ConnectiCare

ConnectiCare Flex Plan 3 (HMO-POS) offered by ConnectiCare, Inc.

Annual Notice of Changes for 2025

You are currently enrolled as a member of ConnectiCare Flex Plan 3 (HMO-POS). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at **connecticare.com/medicare**. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in ConnectiCare Flex Plan 3 (HMO-POS).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with ConnectiCare Flex Plan 3 (HMO-POS).
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at **1-800-224-2273** for additional information. (TTY users should call **711**.) Hours are 8 am to 8 pm 7 days a week from October 1 to March 31 and 8 am to 8 pm Monday- Saturday, April 1 to September 30. This call is free.
- We can also provide information in a way that works for you (information in alternate formats). Please call Member Services at the number listed above if you need plan information in another format or language.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About ConnectiCare Flex Plan 3 (HMO-POS)

- ConnectiCare, Inc. is an HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal.
- When this document says “we,” “us,” or “our,” it means ConnectiCare, Inc. When it says “plan” or “our plan,” it means ConnectiCare Flex Plan 3 (HMO-POS)

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Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for ConnectiCare Flex Plan 3 (HMO-POS) in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$51.00**	**$36.00**
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	**$6,350** (In-Network services) **$10,000** (Out-of-Network services)	**$6,350** (In-Network services) **$10,000** (Out-of-Network services)
Doctor office visits	**Primary care visits:** **In-Network** You pay a **$5** copay per visit **Out-of-Network** You pay **35%** of the total cost per visit **Specialist visits:** **In-Network** You pay a **$50** copay per visit **Out-of-Network** You pay **35%** of the total cost per visit	**Primary care visits:** **In-Network** You pay a **$5** copay per visit **Out-of-Network** You pay **40%** of the total cost per visit **Specialist visits:** **In-Network** You pay a **$50** copay per visit **Out-of-Network** You pay **40%** of the total cost per visit

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	**In-Network:** Days **1-4: $495** copay per day. **$0** copay per day for each additional day, for each inpatient stay. Unlimited days. **Out-of-Network:** You pay **35%** of the total cost for each inpatient stay. Unlimited days. Prior authorization is required.	**In-Network:** Days **1-5: $495** copay per day. **$0** copay per day for each additional day, for each inpatient stay. Unlimited days. **Out-of-Network:** You pay **40%** of the total cost for each inpatient stay. Unlimited days. Prior authorization is required.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: **$300** except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: *Standard cost sharing:* You pay **$9** per prescription. *Preferred cost sharing:* You pay **$2** per prescription. Drug Tier 2: *Standard cost sharing:* You pay **$20** per prescription. *Preferred cost sharing:* You pay **$10** per prescription. Drug Tier 3: *Standard cost sharing:* You pay **$47** per prescription. *Preferred cost sharing:* You pay **$42** per prescription.	Deductible: **$300** except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: *Standard cost sharing:* You pay **$9** per prescription. *Preferred cost sharing:* You pay **$2** per prescription. Drug Tier 2: *Standard cost sharing:* You pay **$20** per prescription. *Preferred cost sharing:* You pay **$10** per prescription. Drug Tier 3: *Standard cost sharing:* You pay **$47** per prescription. *Preferred cost sharing:* You pay **$42** per prescription.

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Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	You pay **$35** per one-month supply of each covered insulin product on this tier. Drug Tier 4: *Standard cost sharing:* You pay **$100** per prescription. *Preferred cost sharing:* You pay **$95** per prescription. Drug Tier 5: *Standard cost sharing:* You pay **27%** of the total cost. *Preferred cost sharing:* You pay **27%** of the total cost. Drug Tier 6: *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	You pay **$35** per one-month supply of each covered insulin product on this tier. Drug Tier 4: *Standard cost sharing:* You pay **$100** per prescription. *Preferred cost sharing:* You pay **$95** per prescription. Drug Tier 5: *Standard cost sharing:* You pay **27%** of the total cost. *Preferred cost sharing:* You pay **27%** of the total cost. Drug Tier 6: *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$51.00**	**$36.00**

Cost	2024 (this year)	2025 (next year)
Optional Supplemental Dental		
POS Dental Plan with $2,000 calendar year maximum	**$25**	**$27**
POS Dental Plan with $3,000 calendar year maximum	**$32**	**$35**
Indemnity Dental Plan with $3,500 calendar year maximum	**$69**	**$128**

