ConnectiCare VIP Prime 1 (HMO)
ConnectiCare VIP Prime 2 (HMO)
ConnectiCare VIP Prime 3 (HMO)
ConnectiCare VIP Prime 4 (HMO)
ConnectiCare VIP Option 1 (HMO-POS)
ConnectiCare VIP Option 2 (HMO-POS)

Summary of Benefits
2010

Connecticut – Effective January 1, 2010

H3528

ConnectiCare®
VIP Medicare Plans

If you are not currently enrolled in a ConnectiCare VIP Medicare Plan, and have questions, contact us toll-free at 1-877-224-8220 between the hours of 8:00 a.m. – 8:00 p.m., Monday through Friday (TTY/TDD users: 1-800-842-9710). Extended hours 11/15 – 3/1, 8:00 a.m. – 8:00 p.m., seven days a week. Or visit us online at **www.connecticare.com/medicare.**

If you are currently enrolled in a ConnectiCare VIP Medicare Plan, and have questions, contact us toll-free at 1-800-CCI-CARE (1-800-224-2273) (TTY/TDD users: 1-800-842-9710) between the hours of 8:00 a.m. – 8:00 p.m., seven days a week.

The Plans described herein are offered by ConnectiCare, Inc., a Medicare Advantage Organization with an annually renewed Medicare contract. The availability of coverage beyond the current contract year (2010) is not guaranteed. Benefits, limitations, service areas and premiums are subject to change on January 1 of each year. Anyone with Medicare Parts A & B who resides in the state of Connecticut may apply for ConnectiCare VIP Medicare Plans with/without drug coverage. Beneficiaries must continue to pay their Medicare Part B premium (and Part A, if applicable), if not otherwise paid for under Medicaid or by another third party. Prior authorization may be needed for certain in network services. Please refer to your Evidence of Coverage for complete details on participating provider networks and obtaining prior authorizations. The Medicare Prescription Drug Benefit is only available to members of the Medicare Advantage Prescription Drug (MA-PD) Plan. If a beneficiary is already enrolled in a MA-PD plan, the enrollee must receive their Medicare Prescription Drug benefit through that plan. To obtain additional network pharmacy information, please contact us toll-free at 1-877-224-8220 (TTY/TDD users: 1-800-842-9710) between the hours of 8:00 a.m. – 8:00 p.m., Monday through Friday. Extended hours 11/15 – 3/1, 8:00 a.m. – 8:00 p.m., seven days a week.

If you have special needs, this document is available in alternate formats.

The person discussing plan options with you is either employed by or contracted with ConnectiCare, Inc. The person may be compensated based on your enrollment in a plan.

SECTION I – INTRODUCTION TO THE SUMMARY OF BENEFITS

Thank you for your interest in ConnectiCare VIP Medicare Plans. Our plans are offered by CONNECTICARE, INC., a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS). This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call ConnectiCare, Inc. and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like ConnectiCare, Inc. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call ConnectiCare, Inc. at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare ConnectiCare VIP Medicare Plans and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plans cover and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE ARE CONNECTICARE VIP MEDICARE PLANS AVAILABLE?

The service area for these plans includes the following counties: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham Counties, CT. You must live in one of these areas to join one of the plans. There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of year. Please call Customer Service for more information.

WHO IS ELIGIBLE TO JOIN A CONNECTICARE VIP MEDICARE PLAN?

You can join a ConnectiCare VIP Medicare Plan if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in a ConnectiCare VIP Medicare Plan unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

For ConnectiCare VIP Prime 1 (HMO), Prime 2 (HMO), Prime 3 (HMO), and Prime 4 (HMO) Plans: ConnectiCare, Inc. has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at **www.connecticare.com.** Our customer service number is listed at the end of this introduction.

For ConnectiCare VIP Option 1 (HMO-POS) and Option 2 (HMO-POS) Plans:
ConnectiCare, Inc. has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at **www.connecticare.com.** Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

For ConnectiCare VIP Prime 1 (HMO), Prime 2 (HMO), Prime 3 (HMO), and Prime 4 (HMO) Plans:
If you chose to go to a doctor outside of our network, you must pay for these services yourself. Neither ConnectiCare, Inc. nor the Original Medicare Plan will pay for these services.

For ConnectiCare VIP Option 1 (HMO-POS) and Option 2 (HMO-POS) Plans:
You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

ConnectiCare VIP Prime 1 (HMO), Prime 2 (HMO), Prime 3 (HMO), and Option 1 (HMO-POS) Plans do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

ConnectiCare VIP Prime 4 (HMO) and Option 2 (HMO-POS) Plans do cover Medicare Part B prescription drugs. **ConnectiCare VIP Prime 4 (HMO) and Option 2 (HMO-POS) Plans** do **NOT** cover Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN CONNECTICARE VIP PRIME 1 (HMO), PRIME 2 (HMO), PRIME 3 (HMO), OR OPTION 1 (HMO-POS)?

