

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

Summary of Benefits 2012

Connecticut – Effective January 1, 2012

ConnectiCare[®]
VIP Medicare Plans

SECTION I – INTRODUCTION TO 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: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, 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 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. For an updated 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 3 (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. For an updated list, visit us at www.connecticare.com. Our customer service number is listed at the end of this introduction.

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 10/15 – 2/14, 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 a Medicare contract. The availability of coverage beyond the current contract year (2012) is not guaranteed. Benefits, formulary, pharmacy network, premiums and/or co-payments/co-insurance may change on January 1, 2013. 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 10/15 – 2/14, 8:00 a.m. – 8:00 p.m., seven days a week.

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 SUMMARY OF BENEFITS

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

For ConnectiCare VIP Prime 1 (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 except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

For ConnectiCare VIP Option 1 (HMO-POS) and Option 3 (HMO-POS) Plans:

Generally, you are restricted to a doctor who is part of your network. However, we will cover your care from any provider for emergency or urgently needed care. Also, our point of service benefit allows you to get care from providers not in your network under certain conditions. For more information, please call the customer service number listed at the end of this introduction.

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

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

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

ConnectiCare VIP Prime 4 (HMO) does cover Medicare Part B prescription drugs. ConnectiCare VIP Prime 4 (HMO) does **NOT** cover Medicare Part D 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 OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare 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 and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- *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 calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of ConnectiCare VIP Prime 1 (HMO), Prime 3 (HMO), Option 1 (HMO-POS), and Option 3 (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. Please refer to the Evidence of Coverage (EOC)

SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS

for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we 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.

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 administered through DME.

WHERE CAN I FIND INFORMATION ON 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 "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

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. (TTY/TDD (800)-842-9710)

Prospective members should call toll-free (877)-224-8220 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-842-9710)

Current members should call locally (800)-224-2273 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-842-9710)

Prospective members should call locally (877)-224-8220 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-842-9710)

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

Current members should call locally (800)-224-2273 for questions related to 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 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.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

