2024 Summary of Benefits

ConnectiCare Choice Plan 2 (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 review 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 a **ConnectiCare Choice Plan 2 (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 Choice Plan 2 (HMO-POS) has a network of doctors, hospitals, and other providers. Except in emergency, urgent care, or out of area dialysis, if you use providers that are not in our network, we 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 (HMO-POS) 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

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 Choice Plan 2 (HMO-POS)
Monthly Plan Premium (For all counties in Connecticut.)	You pay $0 You must continue to pay your Medicare Part B premium.
Medical Deductible	You pay $0
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs.)	$6,000 annually. This is the most you pay for copays, coinsurance, and other costs for medical services for the year.
Inpatient Hospital Coverage (May require approval.)	$295 copay per day for days one through six per admission. You pay nothing per day for days seven and beyond per admission.
Outpatient Hospital Coverage (May require approval.) • Outpatient Hospital Services (including observation services): • Ambulatory Surgery Centers:	 $200 copay per stay. $100 copay.
Doctor Visits (in-office/telehealth) • Primary care provider (PCP): • Specialist:	 You pay $0 You pay $0 for annual physical exam. $10 copay per visit.
Preventive Care Our plan covers many preventive services, including:	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).

Premiums and Benefits	ConnectiCare Choice Plan 2 (HMO-POS)
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	$10 copay per visit within the United States.
Diagnostic Services/Labs/Imaging (May require approval.)	
• Diagnostic Radiology Services (e.g., MRI):	$175 copay.
• Lab Services:	In-network: $0 at physician's office or independent facility, $10 all other locations.
• Diagnostic Tests and Procedures:	$25 copay.
• Outpatient x-rays:	$15 copay.
• Therapeutic Radiology Services (such as radiation treatment for cancer):	20% of the cost.
Hearing Services You are covered for one routine hearing exam each year and for exams to diagnose and treat hearing and balance issues.	$10 copay per visit.
Dental Services	
• Medicare-covered Dental Services:	$10 copay.
• Preventive Dental Services: Includes oral exams, cleanings, bitewing x-rays, and complete series (panorex x-rays):	In-network: You pay $0 Covers up to one oral exam, one cleaning and fluoride treatment every 6 months. Covers one standard x-ray every 6 months and one complete series (panorex x-rays) every 36 months.
• Comprehensive Dental Services (may require approval) Diagnostic; Minor Restorative Services: Fillings. Fixed Bridgework: Crowns and Inlays, Endodontics, Periodontics, Extractions: Root Canal Therapy, Periodontal Scaling and Planning, Periodontal Surgery and Maintenance, Extractions and Oral Surgery canal therapy, periodontal scaling and planing, periodontal surgery and maintenance, extractions, and oral surgery.	$3,000 Annual Benefit Maximum In-network: 20% of the cost after the $100 calendar-year deductible is met. 50% of the cost after the $100 calendar-year deductible is met.

Premiums and Benefits	ConnectiCare Choice Plan 2 (HMO-POS)
• Comprehensive Dental Services (Continued) (may require approval) Prosthodontics, Other Oral/Maxillofacial Surgery; Other Services: Partial and full denture, denture adjustments, recement of fixed bridges, and implants.	50% of the cost after the $100 calendar-year deductible is met. 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.
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.	$10 copay per visit.
• Eyewear — Routine:	Up to $500 every year for one pair of eyeglasses or contact lenses.
• Eyeglasses or contact lenses after cataract surgery (eyewear must be obtained within 12 months of surgery):	You pay $0
Mental Health Services (May require approval.)	
• Inpatient visit:	$2,179 per admission. Our plan covers up to 90 days per inpatient mental health admission. 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):	$10 copay per visit.
• Outpatient individual therapy visit (in-office/telehealth):	$10 copay per visit.

Premiums and Benefits	ConnectiCare Choice Plan 2 (HMO-POS)
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.	Our plan covers up to 100 days in a SNF per benefit period. 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.
Physical Therapy	$10 copay per visit.
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 ground emergent ambulance services outside of the United States. You are not covered for air ambulance services outside of the United States.	$50 copay. 20% of the cost. $50 copay.
Transportation (Non-emergency)	Not covered.

Prescription Drugs for ConnectiCare Choice Plan 2 (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.	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.

Additional Benefits

Benefits	ConnectiCare Choice Plan 2 (HMO-POS)
Acupuncture (May require approval.)	$30 copay per visit. Covers up to 20 visits for chronic low back pain every year (maximum of 12 visits in 90 days).
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.	$10 copay per visit.
Chiropractic Care Manipulation of the spine to correct a subluxation (when one or more of the bones in your spine move out of position):	$20 copay per visit.
Occupational, Speech, and Language Therapy	$10 copay per visit.
Cardiac Rehabilitation (in-office/virtual)	$10 copay per visit.
Intensive Cardiac Rehabilitation	$60 copay per visit.
Pulmonary Rehabilitation (May require approval.)	$10 copay per visit.
Home Health Care (May require approval.)	You pay $0
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 (Wheelchairs, oxygen): • Prosthetics (Braces, artificial limbs):	You pay $0 You pay $0

Other Benefits	ConnectiCare Choice Plan 2 (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:	You pay $0 You pay $0
Renal Dialysis	You pay 20% of the cost.
Wellness Programs • Fitness: • Teladoc®:	SilverSneakers® — You pay $0 $0 copay per visit.
Over-the-Counter Items	$50 per month by mail order only.
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 the United States. See page II-6 for additional cost-sharing information for ambulance services.	$100 copay per visit. If you are admitted to the hospital within one day, your copayment is waived.

ConnectiCare, Inc. is an HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal. Teladoc and related marks are trademarks of Teladoc Health, Inc. and are used by ConnectiCare with permission. SilverSneakers is a registered trademark of Tivity Health, Inc.

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.