ConnectiCare, Inc. has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at **www.connecticare.com**. Our customer service number is listed at the end of this introduction.

ConnectiCare, Inc. has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

ConnectiCare, Inc. uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at **www.connecticare.com**.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of ConnectiCare, Inc., you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualidigm 1-860-632-2008, or 1-800-553-7590.

As a member of ConnectiCare VIP Prime 1 (HMO), Prime 2 (HMO), Prime 3 (HMO), and Option 1 (HMO-POS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualidigm 1-860-632-2008, or 1-800-553-7590.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact ConnectiCare, Inc. for more details.

SECTION I – INTRODUCTION TO THE SUMMARY OF BENEFITS

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact ConnectiCare, Inc. for more details.

– Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

– Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

– Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

– Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

– Injectable Drugs: Most injectable drugs administered incident to a physician's service.

– Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.

– Some Oral Cancer Drugs: If the same drug is available in injectable form.

– Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

– Inhalation and Infusion Drugs provided through DME.

PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on **www.medicare.gov** and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at (877)-224-8220 to obtain a copy of the plan ratings for this plan. TTY users call (800)-842-9710.

Please call ConnectiCare, Inc. for more information about ConnectiCare VIP Medicare Plans.

Visit us at **www.connecticare.com** or, call us:

Customer Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. – 8:00 p.m. Eastern

Current members should call toll-free (800)-224-2273 for questions related to the Medicare Advantage Program and/or the Medicare Part D Prescription Drug program. (TTY/TDD (800)-842-9710)

Prospective members should call toll-free (877)-224-8220 for questions related to the Medicare Advantage Program and/or the Medicare Part D Prescription Drug program. (TTY/TDD (800)-842-9710)

Current members should call locally (800)-224-2273 for questions related to the Medicare Advantage Program and/or the Medicare Part D Prescription Drug program. (TTY/TDD (800)-842-9710)

Prospective members should call locally (877)-224-8220 for questions related to the Medicare Advantage Program and/or the Medicare Part D Prescription Drug program. (TTY/TDD (800)-842-9710)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit **www.medicare.gov** on the web.

If you have special needs, this document may be available in other formats.