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)
IMPORTANT INFORMATION		
<p>1 Premium and Other Important Information</p>	<p>In 2011 the monthly Part B Premium was \$96.40 and may change for 2012 and the annual Part B deductible amount was \$162 and may change for 2012.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$5,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
IMPORTANT INFORMATION			
<p>General \$119 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$3,400 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$5,500 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>	<p>General \$179 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$5,500 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p> <p>In and Out-of-Network \$5,500 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network \$6,700 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p> <p>In and Out-of-Network \$6,700 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
IMPORTANT INFORMATION		
<p>2 Doctor and Hospital Choice</p> <p>(For more information, see Emergency Care – #15 and Urgently Needed Care –#16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p>
SUMMARY OF BENEFITS		
INPATIENT CARE		
<p>3 Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2011 the amounts for each benefit period were:</p> <p>Days 1 – 60: \$1132 deductible</p> <p>Days 61 – 90: \$283 per day</p> <p>Days 91 – 150: \$566 per lifetime reserve day</p> <p>These amounts may change for 2012.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$250 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
IMPORTANT INFORMATION			
<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p>
SUMMARY OF BENEFITS			
INPATIENT CARE			
<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$200 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$200 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$200 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$250 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
INPATIENT CARE		
<p>4 Inpatient Mental Health Care</p>	<p>In 2011 the amounts for each benefit period were:</p> <p>Days 1 – 60: \$1132 deductible</p> <p>Days 61 – 90: \$283 per day</p> <p>Days 91 – 150: \$566 per lifetime reserve day</p> <p>These amounts may change for 2012.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$200 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
INPATIENT CARE			
<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$200 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$200 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$200 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 – 7: \$200 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
INPATIENT CARE		
<p>5 Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1 – 20: \$0 per day</p> <p>Days 21 – 100: \$141.50 per day</p> <p>These amounts may change for 2012.</p> <p>100 days for each benefit period.</p> <p>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.</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays:</p> <p>Days 1 – 20: \$50 copay per day</p> <p>Days 21 – 100: \$100 copay per day</p>
<p>6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p>
<p>7 Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
INPATIENT CARE			
<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays:</p> <p>Days 1 – 20: \$50 copay per day</p> <p>Days 21 – 100: \$100 copay per day</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays:</p> <p>Days 1 – 20: \$50 copay per day</p> <p>Days 21 – 100: \$100 copay per day</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays:</p> <p>Days 1 – 20: \$50 copay per day</p> <p>Days 21 – 100: \$100 copay per day</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays:</p> <p>Days 1 – 20: \$50 copay per day</p> <p>Days 21 – 100: \$100 copay per day</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p>
<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
OUTPATIENT CARE		
<p>8 Doctor Office Visits</p>	<p>20% coinsurance</p>	<p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$30 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$30 copay for each specialist visit for Medicare-covered benefits.</p>
<p>9 Chiropractic Services</p>	<p>Supplemental routine care not covered</p> <p>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.</p>	<p>In-Network \$20 copay for each Medicare-covered visit</p> <p>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.</p>
<p>10 Podiatry Services</p>	<p>Supplemental routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network \$30 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
OUTPATIENT CARE			
<p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p>	<p>In-Network \$20 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$30 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$30 copay for each specialist visit for Medicare-covered benefits.</p>	<p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p>	<p>In-Network \$25 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$40 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$40 copay for each specialist visit for Medicare-covered benefits.</p>
<p>In-Network \$20 copay for each Medicare-covered visit</p> <p>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.</p>	<p>In-Network \$20 copay for each Medicare-covered visit</p> <p>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.</p>	<p>In-Network \$20 copay for each Medicare-covered visit</p> <p>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.</p>	<p>In-Network \$20 copay for each Medicare-covered visit</p> <p>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.</p>
<p>In-Network \$25 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$30 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$25 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$40 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
OUTPATIENT CARE		
<p>11 Outpatient Mental Health Care</p>	<p>40% coinsurance for most outpatient mental health services</p> <p>Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual therapy visit</p> <p>\$30 copay for each Medicare-covered group therapy visit</p> <p>\$30 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$30 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$30 for Medicare-covered partial hospitalization program services</p>
<p>12 Outpatient Substance Abuse Care</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual visits</p> <p>\$30 copay for Medicare-covered group visits</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
OUTPATIENT CARE			
<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual therapy visit</p> <p>\$25 copay for each Medicare-covered group therapy visit</p> <p>\$25 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$25 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$25 for Medicare-covered partial hospitalization program services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual therapy visit</p> <p>\$30 copay for each Medicare-covered group therapy visit</p> <p>\$30 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$30 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$30 for Medicare-covered partial hospitalization program services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual therapy visit</p> <p>\$25 copay for each Medicare-covered group therapy visit</p> <p>\$25 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$25 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$25 for Medicare-covered partial hospitalization program services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for each Medicare-covered individual therapy visit</p> <p>\$40 copay for each Medicare-covered group therapy visit</p> <p>\$40 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$40 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$40 for Medicare-covered partial hospitalization program services</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered individual visits</p> <p>\$25 copay for Medicare-covered group visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual visits</p> <p>\$30 copay for Medicare-covered group visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered individual visits</p> <p>\$25 copay for Medicare-covered group visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for Medicare-covered individual visits</p> <p>\$40 copay for Medicare-covered group visits</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
