

# ConnectiCare Flex Plan 2 (HMO-POS) Medicare Advantage Plan Summary of Benefits 2022

This is a summary of drug and health services covered by ConnectiCare, Inc.  
January 1, 2022 – December 31, 2022

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

## Who can join?

To join **ConnectiCare Flex 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 Flex Plan 2 (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 our Member 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 **800-224-2273** (TTY: **711**), available seven days a week from 8 am to 8 pm.

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

## 2022 SUMMARY OF BENEFITS – CONNECTICARE FLEX PLAN 2 (HMO-POS)

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 **877-224-8220**, TTY users should call **711**. From October 1 to March 31, you can call us 7 days a week from 8 am to 8 pm. From April 1 to September 30, you can call us Monday through Friday from 8 am to 8 pm.

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, 7 days a week. TTY users should call **1-877-486-2048**.

Premiums and Benefits	ConnectiCare Flex Plan 2 (HMO-POS)
<p><b>Monthly Plan Premium</b> <i>(for all counties in Connecticut)</i></p>	<p>\$135</p> <p>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.</p>
<p><b>Medical Deductible</b></p>	<p>You pay nothing</p>
<p><b>Maximum Out-of-Pocket Responsibility</b> <i>(does not include prescription drugs)</i></p>	<p>In-network: \$6,000 annually</p> <p>Out-of-network: \$10,000 annually</p> <p>This is the most you pay for copays, coinsurance, and other costs for medical services for the year.</p>
<p><b>Inpatient Hospital Coverage</b> <i>(may require approval)</i></p>	<p>In-network: \$375 copay per day for days one through four per stay</p> <p>You pay nothing per day for days five and beyond per stay</p> <p>Out-of-network: 30% of the cost per day</p>
<p><b>Outpatient Hospital Coverage</b> <i>(may require approval)</i></p> <ul style="list-style-type: none"> <li>• Outpatient Hospital Services <i>(including observation services)</i></li> <li>• Ambulatory Surgery Centers:</li> </ul>	<p>In-network: \$250 copay</p> <p>Out-of-network: 40% of the cost</p> <p>In-network: \$150 copay</p> <p>Out-of-network: 40% of the cost</p>
<p><b>Doctor Visits</b> <i>(in-office/virtual)</i></p> <ul style="list-style-type: none"> <li>• Primary Care Provider (PCP)</li> <li>• Specialist</li> </ul>	<p>In-network: \$15 copay per visit</p> <p>Out-of-network: \$50 copay per visit</p> <p>You pay nothing for annual physical</p> <p>In-network: \$35 copay per visit</p> <p>Out-of-network: \$50 copay per visit</p>

2022 SUMMARY OF BENEFITS – CONNECTICARE FLEX PLAN 2 (HMO-POS)

Premiums and Benefits	ConnectiCare Flex Plan 2 (HMO-POS)
<p><b>Preventive Care</b></p>	<p>You pay nothing</p> <ul style="list-style-type: none"> <li>- Bone mass measurement</li> <li>- Breast cancer screening (mammogram)</li> <li>- Cardiovascular screening</li> <li>- Cervical and vaginal cancer screening</li> <li>- Colorectal cancer screening (Colonoscopy, - Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>- Depression screening</li> <li>- Diabetes screening</li> <li>- Prostate cancer screening (PSA)</li> <li>- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>- “Welcome to Medicare” preventive visit (one-time) and yearly “Wellness” visit (all additional preventive services approved by Medicare during the contract year will be covered.)</li> </ul>
<p><b>Emergency Care</b></p>	<p>\$90 copay per visit within the United States</p> <p>If you are admitted to the hospital within one day, you do not have to pay your share of the cost for emergency care.</p>
<p><b>Urgently Needed Services</b> <i>(not waived if admitted)</i></p>	<p>\$35 copay per visit within the United States</p>
<p><b>Diagnostic Services/Labs/Imaging</b> <i>(may require approval)</i></p> <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> <li>• Therapeutic Radiology Services <i>(such as radiation treatment for cancer)</i></li> </ul>	<p>In-network: \$250 copay Out-of-network: 40% of the cost</p> <p>In-network: \$15 copay Out-of-network: 40% of the cost</p> <p>In-network: \$25 copay Out-of-network: 40% of the cost</p> <p>In-network: \$40 copay Out-of-network: 40% of the cost</p> <p>In-network: 20% of the cost Out-of-network: 40% of the cost</p>
<p><b>Hearing Services</b></p> <ul style="list-style-type: none"> <li>• Exam to diagnose and treat hearing and balance issues once each year</li> </ul>	<p>In-network: \$35 copay per visit Out-of-network: \$50 copay per visit</p>