If you have any questions about these plans' benefits or costs, please contact ConnectiCare, Inc. for details.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
IMPORTANT INFORMATION							
1 Premium and Other Important Information	In 2009 the monthly Part B Premium was $96.40 and will change for 2010 and the yearly Part B deductible amount was $135 and will change for 2010. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was $85,000 for singles, $170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $0 monthly plan premium in addition to your monthly Medicare Part B premium. **In-Network** $3,400 out-of-pocket limit. All plan services included.	**General** $68 monthly plan premium in addition to your monthly Medicare Part B premium. **In-Network** $3,400 out-of-pocket limit. All plan services included.	**General** $129 monthly plan premium in addition to your monthly Medicare Part B premium. **In-Network** $2,500 out-of-pocket limit. All plan services included.	**General** $0 monthly plan premium in addition to your monthly Medicare Part B premium. **In-Network** $4,500 out-of-pocket limit. All plan services included.	**General** $168 monthly plan premium in addition to your monthly Medicare Part B premium. **In-Network** $2,500 out-of-pocket limit. All plan services included.	**General** $119 monthly plan premium in addition to your monthly Medicare Part B premium. **In-Network** $2,500 out-of-pocket limit. All plan services included.
2 Doctor and Hospital Choice (For more information, see Emergency – #15 and Urgently Needed Care – #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.	**In-Network** You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.	**In-Network** You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.	**In-Network** You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.	**In-Network** No referral required for network doctors, specialists, and hospitals.	**In-Network** No referral required for network doctors, specialists, and hospitals.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
SUMMARY OF BENEFITS							
INPATIENT CARE							
3 **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	In 2009 the amounts for each benefit period were: Days 1 - 60: $1068 deductible Days 61 - 90: $267 per day Days 91 - 150: $534 per lifetime reserve day These amounts will change for 2010. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**In-Network** For Medicare-covered hospital stays: Days 1 - 10: $250 copay per day Days 11 - 90: $0 copay per day $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $200 copay per day Days 8 - 90: $0 copay per day $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $100 copay per day Days 8 - 90: $0 copay per day $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $200 copay per day Days 8 - 90: $0 copay per day $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $100 copay per day Days 8 - 90: $0 copay per day $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $100 copay per day Days 8 - 90: $0 copay per day $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)
INPATIENT CARE			
4 **Inpatient Mental Health Care**	Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above). 190 day lifetime limit in a Psychiatric Hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 10: $250 copay per day Days 11 - 90: $0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $200 copay per day Days 8 - 90: $0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 **Skilled Nursing Facility (SNF)** (in a Medicare-certified skilled nursing facility)	In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: $0 per day Days 21 - 100: $133.50 per day These amounts will change for 2010. 100 days for each benefit period. A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** For Medicare-covered SNF stays: Days 1 - 10: $0 copay per day Days 11 - 100: $100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.	**General** Authorization rules may apply. **In-Network** For Medicare-covered SNF stays: Days 1 - 10: $0 copay per day Days 11 - 100: $100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
INPATIENT CARE			
In-Network For Medicare-covered hospital stays: Days 1 - 7: $100 copay per day Days 8 - 90: $0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $200 copay per day Days 8 - 90: $0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $100 copay per day Days 8 - 90: $0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**In-Network** For Medicare-covered hospital stays: Days 1 - 7: $100 copay per day Days 8 - 90: $0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
General Authorization rules may apply. **In-Network** For Medicare-covered SNF stays: Days 1 - 10: $0 copay per day Days 11 - 100: $100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.	**General** Authorization rules may apply. **In-Network** For Medicare-covered SNF stays: Days 1 - 10: $0 copay per day Days 11 - 100: $75 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.	**General** Authorization rules may apply. **In-Network** For Medicare-covered SNF stays: Days 1 - 10: $0 copay per day Days 11 - 100: $100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.	**General** Authorization rules may apply. **In-Network** For Medicare-covered SNF stays: Days 1 - 10: $0 copay per day Days 11 - 100: $100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
INPATIENT CARE							
6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits.
7 Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.
OUTPATIENT CARE							
8 Doctor Office Visits	20% coinsurance	**General** See "Physical Exams," for more information. **In-Network** $25 copay for each primary care doctor visit for Medicare-covered benefits. $40 copay for each in-area, network urgent care Medicare-covered visit. $40 copay for each specialist visit for Medicare-covered benefits.	**General** See "Physical Exams," for more information. **In-Network** $20 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care Medicare-covered visit. $35 copay for each specialist visit for Medicare-covered benefits.	**General** See "Physical Exams," for more information. **In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $25 copay for each in-area, network urgent care Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits.	**General** See "Physical Exams," for more information. **In-Network** $20 copay for each primary care doctor visit for Medicare-covered benefits. $30 copay for each in-area, network urgent care Medicare-covered visit. $30 copay for each specialist visit for Medicare-covered benefits.	**General** See "Physical Exams," for more information. **In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $25 copay for each in-area, network urgent care Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits.	**General** See "Physical Exams," for more information. **In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $25 copay for each in-area, network urgent care Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits.
9 Chiropractic Services	Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $40 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $35 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $30 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
OUTPATIENT CARE							
10 Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $40 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	**In-Network** $35 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	**In-Network** $30 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.
11 Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual or group therapy visit.	**General** Authorization rules may apply. **In-Network** $35 copay for each Medicare-covered individual or group therapy visit.	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered individual or group therapy visit.	**General** Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered individual or group therapy visit.	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered individual or group therapy visit.	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered individual or group therapy visit.
12 Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual or group visits.	**General** Authorization rules may apply. **In-Network** $35 copay for Medicare-covered individual or group visits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered individual or group visits.	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered individual or group visits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered individual or group visits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered individual or group visits.
13 Outpatient Services/Surgery	20% coinsurance for the doctor 20% of outpatient facility charges	**General** Authorization rules may apply. **In-Network** $0 to $175 copay for each Medicare-covered ambulatory surgical center visit. $0 to $175 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $0 to $150 copay for each Medicare-covered ambulatory surgical center visit. $0 to $150 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $0 to $100 copay for each Medicare-covered ambulatory surgical center visit. $0 to $100 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $0 to $125 copay for each Medicare-covered ambulatory surgical center visit. $0 to $125 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $0 to $100 copay for each Medicare-covered ambulatory surgical center visit. $0 to $100 copay for each Medicare-covered outpatient hospital facility visit.	**General** Authorization rules may apply. **In-Network** $0 to $100 copay for each Medicare-covered ambulatory surgical center visit. $0 to $100 copay for each Medicare-covered outpatient hospital facility visit.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
OUTPATIENT CARE							
14 Ambulance Services (medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits.
15 Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	**General** $50 copay for Medicare-covered emergency room visits. $100,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit	**General** $50 copay for Medicare-covered emergency room visits. $100,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit	**General** $50 copay for Medicare-covered emergency room visits. $100,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit	**General** $50 copay for Medicare-covered emergency room visits. $100,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit	**General** $50 copay for Medicare-covered emergency room visits. $100,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit	**General** $50 copay for Medicare-covered emergency room visits. $100,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit
16 Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** $40 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	**General** $35 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	**General** $25 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	**General** $30 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	**General** $25 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	**General** $25 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
OUTPATIENT CARE							
17 **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered Occupational Therapy visits. $40 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	**General** Authorization rules may apply. **In-Network** $35 copay for Medicare-covered Occupational Therapy visits. $35 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered Occupational Therapy visits. $25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered Occupational Therapy visits. $30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered Occupational Therapy visits. $25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered Occupational Therapy visits. $25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES							
18 **Durable Medical Equipment** (includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.
19 **Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items.
20 **Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies** (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Diabetes self-monitoring training. 20% of the cost for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Diabetes self-monitoring training. 20% of the cost for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Diabetes self-monitoring training. 20% of the cost for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Diabetes self-monitoring training. 20% of the cost for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Diabetes self-monitoring training. 20% of the cost for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Diabetes self-monitoring training. 20% of the cost for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests $30 copay for Medicare-covered X-rays. $175 copay for Medicare-covered diagnostic radiology services. $30 copay for Medicare-covered therapeutic radiology services.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests $30 copay for Medicare-covered X-rays. $175 copay for Medicare-covered diagnostic radiology services. $30 copay for Medicare-covered therapeutic radiology services.
PREVENTIVE SERVICES			
22 Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	**In-Network** $0 copay for Medicare-covered bone mass measurement	**In-Network** $0 copay for Medicare-covered bone mass measurement
23 Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	**In-Network** $0 copay for Medicare-covered colorectal screenings.	**In-Network** $0 copay for Medicare-covered colorectal screenings.
24 Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	**In-Network** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	**In-Network** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.