OUTPATIENT CARE		
<p>13 Outpatient Services/Surgery</p>	<p>20% coinsurance for the doctor’s services</p> <p>Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$175 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$0 to \$175 copay for each Medicare-covered outpatient hospital facility visit</p>
<p>14 Ambulance Services</p> <p>(medically necessary ambulance services)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$175 copay for Medicare-covered ambulance benefits.</p>
<p>15 Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor’s services</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>You don’t have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>\$50,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
OUTPATIENT CARE			
<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$125 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$0 to \$125 copay for each Medicare-covered outpatient hospital facility visit</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$125 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$0 to \$125 copay for each Medicare-covered outpatient hospital facility visit</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$125 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$0 to \$125 copay for each Medicare-covered outpatient hospital facility visit</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$225 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$0 to \$225 copay for each Medicare-covered outpatient hospital facility visit</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$175 copay for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$175 copay for Medicare-covered ambulance benefits.</p>
<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>\$50,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>\$50,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>\$50,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>\$50,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
OUTPATIENT CARE		
<p>16 Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$30 copay for Medicare-covered urgently-needed-care visits</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed-care visit.</p>
<p>17 Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p>In-Network \$30 copay for Medicare-covered Occupational Therapy visits</p> <p>\$30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p>
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
<p>18 Durable Medical Equipment</p> <p>(includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>
<p>19 Prosthetic Devices</p> <p>(includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
OUTPATIENT CARE			
<p>General \$25 copay for Medicare-covered urgently-needed-care visits</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed-care visit.</p>	<p>General \$30 copay for Medicare-covered urgently-needed-care visits</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed-care visit.</p>	<p>General \$40 copay for Medicare-covered urgently-needed-care visits</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed-care visit.</p>	<p>General \$40 copay for Medicare-covered urgently-needed-care visits</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the urgently-needed-care visit.</p>
<p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits</p> <p>\$25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p>	<p>In-Network \$30 copay for Medicare-covered Occupational Therapy visits</p> <p>\$30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p>	<p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits</p> <p>\$25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p>	<p>In-Network \$40 copay for Medicare-covered Occupational Therapy visits</p> <p>\$40 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p>
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>
<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
<p>20 Diabetes Programs and Supplies</p>	<p>20% coinsurance for diabetes self-management training</p> <p>20% coinsurance for diabetes supplies</p> <p>20% coinsurance for diabetic therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p>
<p>21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>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 supplemental routine screening tests, like checking your cholesterol.</p> <p>20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: – lab services – diagnostic procedures and tests</p> <p>\$35 copay for Medicare-covered X-rays</p> <p>\$200 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>20% of the cost for Medicare-covered therapeutic radiology services</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: – lab services – diagnostic procedures and tests</p> <p>\$35 copay for Medicare-covered X-rays</p> <p>\$150 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>20% of the cost for Medicare-covered therapeutic radiology services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: – lab services – diagnostic procedures and tests</p> <p>\$30 copay for Medicare-covered X-rays</p> <p>\$175 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>\$30 copay for Medicare-covered therapeutic radiology services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: – lab services – diagnostic procedures and tests</p> <p>\$35 copay for Medicare-covered X-rays</p> <p>\$150 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>20% of the cost for Medicare-covered therapeutic radiology services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: – lab services – diagnostic procedures and tests</p> <p>\$35 copay for Medicare-covered X-rays</p> <p>\$200 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>20% of the cost for Medicare-covered therapeutic radiology services</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
<p>22 Cardiac and Pulmonary Rehabilitation Services</p>	<p>20% coinsurance Cardiac Rehabilitation services</p> <p>20% coinsurance for Pulmonary Rehabilitation services</p> <p>20% coinsurance for Intensive Cardiac Rehabilitation services</p> <p>This applies to program services provided in a doctor’s office. Specified cost sharing for program services provided by hospital outpatient departments.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for: – Medicare-covered Cardiac Rehabilitation Services – Medicare-covered Intensive Cardiac Rehabilitation Services – Medicare-covered Pulmonary Rehabilitation Services</p>
PREVENTIVE SERVICES		
