer screening (colonoscopy, fecal occult blood test, flexible sigmoidoscopy). – Depression screening. – Diabetes screening. – Prostate cancer screening (PSA). – Vaccines, including flu shots, hepatitis B shots, pneumococcal shots, and COVID-19 vaccines. – "Welcome to Medicare" preventive visit (one-time). – "Wellness" visit (all additional preventive services approved by Medicare during the contract year will be covered.).
Emergency Care	$100 copay per visit within the United States. If you are admitted to the hospital within one day, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services (Not waived if admitted.)	$50 copay per visit within the United States.
Diagnostic Services/Labs/Imaging (May require approval.)	
• Diagnostic radiology services (such as MRIs, CT Scans):	In-network: $275 copay. Out-of-network: 35% of the cost.
• Lab services:	In-network: $0 at physician's office or independent facility, $15 all other locations. Out-of-network: 35% of the cost.
• Diagnostic tests and procedures:	In-network: $25 copay. Out-of-network: 35% of the cost.
• Outpatient x-rays:	In-network: $45 copay. Out-of-network: 35% of the cost.
• Therapeutic radiology services (such as radiation treatment for cancer):	In-network: 20% of the cost. Out-of-network: 35% of the cost.

Premiums and Benefits	ConnectiCare Flex Plan 3 (HMO-POS)
Hearing Services You are covered for one 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: 35% of the cost.
Dental Services	
• Medicare-covered Dental Services:	In Network: $50 copay per visit. Out-of-network: 35% of the cost.
• Preventive Dental Services: Includes oral exams, cleanings, bitewing x-rays, flouride treatments, and complete series (panorex x-rays)	In-network: You pay $0 Covers up to one oral exam, one cleaning, and one fluoride treatment every six months. Covers one standard x-ray every six months and one complete series (panorex x-rays) every 36 months. You can purchase comprehensive dental services as an Optional Supplemental Benefit (see below).
Optional Supplemental Benefit **POS Options**	**$25 monthly premium**. $100 calendar year deductible. $2,000 annual benefit maximum. or **$32 monthly premium**. $100 calendar year deductible. $3,000 annual benefit maximum.
• Comprehensive Dental Services (May require approval.)	
Diagnostic; Minor Restorative Services: Fillings.	In-network: You pay 20% of the cost after the $100 calendar-year deductible is met.
Fixed Bridgework; Crowns and Inlays; Endodontics; Periodontics; Extractions: Root canal therapy, periodontal scaling and planing, periodontal surgery and maintenance, extractions, and oral surgery.	50% of the cost after the $100 calendar-year deductible is met.
Prosthodontics, Other Oral/Maxillofacial Surgery; Other Services: Partial and full dentures, denture adjustments, recement of fixed bridges, implants.	50% of the cost after the $100 calendar-year deductible is met.

Premiums and Benefits	ConnectiCare Flex Plan 3 (HMO-POS)
(Continued)	Out-of-network: you pay the difference between the out-of-network allowance and the total amount billed by the dentist, in addition to your in-network share of the cost.
Indemnity Option • Preventive and comprehensive dental services:	**$69 monthly premium**. $3,500 annual benefit maximum. You pay 50% of the cost for all covered services.
Vision Services • Vision exam: You are covered for one routine eye exam each year and for exams to diagnose and treat diseases and conditions of the eye.	In-network: $50 copay per visit. Out-of-network: not covered.
• Eyewear – routine: You are covered for one pair of eyewear per year.	In-network: up to $300 allowance per calendar year. Out-of-network: not covered.
• Eyeglasses or contact lenses after cataract surgery (eyewear must be obtained within 12 months of surgery):	In-network: you pay $0. Out-of-network: not covered.
Mental Health Services (May require approval.) • Inpatient visit:	In-network: $2,179 per admission. Out-of-network: 35% of the cost. Our plan covers up to 90 days per inpatient mental health stay. Our plan also covers 60 “lifetime reserve days” as long as the stay is covered under the plan. Our plan covers up to 190 days in a lifetime for inpatient mental health services in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital. The cost-sharing applies each time you are admitted inpatient to a psychiatric facility.
• Outpatient group therapy visit (in-office only):	In-network: $40 copay per visit. Out-of-network: 35% of the cost.