Benefit	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
21	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests $30 copay for Medicare-covered X-rays. $100 copay for Medicare-covered diagnostic radiology services. $30 copay for Medicare-covered therapeutic radiology services.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests $30 copay for Medicare-covered X-rays. $175 copay for Medicare-covered diagnostic radiology services. $30 copay for Medicare-covered therapeutic radiology services.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests $30 copay for Medicare-covered X-rays. $100 copay for Medicare-covered diagnostic radiology services. $30 copay for Medicare-covered therapeutic radiology services.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests $30 copay for Medicare-covered X-rays. $100 copay for Medicare-covered diagnostic radiology services. $30 copay for Medicare-covered therapeutic radiology services.
PREVENTIVE SERVICES				
22	**In-Network** $0 copay for Medicare-covered bone mass measurement	**In-Network** $0 copay for Medicare-covered bone mass measurement	**In-Network** $0 copay for Medicare-covered bone mass measurement	**In-Network** $0 copay for Medicare-covered bone mass measurement
23	**In-Network** $0 copay for Medicare-covered colorectal screenings.	**In-Network** $0 copay for Medicare-covered colorectal screenings.	**In-Network** $0 copay for Medicare-covered colorectal screenings.	**In-Network** $0 copay for Medicare-covered colorectal screenings.
24	**In-Network** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	**In-Network** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	**In-Network** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	**In-Network** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PREVENTIVE SERVICES							
25 **Mammograms (Annual Screening)** (for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	**In-Network** $0 copay for Medicare-covered screening mammograms.	**In-Network** $0 copay for Medicare-covered screening mammograms.	**In-Network** $0 copay for Medicare-covered screening mammograms.	**In-Network** $0 copay for Medicare-covered screening mammograms.	**In-Network** $0 copay for Medicare-covered screening mammograms.	**In-Network** $0 copay for Medicare-covered screening mammograms.
26 **Pap Smears and Pelvic Exams** (for women with Medicare)	$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year
27 **Prostate Cancer Screening Exams** (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	**In-Network** $0 copay for – Medicare-covered prostate cancer screening	**In-Network** $0 copay for – Medicare-covered prostate cancer screening	**In-Network** $0 copay for – Medicare-covered prostate cancer screening	**In-Network** $0 copay for – Medicare-covered prostate cancer screening	**In-Network** $0 copay for – Medicare-covered prostate cancer screening	**In-Network** $0 copay for – Medicare-covered prostate cancer screening
28 **End-Stage Renal Disease**	20% coinsurance for renal dialysis 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**In-Network** 20% of the cost for renal dialysis 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.	**In-Network** 20% of the cost for renal dialysis 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.	**In-Network** 20% of the cost for renal dialysis 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.	**In-Network** 20% of the cost for renal dialysis 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.	**In-Network** 20% of the cost for renal dialysis 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.	**In-Network** 20% of the cost for renal dialysis 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 **Prescription Drugs**	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.connecticare.com on the web. Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	**Drugs covered under Medicare Part B** **General** 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.connecticare.com on the web. Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	**Drugs covered under Medicare Part B** **General** 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.connecticare.com on the web. Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	**Drugs covered under Medicare Part B** **General** Most drugs not covered. 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs covered under Medicare Part D** **General** **This plan does not offer prescription drug coverage.**	**Drugs covered under Medicare Part B** **General** 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.connecticare.com on the web. Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	**Drugs covered under Medicare Part B** **General** Most drugs not covered. 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. **Drugs covered under Medicare Part D** **General** **This plan does not offer prescription drug coverage.**