<p>23 Preventive Services and Wellness/Education Programs</p>	<p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm Screening – Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. – Cardiovascular Screening – Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine for people with Medicare who are at risk – HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare approved amount for the doctor’s visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. – Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm screening – Bone Mass Measurement – Cardiovascular Screening – Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine – HIV Screening – Breast Cancer Screening (Mammogram) – Medical Nutrition Therapy Services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for: – Medicare-covered Cardiac Rehabilitation Services – Medicare-covered Intensive Cardiac Rehabilitation Services – Medicare-covered Pulmonary Rehabilitation Services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for: – Medicare-covered Cardiac Rehabilitation Services – Medicare-covered Intensive Cardiac Rehabilitation Services – Medicare-covered Pulmonary Rehabilitation Services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for: – Medicare-covered Cardiac Rehabilitation Services – Medicare-covered Intensive Cardiac Rehabilitation Services – Medicare-covered Pulmonary Rehabilitation Services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for: – Medicare-covered Cardiac Rehabilitation Services – Medicare-covered Intensive Cardiac Rehabilitation Services – Medicare-covered Pulmonary Rehabilitation Services</p>
PREVENTIVE SERVICES			
<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm screening – Bone Mass Measurement – Cardiovascular Screening – Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine – HIV Screening – Breast Cancer Screening (Mammogram) – Medical Nutrition Therapy Services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm screening – Bone Mass Measurement – Cardiovascular Screening – Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine – HIV Screening – Breast Cancer Screening (Mammogram) – Medical Nutrition Therapy Services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm screening – Bone Mass Measurement – Cardiovascular Screening – Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine – HIV Screening – Breast Cancer Screening (Mammogram) – Medical Nutrition Therapy Services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> – Abdominal Aortic Aneurysm screening – Bone Mass Measurement – Cardiovascular Screening – Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) – Colorectal Cancer Screening – Diabetes Screening – Influenza Vaccine – Hepatitis B Vaccine – HIV Screening – Breast Cancer Screening (Mammogram) – Medical Nutrition Therapy Services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
PREVENTIVE SERVICES		
<p>23 Preventive Services and Wellness/Education Programs</p>	<ul style="list-style-type: none"> – Medical Nutrition Therapy Services. 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 and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. – Prostate Cancer Screening. Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. – Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. – Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 	<p>General</p> <ul style="list-style-type: none"> – Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) – Smoking Cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including Newsletters
<p>24 Kidney Disease and Conditions</p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for kidney disease education services</p>	<p>In-Network 20% of the cost for renal dialysis</p> <p>\$0 copay for kidney disease education services</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
PREVENTIVE SERVICES			
<p>General</p> <ul style="list-style-type: none"> – Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) – Smoking Cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including Newsletters 	<p>General</p> <ul style="list-style-type: none"> – Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) – Smoking Cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including Newsletters 	<p>General</p> <ul style="list-style-type: none"> – Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) – Smoking Cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including Newsletters 	<p>General</p> <ul style="list-style-type: none"> – Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) – Smoking Cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including Newsletters
<p>In-Network 20% of the cost for renal dialysis</p> <p>\$0 copay for kidney disease education services</p>	<p>In-Network 20% of the cost for renal dialysis</p> <p>\$0 copay for kidney disease education services</p>	<p>In-Network 20% of the cost for renal dialysis</p> <p>\$0 copay for kidney disease education services</p>	<p>In-Network 20% of the cost for renal dialysis</p> <p>\$0 copay for kidney disease education services</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>	<p>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.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Drugs covered under Medicare Part B</p> <p>General 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p>	<p>Drugs covered under Medicare Part B</p> <p>General Most drugs not covered. 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs covered under Medicare Part D</p> <p>General This plan does not offer prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from ConnectiCare VIP Prime 1 (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>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.</p> <p>If you request a formulary exception for a drug and ConnectiCare VIP Prime 1 (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from ConnectiCare VIP Prime 3 (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>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.</p> <p>If you request a formulary exception for a drug and ConnectiCare VIP Prime 3 (HMO) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.</p>		<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from ConnectiCare VIP Option 1 (HMO-POS) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>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.</p> <p>If you request a formulary exception for a drug and ConnectiCare VIP Option 1 (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.</p>	<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from ConnectiCare VIP Option 3 (HMO-POS) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>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.</p> <p>If you request a formulary exception for a drug and ConnectiCare VIP Option 3 (HMO-POS) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>In-Network \$150 deductible on all drugs except Tier 1: Generic Drugs.</p> <p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> – \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> – \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>		<p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> – \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	<p>In-Network \$150 deductible on all drugs except Tier 1: Generic Drugs.</p> <p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> – \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$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 - \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$80 copay for a one-month (30-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 3 (HMO-POS)
<p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$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 - \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$80 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy 		<p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$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 - \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$80 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy 	<p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$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 - \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$80 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 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