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out of pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$6,350** (In-Network services) **$10,000** (Out-of-Network services)	**$6,350** (In-Network services) Once you have paid **$6,350** out of pocket for covered in-network Part A and Part B services, you will pay nothing for your covered in-network Part A and Part B services for the rest of the calendar year. **$10,000** (Out-of-Network services) Once you have paid **$10,000** out-of-pocket for covered out-of-network Part A and B services, you will pay nothing for your out-of-network covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at connecticare.com/medicare. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory at connecticare.com/medicare* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are no changes to our network of pharmacies for next year.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Acupuncture	**In-Network:** You pay a **$30** copay for each Medicare-covered acupuncture visit. **Out-of-Network:** Acupuncture obtained out-of-network is not covered. Prior Authorization is required.	**In-Network:** You pay a **$50** copay for each Medicare-covered acupuncture visit. **Out-of-Network:** Acupuncture obtained out-of-network is not covered. Prior Authorization is required.

Cost	2024 (this year)	2025 (next year)
Ambulatory Surgical Centers	**In-Network:** You pay a **$200** copay for a Medicare-covered ambulatory surgical center visit. **Out-of-Network:** You pay **35%** of the total cost for a Medicare-covered ambulatory surgical center visit. Prior authorization is required.	**In-Network:** You pay a **$200** copay for a Medicare-covered ambulatory surgical center visit. **$0** for Diagnostic Colonoscopy. **Out-of-Network:** You pay **40%** of the total cost for a Medicare-covered ambulatory surgical center visit. Prior authorization is required.
Cardiac Rehabilitation Services	**In-Network:** You pay a **$35** copay for Medicare-covered cardiac rehabilitation services. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered cardiac rehabilitation services.	**In-Network:** You pay a **$35** copay for Medicare-covered cardiac rehabilitation services. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered cardiac rehabilitation services.
Chiropractic Services	**In-Network:** You pay a **$20** copay for Medicare-covered chiropractic services. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered chiropractic services.	**In-Network:** You pay a **$20** copay for Medicare-covered chiropractic services. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered chiropractic services.
Dental - Medicare covered	**In-Network:** You pay a **$50** copay for Medicare-covered dental services. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered dental services.	**In-Network:** You pay a **$50** copay for Medicare-covered dental services. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered dental services.

Cost	2024 (this year)	2025 (next year)
Diabetic Supplies, Services, Shoes and Inserts	**In-Network:** You pay **20%** of the total cost for Diabetic Supplies, Services, Shoes and Inserts. **Out-of-Network:** You pay **35%** of the total cost for Diabetic Supplies, Services, Shoes and Inserts. Diabetic supplies limited to Abbott brands.	**In-Network:** You pay **20%** of the total cost for Diabetic Supplies, Services, Shoes and Inserts. **Out-of-Network:** You pay **40%** of the total cost for Diabetic Supplies, Services, Shoes and Inserts. Diabetic supplies limited to Abbott brands.
Diagnostic Procedures and Tests	**In-Network:** You pay a **$25** copay for Medicare-covered Diagnostic Procedures and Tests. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered Diagnostic Procedures and Tests. Prior authorization is required.	**In-Network:** You pay a **$25** copay for Medicare-covered Diagnostic Procedures and Tests. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered Diagnostic Procedures and Tests. Prior authorization is required.
Diagnostic Radiology	**In-Network:** You pay a **$275** copay for diagnostic radiology. **Out-of-Network:** You pay **35%** of the total cost for diagnostic radiology. Prior authorization is required.	**In-Network:** You pay a **$275** copay for diagnostic radiology. **$0** for Diagnostic Mammograms. **Out-of-Network:** You pay **40%** of the total cost for diagnostic radiology. Prior authorization is required.

Cost	2024 (this year)	2025 (next year)
Doctor office visits	**Primary care visits:** **In-Network** You pay a **$5** copay per visit. **Out-of-Network** You pay **35%** of the total cost per visit. **Specialist visits:** **In-Network** You pay a **$50** copay per visit. **Out-of-Network** You pay **35%** of the total cost per visit.	**Primary care visits:** **In-Network** You pay a **$5** copay per visit. **Out-of-Network** You pay **40%** of the total cost per visit. **Specialist visits:** **In-Network** You pay a **$50** copay per visit. **Out-of-Network** You pay **40%** of the total cost per visit.
Durable Medical Equipment	**In-Network:** You pay **20%** of the total cost for Durable Medical Equipment. **Out-of-Network:** You pay **35%** of the total cost for Durable Medical Equipment. Prior authorization is required.	**In-Network:** You pay **20%** of the total cost for Durable Medical Equipment. **Out-of-Network:** You pay **40%** of the total cost for Durable Medical Equipment. Prior authorization is required.
Emergency Care/Post Stabilization Services	You pay a **$100** copay for Medicare-covered emergency care/post stabilization services. Copay waived if admitted within 1 day.	You pay a **$125** copay for Medicare-covered emergency care/post stabilization services. Copay waived if admitted within 1 day.