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 **Prescription Drugs**		Some drugs have quantity limits. Your provider must get prior authorization from ConnectiCare VIP Prime 1 (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and ConnectiCare VIP Prime 1 (HMO) approves the exception, you will pay Tier 3 cost-sharing for that drug. **In-Network** $150 deductible on all drugs except Tier 1 drugs.	Some drugs have quantity limits. Your provider must get prior authorization from ConnectiCare VIP Prime 2 (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and ConnectiCare VIP Prime 2 (HMO) approves the exception, you will pay Tier 3 cost-sharing for that drug. **In-Network** $0 deductible.	Some drugs have quantity limits. Your provider must get prior authorization from ConnectiCare VIP Prime 3 (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and ConnectiCare VIP Prime 3 (HMO) approves the exception, you will pay Tier 3 cost-sharing for that drug. **In-Network** $0 deductible.		Some drugs have quantity limits. Your provider must get prior authorization from ConnectiCare VIP Option 1 (HMO-POS) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and ConnectiCare VIP Option 1 (HMO-POS) approves the exception, you will pay Tier 3 cost-sharing for that drug. **In-Network** $0 deductible.	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)
PRESCRIPTION DRUGS			
29 Prescription Drugs		**Initial Coverage** After you pay your yearly deductible, you pay the following until total yearly drug costs reach $2,830: **Retail Pharmacy** Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $20 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – $20 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $10 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $30 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $20 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $80 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy	**Initial Coverage** You pay the following until total yearly drug costs reach $2,520: **Retail Pharmacy** Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $20 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – $20 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $10 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $30 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $20 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $80 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS			
Initial Coverage You pay the following until total yearly drug costs reach $2,830: **Retail Pharmacy** Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $20 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – $20 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $10 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $30 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $20 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $80 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy		**Initial Coverage** You pay the following until total yearly drug costs reach $2,830: **Retail Pharmacy** Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $20 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – $20 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $10 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $30 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $20 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $80 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 **Prescription Drugs**		**Retail Pharmacy** Tier 2 – $80 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $40 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $120 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $80 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $160 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – $160 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $80 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $240 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $160 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy	**Retail Pharmacy** Tier 2 – $80 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $40 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $120 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $80 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $160 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – $160 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $80 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $240 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $160 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy	**Retail Pharmacy** Tier 2 – $80 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $40 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $120 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $80 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $160 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – $160 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $80 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $240 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $160 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy		**Retail Pharmacy** Tier 2 – $80 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $40 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $120 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $80 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – $160 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – $160 copay for a 60-day supply of drugs in this tier from a preferred pharmacy – $80 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – $240 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – $160 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 Prescription Drugs		**Retail Pharmacy** Tier 4 – 25% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – 25% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy – 25% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – 25% coinsurance for a 60-day supply of drugs in this tier from a non-preferred pharmacy **Long Term Care Pharmacy** Tier 1 – $10 copay for a one-month (31-day) supply of drugs in this tier Tier 2 – $40 copay for a one-month (31-day) supply of drugs in this tier Tier 3 – $80 copay for a one-month (31-day) supply of drugs in this tier Tier 4 – 25% coinsurance for a one-month (31-day) supply of drugs in this tier	**Retail Pharmacy** Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – 33% coinsurance for a 60-day supply of drugs in this tier from a non-preferred pharmacy **Long Term Care Pharmacy** Tier 1 – $10 copay for a one-month (31-day) supply of drugs in this tier Tier 2 – $40 copay for a one-month (31-day) supply of drugs in this tier Tier 3 – $80 copay for a one-month (31-day) supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (31-day) supply of drugs in this tier	**Retail Pharmacy** Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – 33% coinsurance for a 60-day supply of drugs in this tier from a non-preferred pharmacy **Long Term Care Pharmacy** Tier 1 – $10 copay for a one-month (31-day) supply of drugs in this tier Tier 2 – $40 copay for a one-month (31-day) supply of drugs in this tier Tier 3 – $80 copay for a one-month (31-day) supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (31-day) supply of drugs in this tier		**Retail Pharmacy** Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy – 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy – 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy – 33% coinsurance for a 60-day supply of drugs in this tier from a non-preferred pharmacy **Long Term Care Pharmacy** Tier 1 – $10 copay for a one-month (31-day) supply of drugs in this tier Tier 2 – $40 copay for a one-month (31-day) supply of drugs in this tier Tier 3 – $80 copay for a one-month (31-day) supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (31-day) supply of drugs in this tier	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 Prescription Drugs		**Mail Order** Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier – $20 copay for a three-month (90-day) supply of drugs in this tier – $20 copay for a 60-day supply of drugs in this tier Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier – $80 copay for a three-month (90-day) supply of drugs in this tier – $80 copay for a 60-day supply of drugs in this tier Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier – $160 copay for a three-month (90-day) supply of drugs in this tier – $160 copay for a 60-day supply of drugs in this tier Tier 4 – 25% coinsurance for a one-month (30-day) supply of drugs in this tier – 25% coinsurance for a three-month (90-day) supply of drugs in this tier – 25% coinsurance for a 60-day supply of drugs in this tier	**Mail Order** Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier – $20 copay for a three-month (90-day) supply of drugs in this tier – $20 copay for a 60-day supply of drugs in this tier Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier – $80 copay for a three-month (90-day) supply of drugs in this tier – $80 copay for a 60-day supply of drugs in this tier Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier – $160 copay for a three-month (90-day) supply of drugs in this tier – $160 copay for a 60-day supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier – 33% coinsurance for a three-month (90-day) supply of drugs in this tier – 33% coinsurance for a 60-day supply of drugs in this tier	**Mail Order** Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier – $20 copay for a three-month (90-day) supply of drugs in this tier – $20 copay for a 60-day supply of drugs in this tier Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier – $80 copay for a three-month (90-day) supply of drugs in this tier – $80 copay for a 60-day supply of drugs in this tier Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier – $160 copay for a three-month (90-day) supply of drugs in this tier – $160 copay for a 60-day supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier – 33% coinsurance for a three-month (90-day) supply of drugs in this tier – 33% coinsurance for a 60-day supply of drugs in this tier		**Mail Order** Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier – $20 copay for a three-month (90-day) supply of drugs in this tier – $20 copay for a 60-day supply of drugs in this tier Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier – $80 copay for a three-month (90-day) supply of drugs in this tier – $80 copay for a 60-day supply of drugs in this tier Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier – $160 copay for a three-month (90-day) supply of drugs in this tier – $160 copay for a 60-day supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier – 33% coinsurance for a three-month (90-day) supply of drugs in this tier – 33% coinsurance for a 60-day supply of drugs in this tier	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)
PRESCRIPTION DRUGS			
29 **Prescription Drugs**		**Coverage Gap** After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	**Coverage Gap** After your total yearly drug costs reach $2,520, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS			
Coverage Gap The plan covers many generics (65%-99% of formulary generic drugs) through the coverage gap. You pay the following: **Retail Pharmacy** Tier 1 – $10 copay for a one-month (30-day) supply of all drugs covered in this tier from a preferred pharmacy – $20 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy – $20 copay for a 60-day supply of all drugs covered in this tier from a preferred pharmacy – $10 copay for a one-month (30-day) supply of all drugs covered in this tier from a non-preferred pharmacy – $30 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy – $20 copay for a 60-day supply of all drugs covered in this tier from a non-preferred pharmacy		**Coverage Gap** The plan covers many generics (65%-99% of formulary generic drugs) through the coverage gap. You pay the following: **Retail Pharmacy** Tier 1 – $10 copay for a one-month (30-day) supply of all drugs covered in this tier from a preferred pharmacy – $20 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy – $20 copay for a 60-day supply of all drugs covered in this tier from a preferred pharmacy – $10 copay for a one-month (30-day) supply of all drugs covered in this tier from a non-preferred pharmacy – $30 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy – $20 copay for a 60-day supply of all drugs covered in this tier from a non-preferred pharmacy	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 **Prescription Drugs**				**Long Term Care Pharmacy** Tier 1 – $10 copay for a one-month (31-day) supply of all drugs covered in this tier **Mail Order** Tier 1 – $10 copay for a one-month (30-day) supply of all drugs covered in this tier – $20 copay for a three-month (90-day) supply of all drugs covered in this tier – $20 copay for a 60-day supply of all drugs covered in this tier For all other covered drugs, after your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.		**Long Term Care Pharmacy** Tier 1 – $10 copay for a one-month (31-day) supply of all drugs covered in this tier **Mail Order** Tier 1 – $10 copay for a one-month (30-day) supply of all drugs covered in this tier – $20 copay for a three-month (90-day) supply of all drugs covered in this tier – $20 copay for a 60-day supply of all drugs covered in this tier For all other covered drugs, after your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 Prescription Drugs		**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or – 5% coinsurance. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from ConnectiCare VIP Prime 1 (HMO).	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or – 5% coinsurance. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from ConnectiCare VIP Prime 2 (HMO).	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or – 5% coinsurance. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from ConnectiCare VIP Prime 3 (HMO).		**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or – 5% coinsurance. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from ConnectiCare VIP Option 1 (HMO-POS).	