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 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 		<p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 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 	<p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 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

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$80 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (31-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 3 (HMO-POS)
<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 33% coinsurance for a three-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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$80 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier 		<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 33% coinsurance for a three-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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$80 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier 	<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$80 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 25% coinsurance for a one-month (31-day) supply of drugs in this tier

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Mail Order Tier 1: Generic Drugs – \$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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs – \$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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs – \$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</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Mail Order Tier 1: Generic Drugs – \$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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs – \$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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs – \$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</p>		<p>Mail Order Tier 1: Generic Drugs – \$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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs – \$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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs – \$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</p>	<p>Mail Order Tier 1: Generic Drugs – \$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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs – \$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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs – \$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</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Tier 3: Non-Preferred Brand Drugs – \$160 copay for a 60-day supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs – 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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Coverage Gap After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan’s costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Tier 3: Non-Preferred Brand Drugs – \$160 copay for a 60-day supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs – 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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Additional Coverage Gap You pay the following:</p> <p>Retail Pharmacy Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of all drugs covered in this tier from a preferred pharmacy</p>		<p>Tier 3: Non-Preferred Brand Drugs – \$160 copay for a 60-day supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs – 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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Additional Coverage Gap You pay the following:</p> <p>Retail Pharmacy Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of all drugs covered in this tier from a preferred pharmacy</p>	<p>Tier 3: Non-Preferred Brand Drugs – \$160 copay for a 60-day supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs – 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</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Coverage Gap After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan’s costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Tier 1: Generic Drugs – \$20 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy</p> <p>– \$20 copay for a 60-day supply of all drugs covered in this tier from a preferred pharmacy</p> <p>– \$10 copay for a one-month (30-day) supply of all drugs covered in this tier at a non-preferred pharmacy</p> <p>– \$30 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy</p> <p>– \$20 copay for a 60-day supply of all drugs covered in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Tier 1: Generic Drugs – \$10 copay for a one-month (31-day) supply of all drugs covered in this tier</p>		<p>Tier 1: Generic Drugs – \$20 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy</p> <p>– \$20 copay for a 60-day supply of all drugs covered in this tier from a preferred pharmacy</p> <p>– \$10 copay for a one-month (30-day) supply of all drugs covered in this tier at a non-preferred pharmacy</p> <p>– \$30 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy</p> <p>– \$20 copay for a 60-day supply of all drugs covered in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Tier 1: Generic Drugs – \$10 copay for a one-month (31-day) supply of all drugs covered in this tier</p>	

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Mail Order Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of all drugs covered in this tier</p> <p>– \$20 copay for a three-month (90-day) supply of all drugs covered in this tier</p> <p>– \$20 copay for a 60-day supply of all drugs covered in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>After your total yearly drug costs reach \$2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan’s costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. 		<p>Mail Order Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of all drugs covered in this tier</p> <p>– \$20 copay for a three-month (90-day) supply of all drugs covered in this tier</p> <p>– \$20 copay for a 60-day supply of all drugs covered in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>After your total yearly drug costs reach \$2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan’s costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. 	<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>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).</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the plan’s cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach \$2,930:</p> <p>Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs – \$40 copay for a one-month (30-day) supply of drugs in this tier</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>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).</p> <p>Out-of-Network Initial Coverage You will be reimbursed up to the plan’s cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p>Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs – \$40 copay for a one-month (30-day) supply of drugs in this tier</p>		<p>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).</p> <p>Out-of-Network Initial Coverage You will be reimbursed up to the plan’s cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p>Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs – \$40 copay for a one-month (30-day) supply of drugs in this tier</p>	<p>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 3 (HMO-POS).</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the plan’s cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach \$2,930:</p> <p>Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs – \$40 copay for a one-month (30-day) supply of drugs in this tier</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Tier 3: Non-Preferred Brand Drugs – \$80 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs – 25% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Tier 3: Non-Preferred Brand Drugs – \$80 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs – 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p>		<p>Tier 3: Non-Preferred Brand Drugs – \$80 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs – 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p>	<p>Tier 3: Non-Preferred Brand Drugs – \$80 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs – 25% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Out-of-Network Coverage Gap You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Additional Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:</p> <p>Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of all drugs covered in this tier</p> <p>Tier 2: Preferred Brand Drugs You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p>		<p>Additional Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:</p> <p>Tier 1: Generic Drugs – \$10 copay for a one-month (30-day) supply of all drugs covered in this tier</p> <p>Tier 2: Preferred Brand Drugs You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p>	<p>Out-of-Network Coverage Gap You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Tier 3: Non-Preferred Brand Drugs</p> <p>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Tier 4: Specialty Tier Drugs</p> <p>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>		<p>Tier 3: Non-Preferred Brand Drugs</p> <p>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Tier 4: Specialty Tier Drugs</p> <p>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>25 Outpatient Prescription Drugs</p>		<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan’s cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> – 5% coinsurance, or – \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan’s cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> – 5% coinsurance, or – \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p>		<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan’s cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> – 5% coinsurance, or – \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p>	<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan’s cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> – 5% coinsurance, or – \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan’s In-Network allowable amount.</p>