Premiums and Benefits	ConnectiCare Flex Plan 2 (HMO-POS)
<p><b>Dental Services</b></p> <ul style="list-style-type: none"> <li>Medicare-covered Dental Services</li> <li>Preventive and Comprehensive Dental Services</li> </ul> <p><b>Optional Supplemental Benefit</b></p> <p><b>PPO Options</b></p> <ul style="list-style-type: none"> <li>Preventive and Diagnostic Dental Services Includes oral exams, cleanings, fluoride treatments, bitewing x-rays, and complete series (panorex x-rays)</li> <li>Comprehensive Dental Services <i>(may require approval)</i> Restorative services: Fixed Bridgework, Crowns and Inlays Endodontics, Periodontics, Extractions: Root Canal Therapy, Periodontal Scaling and Planing, Periodontal Surgery and Maintenance, Extractions, and Oral Surgery Prosthodontics, other oral/maxillofacial surgery, other services: Partial and Full Dentures, Denture Adjustments, Recement of Fixed Bridges, Implants</li> </ul> <p><b>Indemnity Option</b></p> <ul style="list-style-type: none"> <li>Preventive and Comprehensive Dental Services</li> </ul>	<p>In-network: \$35 copay per visit Out-of-network: \$50 copay per visit</p> <p>Not covered You can purchase these services as an Optional Supplemental Benefit (see below)</p> <p><b>\$39 monthly premium</b> \$100 calendar year deductible \$2,000 annual benefit maximum</p> <p><b>or</b> <b>\$49 monthly premium</b> \$100 calendar year deductible \$3,000 annual benefit maximum</p> <p>You pay nothing</p> <p>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</p> <p>20% of the cost after the \$100 calendar-year deductible is met 50% 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><b>\$39 monthly premium</b> \$3,500 annual benefit maximum You pay 50% of the cost for all covered services</p>

Premiums and Benefits	ConnectiCare Flex Plan 2 (HMO-POS)
<p><b>Vision Services</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Eyewear – Routine</li> <li>• Eyeglasses or contact lenses after cataract surgery (eyewear must be obtained within 12 months of surgery.)</li> </ul>	<p>In-network: \$35 copay per visit                      Out-of-network: Not covered</p> <p>Not covered</p> <p>In-network: You pay nothing                      Out-of-network: Not covered</p>
<p><b>Mental Health Services</b>                      (may require approval)</p> <ul style="list-style-type: none"> <li>• Inpatient visit</li> <li>• Outpatient group therapy visit                      (<i>in-office only</i>)</li> <li>• Outpatient individual therapy visit                      (<i>in-office/virtual</i>)</li> </ul>	<p>In-network: \$1,871 per admission                      Out-of-network: 40% of the cost per visit</p> <p>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.</p> <p>The cost-sharing applies each time you are admitted inpatient to a Psychiatric Facility</p> <p>In-network: \$35 copay per visit                      Out-of-network: 40% of the cost</p> <p>In-network: \$35 copay per visit                      Out-of-network: 40% of the cost</p>

