

# **ConnectiCare Choice Dual Basic (HMO D-SNP)**

Medicare Advantage Plan

# **Summary of Benefits 2021**

This is a summary of drug and health services covered by ConnectiCare Insurance Company, Inc. January 1, 2021 – December 31, 2021

Please Note: No referrals are required for this plan.

**ConnectiCare.**

# Summary of Benefits – ConnectiCare Choice Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

**ConnectiCare Insurance Company, Inc.** is a Medicare Advantage HMO D-SNP plan with a Medicare contract and a contract with the Connecticut Medicaid Program. Enrollment in the Plan depends on contract renewal. The benefit information provided is a summary of what we cover and what you pay. 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 refer to your "Evidence of Coverage." You can find this document on our website at [connecticare.com/medicare](http://connecticare.com/medicare), or call us at the phone number(s) below and we'll send you a copy.

## Enrollment and eligibility

To join and remain eligible for the ConnectiCare Choice Dual Basic (HMO D-SNP) plan, you must be:

- Entitled to Medicare Part A,
- Enrolled in Medicare Part B,
- Enrolled in the Connecticut Medicaid Program (HUSKY Health), and
- Living 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 Dual Basic has a network of doctors, hospitals, pharmacies, and other providers. Except in emergency situations, if you use providers that are not in our network, the plan may not pay for these services.

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](http://connecticare.com/medicare). Or, call us and we'll send you a copy.

Your cost share will be the same whether you purchase your covered Part D drugs at one of our network "preferred" pharmacies or at one of our "standard" pharmacies.

If you receive a bill from a provider for Medicare-covered services, please do not pay the bill. Instead, please submit the bill to us for processing and determining if you have any responsibility. Please see Chapter 7 of your ConnectiCare Choice Dual Basic (HMO D-SNP) **Evidence of Coverage** for more information.

You can see our plan's provider and pharmacy directory on our website at [connecticare.com/medicare](http://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](http://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 Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

<b>Premiums and Benefits</b>	<b>ConnectiCare Choice Dual Basic (HMO D-SNP)</b>	<b>What you should know</b>
Monthly Plan Premium	You pay nothing	Your plan premium is paid on your behalf by your "Extra Help". (See page II-9 for more information on "Extra Help.") In addition, you must continue to pay your Medicare Part B, unless your Part B premium is paid for you by Medicaid or another third party.
Deductible	You pay nothing	
Maximum Out-of-Pocket Responsibility ( <i>does not include prescription drugs</i> )	\$7,550	This is the most you pay for copays, coinsurance, and other costs for medical services for the year.
Inpatient Hospital Coverage	You pay nothing	Prior authorization required
Outpatient Hospital Coverage: <ul style="list-style-type: none"> <li>• Outpatient Hospital Services</li> <li>• Ambulatory Surgery Centers</li> </ul>	You pay nothing  You pay nothing	Prior authorization required for some services  Prior authorization required for some services
Doctor Visits (In office/Virtual): <ul style="list-style-type: none"> <li>• Primary Care Provider (PCP)</li> <li>• Specialist</li> </ul>	You pay nothing  You pay nothing for Annual Physical  You pay nothing	No referrals are required for this plan.
Preventive Care	You pay nothing	Includes influenza vaccine, colorectal cancer screening, screening mammography, and all other preventive care.
Emergency Care	You pay nothing	
Urgently Needed Services	You pay nothing	