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>26 Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see “Optional Benefits.”)</p> <p>\$30 copay for Medicare-covered dental benefits</p>
<p>27 Hearing Services</p>	<p>Supplemental routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> – \$30 copay for Medicare-covered diagnostic hearing exams – \$30 copay for up to 1 supplemental routine hearing exam(s) every year
<p>28 Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Supplemental routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> – one pair of eyeglasses or contact lenses after cataract surgery – \$0 to 30 copay for exams to diagnose and treat diseases and conditions of the eye. – \$0 to \$30 copay for up to 1 supplemental routine eye exam(s) every year

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see “Optional Benefits.”)</p> <p>\$25 copay for Medicare-covered dental benefits</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see “Optional Benefits.”)</p> <p>\$30 copay for Medicare-covered dental benefits</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see “Optional Benefits.”)</p> <p>\$25 copay for Medicare-covered dental benefits</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see “Optional Benefits.”)</p> <p>\$40 copay for Medicare-covered dental benefits</p>
<p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> – \$25 copay for Medicare-covered diagnostic hearing exams – \$25 copay for up to 1 supplemental routine hearing exam(s) every year 	<p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> – \$30 copay for Medicare-covered diagnostic hearing exams – \$30 copay for up to 1 supplemental routine hearing exam(s) every year 	<p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> – \$25 copay for Medicare-covered diagnostic hearing exams – \$25 copay for up to 1 supplemental routine hearing exam(s) every year 	<p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> – \$40 copay for Medicare-covered diagnostic hearing exams – \$40 copay for up to 1 supplemental routine hearing exam(s) every year
<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> – one pair of eyeglasses or contact lenses after cataract surgery – \$0 to \$25 copay for exams to diagnose and treat diseases and conditions of the eye. – \$0 to \$25 copay for up to 1 supplemental routine eye exam(s) every year 	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> – one pair of eyeglasses or contact lenses after cataract surgery – \$0 to \$30 copay for exams to diagnose and treat diseases and conditions of the eye. – \$0 to \$30 copay for up to 1 supplemental routine eye exam(s) every year 	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> – one pair of eyeglasses or contact lenses after cataract surgery – \$0 to \$25 copay for exams to diagnose and treat diseases and conditions of the eye. – \$0 to \$25 copay for up to 1 supplemental routine eye exam(s) every year 	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> – one pair of eyeglasses or contact lenses after cataract surgery – \$0 to \$40 copay for exams to diagnose and treat diseases and conditions of the eye. – \$0 to \$40 copay for up to 1 supplemental routine eye exam(s) every year

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
Over-the-Counter Items	Not covered.	General The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	In-Network This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
General The plan does not cover Over-the-Counter items.	General The plan does not cover Over-the-Counter items.	General The plan does not cover Over-the-Counter items.	General The plan does not cover Over-the-Counter items.
In-Network This plan does not cover supplemental routine transportation.	In-Network This plan does not cover supplemental routine transportation.	In-Network This plan does not cover supplemental routine transportation.	In-Network This plan does not cover supplemental routine transportation.
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.