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)
PRESCRIPTION DRUGS			
29 Prescription Drugs		**Out-of-Network Initial Coverage** After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier Tier 4 – 25% coinsurance for a one-month (30-day) supply of drugs in this tier	**Out-of-Network Initial Coverage** You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,520: Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS			
Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier		**Out-of-Network Initial Coverage** You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: Tier 1 – $10 copay for a one-month (30-day) supply of drugs in this tier Tier 2 – $40 copay for a one-month (30-day) supply of drugs in this tier Tier 3 – $80 copay for a one-month (30-day) supply of drugs in this tier Tier 4 – 33% coinsurance for a one-month (30-day) supply of drugs in this tier	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 **Prescription Drugs**		**Out-of-Network Coverage Gap** After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by ConnectiCare VIP Prime 1 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to ConnectiCare VIP Prime 1 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	**Out-of-Network Coverage Gap** After your total yearly drug costs reach $2,520, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by ConnectiCare VIP Prime 2 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to ConnectiCare VIP Prime 2 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	**Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following: Tier 1 – $10 copay for a one-month (30-day) supply of all drugs covered in this tier Tier 2 – After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by ConnectiCare VIP Prime 3 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to ConnectiCare VIP Prime 3 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.		**Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following: Tier 1 – $10 copay for a one-month (30-day) supply of all drugs covered in this tier Tier 2 – After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by ConnectiCare VIP Option 1 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to ConnectiCare VIP Option 1 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)
PRESCRIPTION DRUGS			
29 Prescription Drugs			