## Summary of Benefits – ConnectiCare Choice Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

<b>Premiums and Benefits</b>	<b>ConnectiCare Choice Dual Basic (HMO D-SNP)</b>	<b>What you should know</b>
Worldwide Emergent/Urgent Care ( <i>coverage outside the United States and U.S. territories</i> )	Not covered	
Diagnostic Services/Labs/Imaging: <ul style="list-style-type: none"> <li>• Diagnostic Radiology Services (<i>e.g., MRI</i>)</li> <li>• Lab Services</li> <li>• Diagnostic Tests and Procedures</li> <li>• Outpatient x-rays</li> </ul>	You pay nothing  You pay nothing  You pay nothing  You pay nothing	Prior authorization required  Prior authorization required for some services  Prior authorization required for some services  Prior authorization required for some services
Hearing Services: <ul style="list-style-type: none"> <li>• Hearing exam</li> <li>• Hearing aids</li> </ul>	You pay nothing  Not covered	You are covered for exams to diagnose and treat hearing and balance issues and other Medicare-covered services only.
Dental Services:  Medicare-covered Dental Services  Preventive Dental Services          Comprehensive Dental Services	You pay nothing  You pay nothing for oral exams, cleanings, fluoride, and x-rays (limitations apply)          Not covered  You can purchase these services as an Optional Supplemental Benefit (see page II-5)	Preventive dental services are not subject to the deductible. Covered services include: <ul style="list-style-type: none"> <li>• One every 6 months: oral exams, cleanings, fluoride, standard x-rays</li> <li>• One every 36 months: complete series x-ray</li> </ul>

## Summary of Benefits – ConnectiCare Choice Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

<b>Premiums and Benefits</b>	<b>ConnectiCare Choice Dual Basic (HMO D-SNP)</b>	<b>What you should know</b>
<p>Dental Services (continued):</p> <p><b>Optional Supplemental Benefit</b></p> <p>Comprehensive Dental Services</p> <p><b>Comprehensive Dental Services</b></p> <p>Covered services include:</p> <p>Basic Services</p> <ul style="list-style-type: none"> <li>• Restorative services</li> </ul> <p>Major Dental Services</p> <ul style="list-style-type: none"> <li>• Endodontics, Periodontics, Extractions</li> <li>• Prosthodontics, other oral/maxillofacial surgery, other services</li> </ul>	<p>\$39 monthly premium</p> <p>\$100 calendar year deductible</p> <p>\$2,000 annual benefit maximum</p> <p style="text-align: center;"><b>or</b></p> <p>\$49 monthly premium</p> <p>\$100 calendar year deductible</p> <p>\$3,000 annual benefit maximum</p> <p>20% of the cost after the \$100 calendar-year deductible is met</p> <p>50% of the cost after the \$100 calendar-year deductible is met</p>	<p>Prior authorization required for some services</p> <p>Covers: Restorations (fillings)</p>

## Summary of Benefits – ConnectiCare Choice Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

<b>Premiums and Benefits</b>	<b>ConnectiCare Choice Dual Basic (HMO D-SNP)</b>	<b>What you should know</b>
<p>Vision Services:</p> <ul style="list-style-type: none"> <li>• Vision exam</li>   <li>• Eyewear - routine</li>   <li>• Eyeglasses or contact lenses after cataract surgery</li> </ul>	<p>You pay nothing</p> <p>\$200 allowance for eyewear every year</p> <p>You pay nothing</p>	<p>You are covered for one routine eye exam each year.</p> <p>You are covered for exams to diagnose and treat diseases and conditions of the eye.</p> <p>Routine eyewear must be dispensed by EyeMed participating providers. Please visit: <a href="https://www.eyemedvisioncare.com">https://www.eyemedvisioncare.com</a>, click "find a provider", and in the drop down choose "select network" or call toll-free 1-833-337-3134.</p> <p>Eyewear must be obtained within 12 months of surgery.</p>
<p>Mental Health Services:</p> <ul style="list-style-type: none"> <li>• Inpatient visit</li> <li>• Outpatient group therapy visit (In office only)</li> <li>• Outpatient individual therapy visit (In office/Virtual)</li> </ul>	<p>You pay nothing</p> <p>You pay nothing</p> <p>You pay nothing</p>	<p>Prior authorization required</p> <p>Prior authorization required</p> <p>Prior authorization required</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>You pay nothing</p>	<p>Our plan covers up to 100 days in a SNF per benefit period.</p> <p>Prior authorization required</p> <p>A benefit period begins the day you're admitted into a SNF. The benefit period ends when you haven't received 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.</p>
<p>Physical Therapy</p>	<p>You pay nothing</p>	
<p>Ambulance (<i>air and ground</i>)</p>	<p>You pay nothing</p>	<p>Prior authorization required for non-emergent services</p>