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>Point of Service</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
		<p>Out-of-Network Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> – Inpatient Hospital Acute – Cardiac Rehabilitation Services – Intensive Cardiac Rehabilitation Services – Pulmonary Rehabilitation Services – Primary Care Physician Services – Chiropractic Services – Occupational Therapy Services – Physician Specialist Services – Podiatry Services – Other Health Care Professional – Physical Therapy and Speech-Language Pathology Services – Outpatient Diagnostic Procedures/Tests/Lab Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Outpatient Hospital Services – Ambulatory Surgical Center (ASC) Services – Outpatient Blood Services – Ambulance Services – Durable Medical Equipment (DME) – Prosthetics/Medical Supplies – Medicare-covered Preventive Services 	<p>Out-of-Network Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> – Inpatient Hospital Acute – Cardiac Rehabilitation Services – Intensive Cardiac Rehabilitation Services – Pulmonary Rehabilitation Services – Primary Care Physician Services – Chiropractic Services – Occupational Therapy Services – Physician Specialist Services – Podiatry Services – Other Health Care Professional – Physical Therapy and Speech-Language Pathology Services – Outpatient Diagnostic Procedures/Tests/Lab Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Outpatient Hospital Services – Ambulatory Surgical Center (ASC) Services – Outpatient Blood Services – Ambulance Services – Durable Medical Equipment (DME) – Prosthetics/Medical Supplies – Medicare-covered Preventive Services

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>Point of Service</p>		

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
		<ul style="list-style-type: none"> – Supplemental Preventive Health Services – Eye Exams – Hearing Exams <p>\$5,500 out-of-pocket limit every year for POS benefits</p> <p>\$250,000 plan coverage limit every year for the following POS Benefits:</p> <ul style="list-style-type: none"> – Inpatient Hospital Acute – Cardiac Rehabilitation Services – Intensive Cardiac Rehabilitation Services – Pulmonary Rehabilitation Services – Primary Care Physician Services – Chiropractic Services – Occupational Therapy Services – Physician Specialist Services – Podiatry Services – Other Health Care Professional – Physical Therapy and Speech-Language Pathology Services – Outpatient Diagnostic Procedures/ Tests/Lab Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Outpatient Hospital Services – Ambulatory Surgical Center (ASC) Services – Outpatient Blood Services 	<ul style="list-style-type: none"> – Supplemental Preventive Health Services – Eye Exams – Hearing Exams <p>\$6,700 out-of-pocket limit every year for POS benefits</p> <p>\$250,000 plan coverage limit every year for the following POS Benefits:</p> <ul style="list-style-type: none"> – Inpatient Hospital Acute – Cardiac Rehabilitation Services – Intensive Cardiac Rehabilitation Services – Pulmonary Rehabilitation Services – Primary Care Physician Services – Chiropractic Services – Occupational Therapy Services – Physician Specialist Services – Podiatry Services – Other Health Care Professional – Physical Therapy and Speech-Language Pathology Services – Outpatient Diagnostic Procedures/ Tests/Lab Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Outpatient Hospital Services – Ambulatory Surgical Center (ASC) Services – Outpatient Blood Services

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>Point of Service</p>		

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
		<ul style="list-style-type: none"> - Ambulance Services - Durable Medical Equipment(DME) - Prosthetics/Medical Supplies - Medicare-covered Preventive Services - Supplemental Preventive Health Services - Eye Exams - Hearing Exams <p>For hospital stays: Days 1 – 7: \$300 copay per day</p> <p>Days 8 – 90: \$0 copay per day</p> <p>\$40 copay for</p> <ul style="list-style-type: none"> - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Other Health Care Professional - Physical Therapy and Speech-Language Pathology Services - Eye Exams - Hearing Exams 	<ul style="list-style-type: none"> - Ambulance Services - Durable Medical Equipment (DME) - Prosthetics/Medical Supplies - Medicare-covered Preventive Services - Supplemental Preventive Health Services - Eye Exams - Hearing Exams <p>20% of the cost per hospital day.</p> <p>20% of the cost for</p> <ul style="list-style-type: none"> - Primary Care Physician Services - Chiropractic Services - Occupational Therapy Services - Physician Specialist Services - Podiatry Services - Other Health Care Professional - Physical Therapy and Speech-Language Pathology Services - Outpatient Diagnostic Procedures/Tests/Lab Services - Diagnostic Radiological Services - Therapeutic Radiological Services - Outpatient X-Rays - Outpatient Hospital Services