Premiums and Benefits	ConnectiCare Flex Plan 2 (HMO-POS)
<p><b>Skilled Nursing Facility (SNF)</b> <i>(may require approval)</i></p> <p>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.</p>	<p>In-network: You pay nothing per day for days one through 20 per benefit period</p> <p>\$184 copay per day for days 21 through 100 per benefit period</p> <p>Out-of-network: 40% of the cost per day for days one through 100 per benefit period</p> <p>Our plan covers up to 100 days in a SNF per benefit period.</p>
<p><b>Physical Therapy</b></p>	<p>In-network: \$35 copay per visit</p> <p>Out-of-network: \$50 copay per visit</p>
<p><b>Ambulance</b> <i>(may require approval; not waived if admitted)</i></p> <ul style="list-style-type: none"> <li>• Ground</li> <li>• Air</li> <li>• Worldwide Ground Ambulance</li> </ul> <p>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.</p>	<p>\$300 copay</p> <p>20% of the cost</p> <p>\$300 copay</p>
<p><b>Transportation</b> <i>(non-emergency)</i></p>	<p>Not covered</p>

## Prescription Drugs for ConnectiCare Flex Plan 2 (HMO-POS)

Medicare Part B Drugs	
<p>We cover Part B drugs such as chemotherapy and some drugs administered by your doctor. <i>(may require approval)</i></p> <p>Step therapy may be required for some Part B drugs.</p>	<p>In-network:</p> <p>10% of the cost for Medicare-covered Part B drugs <b>in the home</b></p> <p>20% of the cost for Medicare-covered Part B drugs <b>dispensed at a retail pharmacy, mail order pharmacy, physician office, and outpatient facility</b></p> <p>Out-of-network: 40% of the cost</p>

### Medicare Part D Drugs

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.

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) and Tier 2 (generic) drugs. There is a deductible for Tier 3 (preferred brand), Tier 4 (non-preferred drug), 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 \$4,430. The total drug costs paid by both you and our Part D plan will help you reach the coverage gap.



**Retail Cost-Sharing**

<b>ConnectiCare Flex Plan 2 30-Day Supply of Drugs</b>					
<b>Tier</b>	<b>Deductible</b>	<b>Initial Coverage \$0-\$4,430</b>		<b>Coverage Gap \$4,430 - \$7,050</b>	<b>Catastrophic Over \$7,050</b>
	<b>You Pay</b>	<b>Preferred Pharmacy</b>	<b>Standard Pharmacy</b>	<b>You Pay</b>	<b>You Pay the greater of:</b>
Tier 1: Preferred Generic	\$0	\$2	\$9	25%	5% or \$3.95
Tier 2: Generic	\$0	\$10	\$20	25%	5% or \$3.95
Tier 3: Preferred Brand	\$300	\$42	\$47	25%	5% or \$9.85
Tier 4: Non- Preferred Drug		\$95	\$100	25%	5% or \$3.95 for generic/preferred multi-source drugs  5% or \$9.85 for all other drugs
Tier 5: Specialty		27%	27%	25%	5% or \$3.95 for generic/preferred multi-source drugs  5% or \$9.85 for all other drugs

**Preferred Mail Order Cost-Sharing**

<b>ConnectiCare Flex Plan 2</b>			
<b>Tier</b>	<b>Deductible</b>	<b>Initial Coverage \$0-\$4,430</b>	
	<b>You pay</b>	<b>30-day supply</b>	<b>90-day supply</b>
Tier 1: Preferred Generic	\$0	\$0	\$0
Tier 2: Generic	\$0	\$0	\$0
Tier 3: Preferred Brand	\$300	\$42	\$126
Tier 4: Non-Preferred Drug		\$95	\$285
Tier 5: Specialty		27%	Not available in long-term supply

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 \$4,430.

While in the coverage gap in 2022: You will pay 25% of the plan’s cost for all 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 **\$7,050**, you will enter the catastrophic coverage stage. In this stage, you pay the greater of: 5% of the cost or you pay **\$3.95** for generic drugs (including brand-name drugs treated as generic) and **\$9.85** for all other drugs.