Cost	2024 (this year)	2025 (next year)
Hearing Services	**In-Network:** You pay a **$50** copay for one routine hearing exam per year. You pay a **$50** copay for Medicare covered hearing exams. **Out-of-Network:** You pay **35%** of the total cost for one routine hearing exam per year. You pay **35%** of the total cost for Medicare covered hearing exams.	**In-Network:** You pay a **$0** copay for one routine hearing exam per year. You pay a **$50** copay for Medicare covered hearing exams. **Out-of-Network:** You pay **40%** of the total cost for one routine hearing exam per year. You pay **40%** of the total cost for Medicare covered hearing exams.
Home Health	**In-Network:** You pay a **$0** copay for home health services. **Out-of-Network:** You pay **35%** of the total cost for home health services. Prior authorization is required.	**In-Network:** You pay a **$0** copay for home health services. **Out-of-Network:** You pay **40%** of the total cost for home health services. Prior authorization is required.
Inpatient hospital stays	**In-Network:** Days **1-4: $495** copay per day; **$0** copay per day for each additional day, for each inpatient stay. Unlimited days. **Out-of-Network:** You pay **35%** of the total cost for each inpatient stay. Unlimited days. Prior authorization is required.	**In-Network:** Days **1-5: $495** copay per day; **$0** copay per day for each additional day, for each inpatient stay. Unlimited days. **Out-of-Network:** You pay **40%** of the total cost for each inpatient stay. Unlimited days. Prior authorization is required.

Cost	2024 (this year)	2025 (next year)
Inpatient Psychiatric Hospital Stays	**In-Network:** You pay a **$2,179** copay for each Inpatient Psychiatric Hospital stay. **Out-of-Network:** You pay **35%** of the total cost for each Inpatient Psychiatric Hospital stay. Prior authorization is required.	**In-Network:** You pay a **$2,290** copay for each Inpatient Psychiatric Hospital stay. **Out-of-Network:** You pay **40%** of the total cost for each Inpatient Psychiatric Hospital stay. Prior authorization is required.
Intensive Cardiac Rehabilitation Services	**In-Network:** You pay a **$60** copay for Medicare-covered intensive cardiac rehabilitation services. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered intensive cardiac rehabilitation services.	**In-Network:** You pay a **$55** copay for Medicare-covered intensive cardiac rehabilitation services. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered intensive cardiac rehabilitation services.
Kidney Disease Education	**In-Network:** You pay **0%** of the total cost for kidney disease education. **Out-of-Network:** You pay **35%** of the total cost for kidney disease education.	**In-Network:** You pay **0%** of the total cost for kidney disease education. **Out-of-Network:** You pay **40%** of the total cost for kidney disease education.
Lab Services	**In-Network:** You pay a **$0** copay for lab services performed in an office or independent facility. You pay a **$15** copay for lab services performed at all other locations. **Out-of-Network:** You pay **35%** of the total cost of lab services. Prior authorization is required.	**In-Network:** You pay a **$0** copay for lab services performed in an office or independent facility. You pay a **$15** copay for lab services performed at all other locations. **Out-of-Network:** You pay **40%** of the total cost of lab services. Prior authorization is required.