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS			
Out-of-Network Coverage Gap Tier 3 – After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by ConnectiCare VIP Prime 3 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to ConnectiCare VIP Prime 3 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. Tier 4 – After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by ConnectiCare VIP Prime 3 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to ConnectiCare VIP Prime 3 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.		**Out-of-Network Coverage Gap** Tier 3 – After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by ConnectiCare VIP Option 1 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to ConnectiCare VIP Option 1 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. Tier 4 – After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by ConnectiCare VIP Option 1 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to ConnectiCare VIP Option 1 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
PRESCRIPTION DRUGS							
29 **Prescription Drugs**		**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: – A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or – 5% coinsurance.	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: – A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or – 5% coinsurance.	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: – A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or – 5% coinsurance.		**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: – A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or – 5% coinsurance.	

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)	ConnectiCare VIP Prime 2 (HMO)	ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 2 (HMO-POS)
30 **Dental Services**	Preventive dental services (such as cleaning) not covered.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $40 copay for Medicare-covered dental benefits.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $35 copay for Medicare-covered dental benefits.	**In-Network** $25 copay for Medicare-covered dental benefits. – $25 copay for up to 2 oral exam(s) every year – $25 copay for up to 2 cleaning(s) every year	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $30 copay for Medicare-covered dental benefits.	**In-Network** $25 copay for Medicare-covered dental benefits. – $25 copay for up to 2 oral exam(s) every year – $25 copay for up to 2 cleaning(s) every year	**In-Network** $25 copay for Medicare-covered dental benefits. – $25 copay for up to 2 oral exam(s) every year – $25 copay for up to 2 cleaning(s) every year
31 **Hearing Services**	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** Hearing aids not covered. – $40 copay for Medicare-covered diagnostic hearing exams – $40 copay for up to 1 routine hearing test(s) every year	**In-Network** Hearing aids not covered. – $35 copay for Medicare-covered diagnostic hearing exams – $35 copay for up to 1 routine hearing test(s) every year	**In-Network** Hearing aids not covered. – $25 copay for Medicare-covered diagnostic hearing exams – $25 copay for up to 1 routine hearing test(s) every year	**In-Network** Hearing aids not covered. – $30 copay for Medicare-covered diagnostic hearing exams – $30 copay for up to 1 routine hearing test(s) every year	**In-Network** Hearing aids not covered. – $25 copay for Medicare-covered diagnostic hearing exams – $25 copay for up to 1 routine hearing test(s) every year	**In-Network** Hearing aids not covered. – $25 copay for Medicare-covered diagnostic hearing exams – $25 copay for up to 1 routine hearing test(s) every year
32 **Vision Services**	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** $0 copay for – one pair of eyeglasses or contact lenses after cataract surgery – $40 copay for exams to diagnose and treat diseases and conditions of the eye. – $40 copay for up to 1 routine eye exam(s) every year	**In-Network** $0 copay for – one pair of eyeglasses or contact lenses after cataract surgery – $35 copay for exams to diagnose and treat diseases and conditions of the eye. – $35 copay for up to 1 routine eye exam(s) every year	**In-Network** $0 copay for – one pair of eyeglasses or contact lenses after cataract surgery – $25 copay for exams to diagnose and treat diseases and conditions of the eye. – $25 copay for up to 1 routine eye exam(s) every year	**In-Network** $0 copay for – one pair of eyeglasses or contact lenses after cataract surgery – $30 copay for exams to diagnose and treat diseases and conditions of the eye. – $30 copay for up to 1 routine eye exam(s) every year	**In-Network** $0 copay for – one pair of eyeglasses or contact lenses after cataract surgery – $25 copay for exams to diagnose and treat diseases and conditions of the eye. – $25 copay for up to 1 routine eye exam(s) every year	**In-Network** $0 copay for – one pair of eyeglasses or contact lenses after cataract surgery – $25 copay for exams to diagnose and treat diseases and conditions of the eye. – $25 copay for up to 1 routine eye exam(s) every year