Premiums and Benefits	ConnectiCare Flex Plan 3 (HMO-POS)
(Continued) • Outpatient individual therapy visit (in-office/virtual):	In-network: $40 copay per visit. Out-of-network: 35% of the cost.
Skilled Nursing Facility (SNF) (May require approval.) 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: You pay nothing per day for days one through 20 per benefit period. $203 copay per day for days 21 through 100 per benefit period. Out-of-network: 35% of the cost per day for days one through 100 per benefit period. Our plan covers up to 100 days in a SNF per benefit period.
Physical Therapy	In-network: $40 copay per visit. Out-of-network: 35% of the cost.
Ambulance (May require approval; not waived if admitted.) • Ground: • Air: • Worldwide Ground Ambulance: 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.	In-network: $325 copay. Out-of-network: $325 copay. In-network: 20% of the cost. Out-of-network: 20% of the cost. $325 copay.
Transportation (non-emergency)	Not covered.

Prescription Drugs for ConnectiCare Flex Plan 3 (HMO-POS)

MEDICARE PART B DRUGS	
Chemotherapy drugs and other Part B drugs (May require approval.) These drugs may require step therapy and/or prior approval.	In-network: You pay 0% to 10% based on Part B rebatable adjustment for Part B drugs **in the home**. You pay 0% to 20% based on Part B rebatable adjustment for Part B drugs **dispensed at a retail pharmacy, mail order pharmacy, physician office, and outpatient facility**. You pay no more than $35 for one-month supply of insulin. Out-of-network: 35% of the cost.

Medicare Part D Drugs

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

How much you pay for your prescription drugs depends on what tier your drug is in and what stage of the benefit you are in. There are four stages in your Part D prescription drug coverage.

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), Tier 2 (Generic) drugs, Tier 6 (Select Care Drugs), insulins, and most vaccines. There is a $300 deductible for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty) drugs.

Initial Coverage

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

In this stage, you and the plan share the costs of some of the covered drugs until your total drug costs, including deductible, exceed **$5,030**. 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 3 (HMO-POS) — 30-Day Supply of Drugs					
Tier	Deductible	Initial Coverage $0-$5,030		Coverage Gap $5,030-$8,000	Catastrophic Over $8,000
	You pay	Preferred pharmacy	Standard pharmacy	You pay	You pay
Tier 1: Preferred Generic	$0	$2	$9	25%	$0
Tier 2: Generic	$0	$10	$20	25%	$0
Tier 3: Preferred Brand	$300	$42	$47	25%	$0
Tier 4: Non-Preferred Drugs		$95	$100	25%	$0
Tier 5: Specialty		27%	27%	25%	$0
Tier 6: Select Care Drugs	$0	$0	$0	$0	$0

You pay no deductible and no more than $35 for one-month supply of covered Insulins and $0 for most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

Preferred Mail Order Cost-Sharing

ConnectiCare Flex Plan 3 (HMO-POS)			
Tier	Deductible	Initial Coverage $0-$5,030	
	You pay	30-day supply	90-day supply
Tier 1: Preferred Generic	$0	$0	$0
Tier 2: Generic	$0	$0	$0
Tier 3: Preferred Brand	$300	$42	$126
Tier 4: Non-Preferred Drugs		$95	$285
Tier 5: Specialty		27%	Not available in long-term supply
Tier 6: Select Care Drugs	$0	$0	$0

You pay no deductible and no more than $35 for one-month supply of covered Insulins and $0 for most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

If you live in a long-term care facility or use a non-preferred mail order pharmacy, you pay the same as at a standard 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 $5,030.

While in the coverage gap in 2024: You will continue to pay $0 for Select Care Drugs (Tier 6), no more than $35 for one-month supply of covered insulins, $0 for most adult Part D vaccines, and 25% of the plan's costs for all other drugs.

The 70% discount for brand-name drugs paid by the drug manufacturer, combined with the 25% you pay, counts toward your true out-of-pocket (TrOOP) costs. This helps you get out of the coverage gap. **Not everyone will reach the coverage gap**.

Catastrophic Coverage

After your yearly true out-of-pocket (TrOOP) drug costs exceed **$8,000**, you will enter the catastrophic coverage stage. In this stage, you pay **$0**.