## Summary of Benefits – ConnectiCare Choice Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

Premiums and Benefits	ConnectiCare Choice Dual Basic (HMO D-SNP)	What you should know
Transportation ( <i>non-emergency</i> )	Not covered	
Medicare Part B Drugs	You pay nothing	We cover Part B drugs such as chemotherapy and some drugs administered by your doctor.  Prior authorization required for some Part B drugs  Step therapy may be required for some Part B drugs
Acupuncture	You pay nothing  Covers up to 20 visits for chronic lower back pain every year	Prior authorization required  Visit limits: Maximum of 12 visits in 90 days
Foot Care ( <i>podiatry services</i> ):  • Foot exams and treatment	You pay nothing	If you have diabetes-related nerve damage and/or meet certain conditions, exams and treatment are covered.
Chiropractic Care  <i>We cover only manipulation of the spine to correct a subluxation (when one or more of the bones in your spine move out of position).</i>	You pay nothing	
Occupational, Speech, and Language Therapy	You pay nothing	
Cardiac and Pulmonary Therapy	You pay nothing	Prior authorization required for pulmonary rehabilitation therapy
Home Health Care	You pay nothing	Prior authorization required
Hospice	You pay nothing	Original Medicare, rather than our plan, will pay for hospice services related to your terminal prognosis.

## Summary of Benefits – ConnectiCare Choice Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

<b>Premiums and Benefits</b>	<b>ConnectiCare Choice Dual Basic (HMO D-SNP)</b>	<b>What you should know</b>
<p>Medical Equipment/Supplies:</p> <ul style="list-style-type: none"> <li>• Durable Medical Equipment (<i>e.g., wheelchairs, oxygen</i>)</li> <li>• Prosthetics/Medical Supplies (<i>e.g., braces, artificial limbs</i>)</li> </ul>	<p>You pay nothing</p> <p>You pay nothing</p>	<p>Prior authorization required for some services</p> <p>Prior authorization required for some services</p>
<p>Diabetic Supplies and Training:</p> <ul style="list-style-type: none"> <li>• Diabetic supplies (<i>includes monitoring supplies and therapeutic shoes or inserts</i>)</li> <li>• Kidney disease education</li> </ul>	<p>You pay nothing</p> <p>You pay nothing</p>	
<p>Eligible Over-the-Counter Items</p>	<p>Covers up to \$50 per quarter mail order only Maximum benefit of \$200 per year</p>	<p>If you do not use the entire \$50 benefit within a quarter, the unused amount does not roll over to the next quarter.</p> <p>Call 1-877-239-2942 (TTY: 711) or visit the link below: <a href="http://connecticare.com/mailOTC">connecticare.com/mailOTC</a></p>
<p>Wellness Programs</p>	<p>Not covered</p>	



# Summary of Benefits – ConnectiCare Choice Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

## Outpatient Prescription Drugs

As a member of ConnectiCare Choice Dual Basic (HMO D-SNP), you are automatically enrolled in Medicare Part D prescription drug coverage. Because of your eligibility for Medicaid (HUSKY Health), you should receive Extra Help from the government (Low Income Subsidy) to help pay for your prescription drugs.

“Extra Help” means that you will receive help paying for your Medicare Part D premium, annual deductible (the amount you pay before your plan starts to pay), and prescription drug cost shares (the amount you pay for a covered drug).

### Prescription Drug Costs

Please refer to the table on the following page for the cost-sharing for a one-month supply of a drug. We will send you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. Because you are eligible for “Extra Help” or “Low Income Subsidy” (LIS), the amount you pay is determined by the prescription and your LIS. Please refer to your LIS Rider and/or Evidence of Coverage for more information on what you pay.

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.

## Summary of Benefits – ConnectiCare Choice Dual Basic (HMO D-SNP)

January 1, 2021 – December 31, 2021

### Part D Prescription Drug Cost Sharing for a 30-day supply of covered drugs

Cost shares may change when entering another phase of the Part D benefit.

Tier Name	Initial Coverage Stage	Coverage Gap Stage	Catastrophic Coverage Stage
All formulary drugs	Generic/Preferred multi-source drugs: \$0 to \$3.70  All other drugs: \$0 to \$9.20  The amount you pay is determined by the prescription and your low-income subsidy (LIS). Please refer to your LIS Rider and/or Evidence of Coverage for more information on what you pay.		\$0

Your cost will not change regardless of where you purchase your Part D prescription drugs. This includes our “preferred” or “standard” pharmacies, mail order, long term care or home infusion.