Cost	2024 (this year)	2025 (next year)
Medicare Part B Drugs	You pay **0% -10%** of the total cost for Medicare-covered Part B drugs in the home. You pay **0%-20%** of the total cost for Medicare-covered Part B drugs dispensed at a retail pharmacy, mail order pharmacy, physician office, and outpatient facility. You pay less if your drug is on the CMS Part B drug rebate list. The list changes quarterly. You pay a maximum of **35%** for a one-month supply of Part B covered insulin. Prior authorization is required.	You pay **0% -10%** of the total cost for Medicare-covered Part B drugs in the home. You pay **0%-20%** of the total cost for Medicare-covered Part B drugs dispensed at a retail pharmacy, mail order pharmacy, physician office, and outpatient facility. You pay less if your drug is on the CMS Part B drug rebate list. The list changes quarterly. You pay a maximum of **40%** for a one-month supply of Part B covered insulin. Prior authorization is required.
Mental Health Care	**In-Network:** You pay a **$40** copay for mental health services. **Out-of-Network:** You pay **35%** of the total cost for mental health services. Prior authorization is required.	**In-Network:** You pay a **$40** copay for mental health services. **Out-of-Network:** You pay **40%** of the total cost for mental health services. Prior authorization is required.
Occupational Therapy Services	**In-Network:** You pay a **$40** copay for occupational therapy. **Out-of-Network:** You pay **35%** of the total cost for occupational therapy.	**In-Network:** You pay a **$40** copay for occupational therapy. **Out-of-Network:** You pay **40%** of the total cost for occupational therapy.
Opioid Treatment Program Services	**In-Network:** You pay a **$40** copay for Medicare-covered opioid treatment program services. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered opioid treatment program services. Prior authorization is required.	**In-Network:** You pay a **$40** copay for Medicare-covered opioid treatment program services. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered opioid treatment program services. Prior authorization is required.

Cost	2024 (this year)	2025 (next year)
Optional Supplemental Dental Services Available for an additional monthly premium. Some limitations apply, please refer to Chapter 4 of your Evidence of Coverage for additional details.	**$25 monthly premium for POS Dental Plan with $2,000 calendar year maximum.** **OR** **$32 monthly premium for POS Dental Plan with $3,000 calendar year maximum;** **OR** **$69 monthly premium for Indemnity Dental Plan with $3,500 calendar year maximum.**	**$27 monthly premium for POS Dental Plan with $2,000 calendar year maximum.** **OR** **$35 monthly premium for POS Dental Plan with $3,000 calendar year maximum;** **OR** **$128 monthly premium for Indemnity Dental Plan with $3,500 calendar year maximum.**
Outpatient Blood Services	**In-Network:** You pay a **$0** copay for outpatient blood services. **Out-of-Network:** You pay **35%** of the total cost for outpatient blood services.	**In-Network:** You pay a **$0** copay for outpatient blood services. **Out-of-Network:** You pay **40%** of the total cost for outpatient blood services.
Outpatient Hospital Services	**In-Network:** You pay a **$325** copay for outpatient hospital services. **Out-of-Network:** You pay **35%** of the total cost for outpatient hospital services. Prior authorization is required.	**In-Network:** You pay a **$325** copay for outpatient hospital services. **$0** for Diagnostic Colonoscopy. **Out-of-Network:** You pay **40%** of the total cost for outpatient hospital services. Prior authorization is required.
Outpatient Observation Services	**In-Network:** You pay a **$325** copay for outpatient observation services. **Out-of-Network:** You pay **35%** of the total cost for outpatient observation services. Prior authorization **is** required.	**In-Network:** You pay a **$325** copay for outpatient observation services. **Out-of-Network:** You pay **40%** of the total cost for outpatient observation services. Prior authorization **is not** required.

Cost	2024 (this year)	2025 (next year)
Outpatient Substance Abuse Services	**In-Network:** You pay a **$40** copay for outpatient substance abuse office or telehealth visit. **Out-of-Network:** You pay **35%** of the total cost for outpatient substance abuse services. Prior authorization is required.	**In-Network:** You pay a **$40** copay for outpatient substance abuse office or telehealth visit. **Out-of-Network:** You pay **40%** of the total cost for outpatient substance abuse services. Prior authorization is required.
Partial Hospitalization	**In-Network:** You pay a **$55** copay for partial hospitalizations. **Out-of-Network:** You pay **35%** of the total cost for partial hospitalizations. Prior authorization is required.	**In-Network:** You pay a **$55** copay for partial hospitalizations. **Out-of-Network:** You pay **40%** of the total cost for partial hospitalizations. Prior authorization is required.
Physical and Speech Therapy Services	**In-Network:** You pay a **$40** copay for physical and speech therapy services. **Out-of-Network:** You pay **35%** of the total cost for physical and speech therapy services.	**In-Network:** You pay a **$40** copay for physical and speech therapy services. **Out-of-Network:** You pay **40%** of the total cost for physical and speech therapy services.
Podiatry Services	**In-Network:** You pay a **$50** copay for Medicare-covered podiatry services. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered podiatry services. Routine not covered.	**In-Network:** You pay a **$50** copay for Medicare-covered podiatry services. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered podiatry services. Routine not covered.

