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ConnectiCare Employer Group Plan (HMO-POS)
2024 Cost Sharing Guide for Medicare Members

Deductible (The amount you pay before your plan starts to pay)	**$0**
Maximum Out-Of-Pocket (The most you will have to pay for services each year. This includes copays and deductibles. This does not include prescription drugs)	**Combined In-Network and Out-of-Network** **$5,000**

The information listed below and on the following pages is not a complete description of benefits. You can find the full list of benefits and plan rules in your Evidence of Coverage, available online at connecticare.com/medicare

Benefit	What You Pay	
Inpatient Hospital Coverage	**In-Network**	**Out-of-Network**
Inpatient Hospital - Acute	Days 1-5: **$300** / day **$0** / each additional day	Days 1-5: **$300** / day **$0** / each additional day
Inpatient Hospital – Mental Health Services (No limit in a general hospital; 190-day lifetime limit in a psychiatric facility)	Days 1-7: **$175** / day **$0** / each additional day	Days 1-7: **$175** / day **$0** / each additional day
Skilled Nursing Facility	Days 1-20: **$0** / day Days 21–54: **$150** / day Days 55–100: **$0** / day	Days 1-20: **$0** / day Days 21–54: **$150** / day Days 55–100: **$0** / day
Outpatient Hospital Coverage	**In-Network**	**Out-of-Network**
Outpatient Hospital Services (Includes surgery, observation, clinic)	**$200**	**$200**
Ambulatory Surgery Centers	**$200**	**$200**
Renal (Kidney) Dialysis	**20%** of the cost	**20%** of the cost
Doctor visits	**In-Network**	**Out-of-Network**
Primary Care Provider (PCP) (In office/telehealth)	**$15**	**$15** (telehealth – not covered)
Specialist (In office/telehealth)	**$40**	**$40** (telehealth – not covered)

ConnectiCare

Outpatient Services	In-Network	Out-of-Network
Preventive Services (Includes annual physical exam, screenings, and some Part B immunizations)	**Covered in full**	**Covered in full**
Emergency Care (Worldwide Coverage)	**$75**	**$75**
Urgently Needed Services	**$35**	**$35**
Diagnostic Services	**In-Network**	**Out-of-Network**
Diagnostic Procedures & Tests	**10%** of the cost	**10%** of the cost
Diagnostic Radiology (High-tech radiology including PET scans, MRIs, MRAs, CAT scans etc.)	**$175**	**$175**
Lab Services	**10%** of the cost	**10%** of the cost
Radiation Therapy	**20%** of the cost	**20%** of the cost
X-ray	**$35**	**$35**
Hearing Services	**In-Network**	**Out-of-Network**
Medicare-Covered Hearing Exam	**$35**	**$35**
Routine Hearing Exam	**$35**	**$35**
Hearing Aid	**Not covered**	**Not covered**
Vision Services	**In-Network**	**Out-of-Network**
Medicare-Covered Eye Exam	**$35**	**$35**
Routine Eye Exam	**$35**	**$35**
Routine Eyewear	**Not covered**	**Not covered**
Mental Health Services	**In-Network**	**Out-of-Network**
Mental Health & Substance Abuse (Individual session in-person/telehealth)	**$15**	**$15** (telehealth – not covered)
Opioid Treatment	**$15**	**$15**
Partial Hospitalization / Intensive Outpatient Services	**$15**	**$15**