# Summary of Medicaid-Covered Benefits

## Statement of Medicaid Benefits and Cost-Sharing Protections

### Eligibility

ConnectiCare Choice Dual Basic (HMO D-SNP) plan members must be enrolled in the HUSKY Health program which pays their Medicare cost sharing. These members are also eligible to receive the additional Medicaid benefits described below and on the following pages.

### Cost sharing and cost-sharing protections for all members

In a ConnectiCare Choice Dual Basic (HMO D-SNP) plan, the state Medicaid Program (HUSKY Health) pays the cost share for Medicare-covered medical services you receive from a provider in ConnectiCare's network who is also a Medicaid participating provider.

If you receive covered services from a non-participating provider, you may be required to pay a cost share based on your Medicaid status below.

### Full Medicaid

**Specified Low-Income Medicare Beneficiary – Plus (SLMB – Plus):** Payment of your Medicare Part B premiums and full Medicaid benefits.

**Qualified Medicare Beneficiary – Plus (QMB – Plus):** Payment of your Medicare Part A and Part B premiums, deductibles, cost-sharing (excluding Part D copays), and full Medicaid benefits.

**Qualified Medicare Beneficiary (QMB):** Payment of your Medicare Part A and Part B premiums, deductibles, cost-sharing (excluding Part D copays), and full Medicaid benefits.

## Medicaid (HUSKY Health) Covered Benefits

The benefit information provided is a summary of what Medicaid covers. It does not list every service that is covered or list every limitation or exclusion. Some services may require prior authorization.

Benefit	Limitations
<b>Acupuncture</b>	Covered when medically necessary, Medicaid coverage rules apply.
<b>Allergy Testing/Shots</b>	Covered when medically necessary.
<b>Ambulance: Emergency ground and rotary air ambulance</b>	For emergencies only (Call 911 for emergency ground ambulance).
<b>Ambulance: Non-emergency air ambulance</b>	To the closest appropriate provider for an approved service. Contact Veyo, a Total Transit company at 1.855.478.7350 or <a href="http://ct.ridewithveyo.com">ct.ridewithveyo.com</a>
<b>Behavioral Health</b> <i>(Mental Health and Substance use Treatment)</i>	Covered services include but are not limited to: <ul style="list-style-type: none"><li>• Freestanding Outpatient Medical Clinic Services</li><li>• Hospital Outpatient Psychiatric Services</li><li>• Freestanding Mental Health and Ambulatory Substance Use Clinic Services</li><li>• Emergency and Inpatient Psychiatric Hospitalization Services</li><li>• Individual Practitioner Services</li></ul> Contact Connecticut Behavioral Health Partnership at <b><a href="http://www.ctbhp.com">www.ctbhp.com</a></b> or 1.877.552.8247 for detailed benefit coverage information.