## 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/](https://ssa.gov/benefits/medicare/prescriptionhelp/)**.

2022 SUMMARY OF BENEFITS – CONNECTICARE FLEX PLAN 2 (HMO-POS)

Other Benefits	ConnectiCare Flex Plan 2 (HMO-POS)
<p><b>Acupuncture</b> <i>(may require approval)</i></p>	<p>In-network: \$30 copay per visit Covers up to 20 visits for chronic lower back pain every year (maximum of 12 visits in 90 days) Out-of-network: Not covered</p>
<p><b>Foot Care</b> <i>(podiatry services)</i></p> <ul style="list-style-type: none"> <li>• Foot exams and treatment (routine exams not covered)</li> </ul> <p>If you have diabetes-related nerve damage and/or meet certain conditions, exams and treatment are covered.</p>	<p>In-network: \$35 copay per visit Out-of-network: \$50 copay per visit</p>
<p><b>Chiropractic Care</b></p> <p>Manipulation of the spine to correct a subluxation (when one or more of the bones in your spine move out of position)</p>	<p>In-network: \$20 copay per visit Out-of-network: \$50 copay per visit</p>
<p><b>Occupational, Speech, and Language Therapy</b></p>	<p>In-network: \$35 copay per visit Out-of-network: \$50 copay per visit</p>
<p><b>Cardiac Therapy</b></p>	<p>In-network: \$35 copay per visit Out-of-network: \$50 copay per visit</p>
<p><b>Intensive Cardiac Therapy</b></p>	<p>In-network: \$100 copay per visit Out-of-network: 50% of the cost</p>
<p><b>Pulmonary Therapy</b> <i>(may require approval)</i></p>	<p>In-network: \$30 copay per visit Out-of-network: \$50 copay per visit</p>
<p><b>Home Health Care</b> <i>(may require approval)</i></p>	<p>In-network: You pay nothing Out-of-network: 40% of the cost</p>
<p><b>Hospice</b></p> <p>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.</p>	<p>You pay nothing</p>

Other Benefits	ConnectiCare Flex Plan 2 (HMO-POS)
<p><b>Medical Equipment/Supplies</b> <i>(may require approval)</i></p> <ul style="list-style-type: none"> <li>• Durable Medical Equipment (e.g., wheelchairs, oxygen)</li> <li>• Prosthetics (e.g., braces, artificial limbs)</li> </ul>	<p>In-network: 20% of the cost Out-of-network: 40% of the cost</p> <p>In-network: 20% of the cost Out-of-network: 40% of the cost</p>
<p><b>Diabetic Supplies and Training</b></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>In-network: 20% of the cost Out-of-network: 30% of the cost</p> <p>In-network: You pay nothing Out-of-network: 20% of the cost</p>
<p><b>Renal Dialysis</b></p>	<p>You pay 20% of the cost</p>
<p><b>Wellness Programs</b></p> <ul style="list-style-type: none"> <li>• Fitness</li> <li>• Teladoc®</li> </ul>	<p>SilverSneakers®: You pay nothing</p> <p>In-network: \$45 copay per visit Out-of-network: Not covered</p>
<p><b>Over-the-Counter Items</b></p>	<p>Not covered</p>
<p><b>Worldwide Emergent/Urgent Care</b> <i>(coverage outside the United States)</i></p> <p>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 VII - 7 for additional cost-sharing information for ambulance services.</p>	<p>\$90 copay per visit</p>

ConnectiCare, Inc. is an HMO/HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal. For more information, contact the plan. Out-of-network/non-contracted providers are under no obligation to treat ConnectiCare members, except in emergency situations. Please call our customer service 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. © 2021 Tivity Health, Inc. All rights reserved. ©2021 Teladoc, Inc. All rights reserved. Teladoc and the Teladoc logo are trademarks of Teladoc, Inc. and may not be used without written permission. ©2021 ConnectiCare, Inc. & Affiliates

# 2022 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 **877-224-8220** (TTY: **711**), 8 am to 8 pm, seven days a week.

## 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 **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

- 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, 2023.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, 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.