Get Help Paying for Your Prescription Drugs

Extra Help

Extra Help is a free Medicare program and is known as Low-Income Subsidy (LIS). It helps people with low or limited income and resources pay Medicare Part D drug plan costs.

What do you get with Extra Help?

- Payment of 75% or more of your drug costs. These include your monthly premium for prescription drugs (**the amount you pay each month**).
- Payment of your annual deductible (**the amount you pay before your plan starts to pay**).
- Payment of coinsurance costs (**the percentage you pay for your prescription drugs**).
- No coverage gap.

You automatically qualify for Extra Help if:

- You have full Medicaid coverage.
- You get help from your state Medicaid program to pay your Part B premiums in a Medicare Savings Program.
- You get Supplemental Security Income (SSI) benefits.

Many other people with low or limited income also qualify for Extra Help and don't know it!

There is no cost to apply. Contact your local Social Security office or call Social Security at **800-772-1213** (TTY: **800-325-0778**). You can also apply online at **ssa.gov/benefits/medicare/prescriptionhelp**.

Additional Benefits

Other Benefits	ConnectiCare Flex Plan 3 (HMO-POS)
Acupuncture (May require approval.)	In-network: $30 copay per visit. Covers up to 20 visits for chronic low back pain every year (maximum of 12 visits in 90 days). Out-of-network: not covered.
Foot Care (podiatry services) • Foot exams and treatment (routine exams not covered): If you have diabetes-related nerve damage and/or meet certain conditions, exams and treatment are covered.	In-network: $50 copay per visit. Out-of-network: 35% of the cost.
Chiropractic Care Manipulation of the spine to correct a subluxation (when one or more of the bones in your spine move out of position).	In-network: $20 copay per visit. Out-of-network: 35% of the cost.
Occupational, Speech, and Language Therapy	In-network: $40 copay per visit. Out-of-network: 35% of the cost.
Cardiac Rehabilitation	In-network: $35 copay per in-office/virtual visit. Out-of-network: 35% of the cost.
Intensive Cardiac Rehabilitation	In-network: $60 copay per visit. Out-of-network: 35% of the cost.
Pulmonary Rehabilitation (May require approval.)	In-network: $15 copay per visit. Out-of-network: 35% of the cost.
Home Health Care (May require approval.)	In-network: you pay $0. Out-of-network: 35% of the cost.
Hospice 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.	You pay $0
Medical Equipment/Supplies (May require approval.) • Durable medical equipment (DME) (wheelchairs, oxygen): • Prosthetics (braces, artificial limbs):	In-network: 20% of the cost. Out-of-network: 35% of the cost. In-network: 20% of the cost. Out-of-network: 35% of the cost.

Other Benefits	ConnectiCare Flex Plan 3 (HMO-POS)
Diabetic Supplies and Training • Diabetic supplies (includes monitoring supplies and therapeutic shoes or inserts; we limit our supplies to Abbott and LifeScan brands): • Kidney disease education:	In-network: 20% of the cost. Out-of-network: 35% of the cost. In-network: You pay $0 Out-of-network: 35% of the cost.
Renal Dialysis	You pay 20% of the cost.
Wellness Programs • Fitness: • Teladoc®:	SilverSneakers®: You pay $0 In-network: $0 copay per visit. Out-of-network: not covered.
Over-the-Counter Items	$50 per quarter – mail order only. Unused balance does not roll over.
Worldwide Emergent/Urgent Care (Coverage outside the United States.) 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 V - 7 for additional cost-sharing information for ambulance services.	$100 copay per visit.

ConnectiCare, Inc. is an HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Medicare Connect Concierge number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. SilverSneakers is a registered trademark of Tivity Health, Inc. ©2023 Tivity Health, Inc. All rights reserved. Teladoc and related marks are trademarks of Teladoc Health, Inc. and are used by ConnectiCare with permission.

2024 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 **800-224-2273** (TTY: **711**), from Oct. 1 to March 31, seven days a week from 8 a.m. to 8 p.m. From April 1 to Sept. 30, Monday through Saturday from 8 a.m. to 8 p.m.

Understanding the Benefits

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **connecticare.com/medicare** or call **800-224-2273** (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, you will likely have to select a new pharmacy for your prescriptions.
- [ ] Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- [ ] **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- [ ] 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/coinsurance may change on January 1, 2025.
- [ ] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, 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 copay for services received by non-contracted providers.