ConnectiCare

Dental Services	In-Network	Out-of-Network
Preventive Dental Care	**Not covered**	
Comprehensive Dental Care	**Not covered**	
Rehabilitation Services	**In-Network**	**Out-of-Network**
Cardiac Rehabilitation (In office/telehealth)	**$0**	**$0** (telehealth – not covered)
Intensive Cardiac Rehabilitation	**$0**	**$0**
Occupational Therapy	**$35**	**$35**
Physical Therapy	**$35**	**$35**
Pulmonary Rehabilitation	**$0**	**$0**
Speech Therapy	**$35**	**$35**
Supervised Exercise Therapy (SET) (For symptomatic peripheral artery disease)	**$0**	**$0**
Transportation Services	**In-Network**	**Out-of-Network**
Ground Ambulance (Within USA/Worldwide)	**$200 / $75** (one-way)	**$200 / $75** (one-way)
Air Ambulance	**$200** (one-way)	**$200** (one-way)
Routine Transportation	**Not Covered**	**Not Covered**
Outpatient Services	In-Network	Out-of-Network
Acupuncture (For chronic lower back pain)	**$30**	**Not covered**
Chiropractic Services (Medicare-covered only)	**$20**	**$20**
Podiatry	**$35**	**$35**

ConnectiCare

Part B Drugs	In-Network	Out-of-Network
Medicare Part B drugs	**0% - 20%** of the cost ($35 one-month supply of insulin)	**0% - 20%** of the cost ($35 one-month supply of insulin)
Other Services and Supplies	**In-Network**	**Out-of-Network**
Diabetes Self-Monitoring & Training	**$0**	**$0**
Diabetic Supplies	**20%** of the cost	**20%** of the cost
Durable Medical Equipment and Prosthetics/Medical Supplies	**20%** of the cost	**20%** of the cost
Fitness benefit with SilverSneakers®*	**$0**	**Not covered**
Home Health Agency Care	**$0**	**$0**
Over-the-Counter (OTC) Health Items	**Not covered**	**Not covered**
Teladoc®** (Virtual visit to get care for non-urgent conditions)	**$0**	**Not covered**

*Benefit includes coverage outside of Connecticut, as long as the facility is in the SilverSneakers network. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved.

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Prescription Drug Coverage		
Initial Coverage Limit (ICL)		
You pay the following until your total yearly drug costs reach $5,030	**30-day supply Retail Pharmacy**	**90-day supply Mail order Pharmacy**
	What you pay	**What you pay**
Tier 1: Preferred Generic	**$5**	**$10**
Tier 2: Generic	**$15**	**$30**
Tier 3: Preferred Brand	**$45** **$35** insulins	**$90**
Tier 4: Non-Preferred Drug	**$100**	**$200**
Tier 5: Specialty Tier*	**33%** of the cost	Not available in long-term supply
Tier 6: Select Care Drugs	**$0**	**$0**
Coverage Gap		
You pay the following once your total yearly drug costs exceed $5,030	**30-day supply Retail Pharmacy**	**90-day supply Mail order Pharmacy**
	What you pay	**What you pay**
Tier 1: Preferred Generic	**$5**	**$10**
Tier 2: Generic	**$15**	**$30**
Tier 3: Preferred Brand	**25%** of the cost **$35** insulins	**25%** of the cost **$105** insulins
Tier 4: Non-Preferred Drug	**25%** of the cost	**25%** of the cost
Tier 5: Specialty Tier*	**25%** of the cost	Not available in long-term supply
Tier 6: Select Care Drugs	**$0**	**$0**

*Tier 5: Specialty Drugs (brand and generic) are available only for 30-day supply

Catastrophic Coverage	
You pay the following once your true yearly out-of-pocket drug costs exceed $8,000	**Retail Pharmacy and Mail Order What you pay**
All Covered Drugs	**$0**

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IMPORTANT INFORMATION

All services covered in this Cost Sharing Guide are subject to medical necessity review. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. In the event of a discrepancy between the information contained in the guide and the provisions of your 2024 Medicare EOC, the specific provisions of the EOC shall prevail over the cost-sharing guide.

Please note that prior authorization is required before you receive certain covered services.

This information is not a complete description of benefits. Call ***800-224-2273 (TTY: 711)*** *for more information. If you have questions, or want to request a copy of the EOC, call Member Services at* ***800-224-2273 (TTY: 711)****. Our hours are 8 a.m. to 8 p.m., seven days a week, October 1 to March 31, and 8 a.m. to 8 p.m., Monday through Saturday, April 1 to September 30. Or visit us at* ***connecticare.com/medicare.***