## Medicaid (HUSKY Health) Covered Benefits

Benefit	Limitations
<b>Birth Control</b>	Requires prescription for all methods of contraception obtained at a pharmacy. Monthly limits apply for condoms. The Plan B morning after pill is also covered with prescription.
<b>Cardiac Care</b> <i>(Includes Diagnostic Screening and Testing)</i>	Covered when medically necessary.
<b>Cardiac Rehabilitation Program</b>	Covered when medically necessary. Prior authorization required.
<b>Chiropractic</b>	<b>Ages Birth through 20:</b> Limited to certain specific services provided by an independent chiropractor or within a clinic/health center setting. <b>Ages 21+:</b> Limited to certain specific services provided only at a Federally Qualified Health Center.
<b>Dental</b>	Covered preventive and comprehensive dental services. Contact Dental Health Partnership at <b>www.ctdhp.com</b> or 1.855.283.3682 for detail benefit coverage information.
<b>Dialysis</b>	Covered when medically necessary.
<b>Diapers and Adult Incontinence Supplies</b>	<b>Ages Birth through 2:</b> Not covered. <b>Ages 3+:</b> Covered if medically necessary. Prescription required.
<b>Diabetic Supplies such as:</b> <i>blood glucose monitor, alcohol wipes, test strips (urine, blood or reagent), lancets</i>	<b>Ages Birth through 20:</b> Covered under both the Pharmacy benefit or under the Medical Equipment benefit. <b>Ages 21+:</b> Covered only under the Medical Equipment benefit. <i>Insulin is covered for all ages under the pharmacy benefit.</i>
<b>Diabetic Shoes/Inserts</b>	<b>Ages 21+:</b> 2 pairs are covered per calendar year without prior authorization.
<b>Emergency Services/Urgent Care</b>	<b>In-state:</b> Covered by an enrolled physician/APRN practice or part of an outpatient hospital department. <b>Out-of-state:</b> Not covered unless visit is medically necessary AND the provider enrolls in HUSKY Health. <b>Out-of-country:</b> Emergency services are not covered when received outside of the US or US territories.
<b>Family Planning</b> (For ongoing care) (Includes birth control, exams, testing and treatment for sexually transmitted diseases and HIV. Also see Birth Control and Maternity)	Covered when medically necessary.
<b>Genetic Testing</b>	Covered when medically necessary.

## Medicaid (HUSKY Health) Covered Benefits

Benefit	Limitations
<b>Gynecology</b>	Covered when medically necessary.
<b>Hearing Exams</b>	Covered when medically necessary.
<b>Hearing Aids</b>	<b>HUSKY Health A, C, D:</b> 1 pair every 3 years.
<b>Hearing Aid Batteries</b>	Requires prescription.
<b>Home Health Care:</b>	
<b>Skilled Nursing Visits at Home</b>	Covered when medically necessary. <b>Maternity Visits:</b> Limited to services for pregnant women at high risk.
<b>Home Health Aide Visits at Home</b>	Must provide hands-on physical care ( <i>for feeding, bathing, toileting, dressing or mobility</i> ). Custodial or homemaker/companion services are not covered.
<b>Physical Therapy (PT), Occupational Therapy (OT), and/or Speech Therapy (ST) Visits at Home</b>	Covered when medically necessary.
<b>Extended Skilled Nursing Visits at Home</b> ( <i>nursing shifts</i> )	Covered when medically necessary.
<b>Hospice at Home</b> <i>Hospice care is aimed at comfort care and relieving symptoms of terminal illness. It usually does not include treatment aimed at cure. For inpatient hospice, see Hospice Inpatient Care.</i>	Hospice services are available to members who are diagnosed with a terminal illness with a life expectancy of 6 months or less. <b>Ages Birth through 20:</b> Members may receive treatment aimed at cure at the same time they are receiving hospice care.
<b>Home Infusion Services at Home</b> ( <i>Intravenous medicine at home</i> )	<b>Ages Birth through 20:</b> Covered when medically necessary. <b>Ages 21+:</b> Home Health Agency will teach members to administer their own medication.
<b>Nursing Visits at Home for Behavioral Health Conditions</b>	Covered when medically necessary. Contact Connecticut Behavioral Health Partnership at <b>www.ctbhp.com</b> or 1.877.552.8247 for detail benefit coverage information.
<b>Hospice Inpatient Care</b> <i>Hospice care is aimed at comfort care and relieving symptoms of a terminal illness. It usually does not include treatment aimed at cure.</i>	Inpatient Hospice services are available to members who are diagnosed with a terminal illness with a life expectancy of 6 months or less.