Cost	2024 (this year)	2025 (next year)
Prosthetics and Medical Supplies	**In-Network:** You pay **20%** of the total cost for prosthetics and medical supplies. **Out-of-Network:** You pay **35%** of the total cost for prosthetics and medical supplies. Prior authorization is required.	**In-Network:** You pay **20%** of the total cost for prosthetics and medical supplies. **Out-of-Network:** You pay **40%** of the total cost for prosthetics and medical supplies. Prior authorization is required.
Psychiatric Services	**In-Network:** You pay a **$40** copay for psychiatric services. **Out-of-Network:** You pay **35%** of the total cost for psychiatric services. Prior authorization is required.	**In-Network:** You pay a **$40** copay for psychiatric services. **Out-of-Network:** You pay **40%** of the total cost for psychiatric services. Prior authorization is required.
Pulmonary Rehabilitation Services	**In-Network:** You pay a **$15** copay for Medicare-covered pulmonary rehabilitation services. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered pulmonary rehabilitation services. Prior authorization is required.	**In-Network:** You pay a **$15** copay for Medicare-covered pulmonary rehabilitation services. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered pulmonary rehabilitation services. Prior authorization is required.
Skilled Nursing Facility (SNF) Care	**In-Network:** You pay a **$0** copay each day for Medicare-covered services for days 1-20. **$203** copay each day for Medicare-covered services for days 21-100 each benefit period. **Out-of-Network:** You pay **35%** of the total cost for Skilled Nursing Facility services. Prior authorization is required.	**In-Network:** You pay a **$0** copay each day for Medicare-covered services for days 1-20. **$214** copay each day for Medicare-covered services for days 21-100 each benefit period. **Out-of-Network:** You pay **40%** of the total cost for Skilled Nursing Facility services. Prior authorization is required.

Cost	2024 (this year)	2025 (next year)
Supervised Exercise Therapy Services	**In-Network:** You pay a **$25** copay for Medicare-covered supervised exercise therapy services. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered supervised exercise therapy services. Prior authorization is required.	**In-Network:** You pay a **$25** copay for Medicare-covered supervised exercise therapy services. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered supervised exercise therapy services. Prior authorization is required.
Therapeutic Radiology	**In-Network:** You pay **20%** of the total cost for therapeutic radiology services. **Out-of-Network:** You pay **35%** of the total cost for therapeutic radiology services. Prior authorization is required.	**In-Network:** You pay **20%** of the total cost for therapeutic radiology services. **Out-of-Network:** You pay **40%** of the total cost for therapeutic radiology services. Prior authorization is required.
Urgently Needed Care	You pay a **$50** copay per visit for Medicare-covered urgently needed services. Copay not waived if admitted.	You pay a **$55** copay per visit for Medicare-covered urgently needed services. Copay not waived if admitted.
Vision Care	**In-Network:** You pay a **$50** copay for one routine eye exam every year. Our plan covers up to a **$300 allowance every year** for one pair of routine eyeglasses and contact lenses up to allowance. **Out-of-Network:** Vision care obtained out-of-network is not covered.	**In-Network:** You pay a **$0** copay for one routine eye exam every year. Our plan covers up to a **$300 allowance every year** for routine eyeglasses or contact lenses up to allowance. **Out-of-Network:** Vision care obtained out-of-network is not covered.