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
<p>Point of Service</p>		

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
		<p>20% of the cost for</p> <ul style="list-style-type: none"> – Outpatient Diagnostic Procedures/Tests/Lab Services – Diagnostic Radiological Services – Therapeutic Radiological Services – Outpatient X-Rays – Outpatient Hospital Services – Ambulatory Surgical Center (ASC) Services – Durable Medical Equipment (DME) – Prosthetics/Medical Supplies <p>\$0 copay for</p> <ul style="list-style-type: none"> – Cardiac Rehabilitation Services – Intensive Cardiac Rehabilitation Services – Pulmonary Rehabilitation Services – Outpatient Blood Services – Medicare-covered Preventive Services – Supplemental Preventive Health Services <p>\$150 copay for</p> <ul style="list-style-type: none"> – Ambulance Services 	<ul style="list-style-type: none"> – Ambulatory Surgical Center (ASC) Services – Ambulance Services – Durable Medical Equipment (DME) – Prosthetics/Medical Supplies – Eye Exams – Hearing Exams <p>\$0 copay for</p> <ul style="list-style-type: none"> – Cardiac Rehabilitation Services – Intensive Cardiac Rehabilitation Services – Pulmonary Rehabilitation Services – Outpatient Blood Services – Medicare-covered Preventive Services – Supplemental Preventive Health Services

SECTION II – SUMMARY OF BENEFITS

Benefit	Original Medicare	ConnectiCare VIP Prime 1 (HMO)
OPTIONAL SUPPLEMENTAL PACKAGE #1		
<p>Premium and Other Important Information</p>		<p>General Package 1 – Dental:</p> <p>\$28 monthly premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> – Preventive Dental – Comprehensive Dental <p>\$1,000 plan coverage limit every year for these benefits.</p>
<p>Dental Services</p>		<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network \$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 1 dental x-ray(s) <p>\$1,000 plan coverage limit for dental benefits every year</p>

ConnectiCare VIP Prime 3 (HMO)	ConnectiCare VIP Prime 4 (HMO)	ConnectiCare VIP Option 1 (HMO-POS)	ConnectiCare VIP Option 3 (HMO-POS)
OPTIONAL SUPPLEMENTAL PACKAGE #1			
<p>General Package 1 – Dental:</p> <p>\$28 monthly premium, in addition to your \$119 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> – Preventive Dental – Comprehensive Dental <p>\$1,000 plan coverage limit every year for these benefits.</p>	<p>General Package 1 – Dental:</p> <p>\$28 monthly premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> – Preventive Dental – Comprehensive Dental <p>\$1,000 plan coverage limit every year for these benefits.</p>	<p>General Package 1 – Dental:</p> <p>\$28 monthly premium, in addition to your \$179 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> – Preventive Dental – Comprehensive Dental <p>\$1,000 plan coverage limit every year for these benefits.</p>	<p>General Package 1 – Dental:</p> <p>28 month premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> – Preventive Dental – Comprehensive Dental <p>\$1,000 plan coverage limit every year for these benefits.</p>
<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network \$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 1 dental x-ray(s) <p>\$1,000 plan coverage limit for dental benefits every year</p>	<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network \$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 1 dental x-ray(s) <p>\$1,000 plan coverage limit for dental benefits every year</p>	<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network \$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 1 dental x-ray(s) <p>\$1,000 plan coverage limit for dental benefits every year</p>	<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network \$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 1 dental x-ray(s) <p>\$1,000 plan coverage limit for dental benefits every year</p>