## Medicaid (HUSKY Health) Covered Benefits

Benefit	Limitations
<b>Hospital Care:</b>	
<b>Inpatient</b>	Inpatient stays and doctor visits while you are inpatient are covered when medically necessary.
<b>Outpatient</b>	Covered when medically necessary.
<b>Specialized Long-Term Hospital Care</b>	Covered when medically necessary.
<b>Laboratory Services</b>	Covered when medically necessary.
<b>Long-Term Care Skilled Nursing Facility</b>	Covered when medically necessary.
<p><b>Maternity (prenatal, delivery and postpartum)</b></p> <p><b>Breast pumps</b></p>	<p><b>Hospital Births:</b> No limitations.  <b>Home births:</b> Covered.</p> <p><b>Breast pumps:</b> Covered once the baby is born. A prescription in the mother's name is required.  <b>Childbirth/Lamaze classes:</b> Not covered.</p>
<p><b>Medical Equipment</b> <i>(for use at home) Definition: Reusable equipment that can withstand repeated use, and is generally used to serve a medical purpose. Includes items such as Walkers, Wheelchairs, Sleep Apnea Equipment, Breast Pumps, etc.</i></p>	<p>Must be medically necessary and meet the definition of Medical Equipment (see Benefit).  Prescription is required.</p>
<p><b>Medical Supplies</b> <i>Disposable i.e. Gauze, Gloves, Syringes</i></p>	<p>Prescription is required.  Covered when medically necessary.</p>
<b>Naturopath</b>	<p><b>Ages Birth through 20:</b> Limited to some specific services; covered when medically necessary.  <b>Ages 21+:</b> Care is covered only when provided in a hospital or outpatient clinic.</p>
<b>Nutritional Counseling</b>	<p>Nutritional counseling is covered when received by a physician, APRN or Physician's Assistant as part of an office visit or when part of a visit in a clinic or community health center. Nutritional counseling with an independent registered dietitian is not covered.</p>
<p><b>Orthotics</b> <i>Prescription custom made supportive inserts to address conditions of the feet and ankles</i></p>	<p>Covered when medically necessary.</p>

## Medicaid (HUSKY Health) Covered Benefits

Benefit	Limitations
<b>Pharmacy</b> <i>Prescription medicine Over-the-Counter medicine, vitamins and supplements</i>	A prescription is required even for Over-the-Counter (vitamins, medicines and supplements) that are covered; some limits apply. Some prescriptions require prior authorization.
<b>Prosthetics</b> <i>An artificial device to replace a missing body part. The body part may be missing due to trauma, disease or congenital condition.</i>	Covered when medically necessary.
<b>Rehab Services: Outpatient</b> <i>Physical Therapy, Occupational Therapy, Speech Therapy</i> <b>Inpatient</b> <i>Physical Therapy, Occupational Therapy, Speech Therapy</i> (For services at home see Home Health Care)	Covered when medically necessary.
<b>Surgery:</b>	
<b>Bariatric</b>	Covered when medically necessary.
<b>Cosmetic</b>	Surgery considered to be cosmetic is not covered.
<b>Inpatient</b>	Covered when medically necessary.
<b>Outpatient</b>	Covered when medically necessary.
<b>Reconstructive</b>	Covered when medically necessary.
<b>Transgender/Reassignment Surgery</b>	Covered when medically necessary.
<b>Transportation to Medical Appointments</b>	Must be transportation to receive a service HUSKY Health covers. Contact Veyo, a Total Transit company at 1.855.478.7350 or ct.ridewithveyo.com
<b>Urgent Care/Walk-in (in-state)</b>	Covered when medically necessary.
<b>Vision Care, Eyeglasses and Contact Lenses</b>	<b>Eyeglasses - Ages 21+:</b> Some limits apply on type of frames and lenses. Limits also apply on how often you can get glasses. CT Medicaid limited reimbursement to 1 pair of eyeglasses once every two rolling calendar years, unless there is a change in vision that necessitates a new pair of eyeglasses. <b>Contact lenses:</b> Only covered for certain diagnoses.
<b>Wigs</b>	Requires prescription. Contact Member Engagement Services at 1.800.859.9889

For information on your Medicaid benefits, contact the Connecticut Department of Social Services at 1-800-842-1508 or visit [www.ct.gov/dss](http://www.ct.gov/dss).



ConnectiCare Insurance Company, Inc. is an HMO D-SNP plan with a Medicare contract and a contract with the Connecticut Medicaid Program. Enrollment in ConnectiCare depends on contract renewal. ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

©2020 ConnectiCare, Inc. & Affiliates



# 2021 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](https://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, you will likely have to select a new pharmacy for your prescriptions.

## Understanding Important Rules

- Benefits, premiums and/or copayments/coinsurance may change on January 1, 2022.
- 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).
- This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