Cost	2024 (this year)	2025 (next year)
Worldwide Emergency Services	You pay a **$100** copay for Worldwide Emergency Services. **$50,000 annual limit combined with Worldwide Urgent Care and Worldwide Ground Ambulance.** Copay waived if admitted within 1 day.	You pay a **$0** copay for Worldwide Emergency Services. **$50,000 annual limit combined with Worldwide Urgent Care and Worldwide Ground Ambulance.** Copay waived if admitted within 1 day.
Worldwide Ground Ambulance	You pay a **$325** copay for each Worldwide Ground Ambulance trip. **$50,000 annual limit combined with Worldwide Emergency Care and Worldwide Urgent Care.** Copay not waived if admitted.	You pay a **$0** copay for each Worldwide Ground Ambulance trip. **$50,000 annual limit combined with Worldwide Emergency Care and Worldwide Urgent Care.** Copay not waived if admitted.
Worldwide Urgent Care	You pay a **$100** copay for Worldwide Urgent Care. **$50,000 annual limit combined with Worldwide Emergency Care and Worldwide Ground Ambulance.** Copay waived if admitted within 1 day.	You pay a **$0** copay for Worldwide Urgent Care. **$50,000 annual limit combined with Worldwide Emergency Care and Worldwide Ground Ambulance**. Copay waived if admitted within 1 day.
X-rays	**In-Network:** You pay a **$45** copay for each Medicare-covered x-ray. **Out-of-Network:** You pay **35%** of the total cost for Medicare-covered x-ray. Prior authorization is required.	**In-Network:** You pay a **$45** copay for each Medicare-covered x-ray. **Out-of-Network:** You pay **40%** of the total cost for Medicare-covered x-ray. Prior authorization is required.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2024, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is **$300**. During this stage, you pay **$9** standard cost sharing and **$2** preferred cost sharing for drugs on Tier 1 (Preferred Generic); **$20** standard cost sharing and **$10** preferred cost sharing for drugs on Tier 2 (Generic); **$0** standard cost sharing and **$0** preferred cost sharing for drugs on Tier 6 (Select Care Drugs); and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) until you have reached the yearly deductible.	The deductible is **$300**. During this stage you pay **$9** standard cost sharing and **$2** preferred cost sharing for drugs on Tier 1 (Preferred Generic); **$20** standard cost sharing and **$10** preferred cost sharing for drugs on Tier 2 (Generic); **$0** standard cost sharing and **$0** preferred cost sharing for drugs on Tier 6 (Select Care Drugs); and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** (continued on next page)	Your cost for a one-month supply at a network pharmacy is: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay **$9** per prescription. *Preferred cost sharing:* You pay **$2** per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay **$20** per prescription. *Preferred cost sharing:* You pay **$10** per prescription.	Your cost for a one-month supply at a network pharmacy is: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay **$9** per prescription. *Preferred cost sharing:* You pay **$2** per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay **$20** per prescription. *Preferred cost sharing:* You pay **$10** per prescription.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage (continued) We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List." Most adult Part D vaccines are covered at no cost to you.	**Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay **$47** per prescription. You pay **$35** per one-month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay **$42** per prescription. You pay **$35** per one-month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay **$100** per prescription. *Preferred cost sharing:* You pay **$95** per prescription. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay **27%** of the total cost. *Preferred cost sharing:* You pay **27%** of the total cost. **Tier 6 (Select Care Drugs):** *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. Once your total drug costs have reached **$5,030**, you will move to the next stage (the Coverage Gap Stage).	**Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay **$47** per prescription. You pay **$35** per one-month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay **$42** per prescription. You pay **$35** per one-month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay **$100** per prescription. *Preferred cost sharing:* You pay **$95** per prescription. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay **27%** of the total cost. *Preferred cost sharing:* You pay **27%** of the total cost. **Tier 6 (Select Care Drugs):** *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription. Once you have paid **$2,000** out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage.*

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). To learn more about this payment option, please contact us at **1-866-845-1803** or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in ConnectiCare Flex Plan 3 (HMO-POS)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our ConnectiCare Flex Plan 3 (HMO-POS).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from ConnectiCare Flex Plan 3 (HMO-POS).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from ConnectiCare Flex Plan 3 (HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
  - – *OR* – Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Connecticut, the SHIP is called **CHOICES** (**C**onnecticut's program for **H**ealth insurance assistance, **O**utreach, **I**nformation and referral, **C**ounseling, **E**ligibility **S**creening).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. CHOICES counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call CHOICES at 1-800-994-9422. You can learn more about CHOICES by visiting their website (www.ct.gov/agingservices).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
    - Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Connecticut AIDS Drug Assistance Program (CADAP). For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call CADAP at 1-800-424-3310. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year (**January – December**). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs**.

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at **1-866-845-1803** or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from ConnectiCare Flex Plan 3 (HMO-POS)

Questions? We're here to help. Please call Member Services at 1-800-224-2273 (TTY only, call 711). We are available for phone calls 8 am to 8 pm 7 days a week from October 1 to March 31 and 8 am to 8 pm Monday- Saturday, April 1- September 30. Calls to these numbers are free.

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for ConnectiCare Flex Plan 3 (HMO-POS). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at connecticare.com/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at connecticare.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/Drug List)*

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.