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33 Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt inludes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	**In-Network** The plan covers the following health/wellness education benefits: – Written health education materials, including Newsletters – $0 copay for each Medicare-covered smoking cessation counseling session.	**In-Network** The plan covers the following health/wellness education benefits: – Written health education materials, including Newsletters – $0 copay for each Medicare-covered smoking cessation counseling session.	**In-Network** The plan covers the following health/wellness education benefits: – Written health education materials, including Newsletters – $0 copay for each Medicare-covered smoking cessation counseling session.	**In-Network** The plan covers the following health/wellness education benefits: – Written health education materials, including Newsletters – $0 copay for each Medicare-covered smoking cessation counseling session.	**In-Network** The plan covers the following health/wellness education benefits: – Written health education materials, including Newsletters – $0 copay for each Medicare-covered smoking cessation counseling session.	**In-Network** The plan covers the following health/wellness education benefits: – Written health education materials, including Newsletters – $0 copay for each Medicare-covered smoking cessation counseling session.
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover routine transportation.	**In-Network** This plan does not cover routine transportation.	**In-Network** This plan does not cover routine transportation.	**In-Network** This plan does not cover routine transportation.	**In-Network** This plan does not cover routine transportation.	**In-Network** This plan does not cover routine transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.

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Point of Service	You may go to any doctor, specialist or hospital that accepts Medicare.					**Out-of-Network** Point of Service coverage is available for the following benefits: – Inpatient Hospital Care – Doctor Office Visits – Chiropractic Services – Podiatry Services – Outpatient Services/Surgery – Ambulance Services – Outpatient Rehabilitation Services – Durable Medical Equipment – Prosthetic Devices – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services – Bone Mass Measurement – Colorectal Screening Exam – Immunizations – Mammograms (Annual Screenings) – Pap Smears and Pelvic Exams – Prostate Cancer Screening Exams – Hearing Services – Vision Services – Physical Exams – Comprehensive Outpatient Rehabilitation Facility (CORF) – Other Health Care Professional Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Cardiac Rehabilitation Services – Outpatient Blood	**Out-of-Network** Point of Service coverage is available for the following benefits: – Inpatient Hospital Care – Doctor Office Visits – Chiropractic Services – Podiatry Services – Outpatient Services/Surgery – Ambulance Services – Outpatient Rehabilitation Services – Durable Medical Equipment – Prosthetic Devices – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services – Bone Mass Measurement – Colorectal Screening Exam – Immunizations – Mammograms (Annual Screenings) – Pap Smears and Pelvic Exams – Prostate Cancer Screening Exams – Hearing Services – Vision Services – Physical Exams – Comprehensive Outpatient Rehabilitation Facility (CORF) – Other Health Care Professional Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Cardiac Rehabilitation Services – Outpatient Blood

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Point of Service						**Out-of-Network** $250,000 limit every year for the following POS Benefits: – Inpatient Hospital Care – Doctor Office Visits – Chiropractic Services – Podiatry Services – Outpatient Services/Surgery – Ambulance Services – Outpatient Rehabilitation Services – Durable Medical Equipment – Prosthetic Devices – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services – Bone Mass Measurement – Colorectal Screening Exam – Immunizations – Mammograms (Annual Screenings) – Pap Smears and Pelvic Exams – Prostate Cancer Screening Exams – Hearing Services – Vision Services – Physical Exams – Comprehensive Outpatient Rehabilitation Facility (CORF) – Other Health Care Professional Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Cardiac Rehabilitation Services – Outpatient Blood	**Out-of-Network** $250,000 limit every year for the following POS Benefits: – Inpatient Hospital Care – Doctor Office Visits – Chiropractic Services – Podiatry Services – Outpatient Services/Surgery – Ambulance Services – Outpatient Rehabilitation Services – Durable Medical Equipment – Prosthetic Devices – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services – Bone Mass Measurement – Colorectal Screening Exam – Immunizations – Mammograms (Annual Screenings) – Pap Smears and Pelvic Exams – Prostate Cancer Screening Exams – Hearing Services – Vision Services – Physical Exams – Comprehensive Outpatient Rehabilitation Facility (CORF) – Other Health Care Professional Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Cardiac Rehabilitation Services – Outpatient Blood

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Point of Service						**Out-of-Network** $200 copay per hospital stay. For hospital stays: Days 1 - 7: $200 copay per day Days 8 - 90: $0 copay per day $40 copay for – Doctor Office Visits – Chiropractic Services – Podiatry Services – Outpatient Rehabilitation Services – Hearing Services – Vision Services – CORF – Other Health Care Professional Services $100 copay for – Ambulance Services 20% of the cost for – Outpatient Services/Surgery – Durable Medical Equipment – Prosthetic Devices – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays	**Out-of-Network** $200 copay per hospital stay. For hospital stays: Days 1 - 7: $200 copay per day Days 8 - 90: $0 copay per day $40 copay for – Doctor Office Visits – Chiropractic Services – Podiatry Services – Outpatient Rehabilitation Services – Hearing Services – Vision Services – CORF – Other Health Care Professional Services $100 copay for – Ambulance Services 20% of the cost for – Outpatient Services/Surgery – Durable Medical Equipment – Prosthetic Devices – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays

ConnectiCare, Inc.

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