CareAdvantage Preferred (HMO) offered by CarePartners of Connecticut

Annual Notice of Changes for 2025

You are currently enrolled as a member of CarePartners of Connecticut CareAdvantage Preferred. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 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 www.carepartnersct.com. 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 www.medicare.gov/plan-compare 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 CarePartners of Connecticut CareAdvantage Preferred.
- 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 CarePartners of Connecticut CareAdvantage Preferred.
- 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 1-888-341-1507 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to September 30. This call is free.
- This information is available in different formats, including large print.
- **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 CarePartners of Connecticut CareAdvantage Preferred

- CarePartners of Connecticut is an HMO plan with a Medicare contract. Enrollment in CarePartners of Connecticut depends on contract renewal.
- When this document says "we," "us," or "our," it means CarePartners of Connecticut. When it says "plan" or "our plan," it means CarePartners of Connecticut CareAdvantage Preferred.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for CarePartners of Connecticut CareAdvantage Preferred 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 than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$4,900	$4,900
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $45 per visit	Primary care visits: $0 per visit Specialist visits: $45 per visit
Inpatient hospital stays	$395 per day for days 1-5 and $0 after day 5 for Medicare-covered services received in a general acute care, rehabilitation, or long-term acute care or psychiatric hospital.	$395 per day for days 1-5 and $0 after day 5 for Medicare-covered services received in a general acute care, rehabilitation, or long-term acute care or psychiatric hospital.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 1.5 for details.) Tier 1 and Tier 2 drugs include enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, vitamins and minerals, and cough/cold products.	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** $0-$10 per prescription at a retail pharmacy for a 30-day supply. $0-$20 per prescription at a retail pharmacy for up to a 60-day supply. $0-$30 per prescription at a retail pharmacy for up to a 90-day supply. $0 per prescription at a mail order pharmacy for a 30-day supply. $0 per prescription at a mail order pharmacy for up to a 60-day supply. $0 per prescription at a mail order pharmacy for up to a 90-day supply.	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** $0-$10 per prescription at a retail pharmacy for a 30-day supply. $0-$20 per prescription at a retail pharmacy for up to a 60-day supply. $0-$30 per prescription at a retail pharmacy for up to a 90-day supply. $0 per prescription at a mail order pharmacy for a 30-day supply. $0 per prescription at a mail order pharmacy for up to a 60-day supply. $0 per prescription at a mail order pharmacy for up to a 90-day supply.

Cost	2024 (this year)	2025 (next year)
	Drug Tier 2: $0-$15 per prescription at a retail pharmacy for a 30-day supply. $0-$30 per prescription at a retail pharmacy for up to a 60-day supply. $0-$45 per prescription at a retail pharmacy for up to a 90-day supply. $0 per prescription at a mail order pharmacy for a 30-day supply. $0 per prescription at a mail order pharmacy for up to a 60-day supply. $0 per prescription at a mail order pharmacy for up to a 90-day supply. **Drug Tier 3:** $47 per prescription at a retail pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier.	**Drug Tier 2:** $5-$15 per prescription at a retail pharmacy for a 30-day supply. $10-$30 per prescription at a retail pharmacy for up to a 60-day supply. $15-$45 per prescription at a retail pharmacy for up to a 90-day supply. $5 per prescription at a mail order pharmacy for a 30-day supply. $10 per prescription at a mail order pharmacy for up to a 60-day supply. $10 per prescription at a mail order pharmacy for up to a 90-day supply. **Drug Tier 3:** 25% coinsurance per prescription at a retail pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	$94 per prescription at a retail pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier. $141 per prescription at a retail pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier. $47 per prescription at a mail order pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier. $94 per prescription at a mail order pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier.	25% coinsurance per prescription at a retail pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier. 25% coinsurance per prescription at a retail pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier. 25% coinsurance per prescription at a mail order pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier. 25% coinsurance per prescription at a mail order pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	$94 per prescription at a mail order pharmacy for up to a 90-day supply. You pay $70 for a 90-day supply of each covered insulin product on this tier.	25% coinsurance per prescription at a mail order pharmacy for up to a 90-day supply. You pay $70 for a 90-day supply of each covered insulin product on this tier.
	Drug Tier 4: $100 per prescription at a retail pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier.	**Drug Tier 4:** 50% coinsurance per prescription at a retail pharmacy for a 30-day supply. You pay $35 per month supply of each covered insulin product on this tier.
	$200 per prescription at a retail pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier.	50% coinsurance per prescription at a retail pharmacy for up to a 60-day supply. You pay $70 for a 60-day supply of each covered insulin product on this tier.
	$300 per prescription at a retail pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier.	50% coinsurance per prescription at a retail pharmacy for up to a 90-day supply. You pay $105 for a 90-day supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	\$100 per prescription at a mail order pharmacy for a 30-day supply. You pay \$35 per month supply of each covered insulin product on this tier. \$200 per prescription at a mail order pharmacy for up to a 60-day supply. You pay \$70 for a 60-day supply of each covered insulin product on this tier. \$200 per prescription at a mail order pharmacy for up to a 90-day supply. You pay \$70 for a 90-day supply of each covered insulin product on this tier. **Drug Tier 5:** 33% per prescription at a retail or mail order pharmacy for a 30-day supply. 60-day and 90-day supplies are not covered for drugs on Tier 5.	50% coinsurance per prescription at a mail order pharmacy for a 30-day supply. You pay \$35 per month supply of each covered insulin product on this tier. 50% coinsurance per prescription at a mail order pharmacy for up to a 60-day supply. You pay \$70 for a 60-day supply of each covered insulin product on this tier. 50% coinsurance per prescription at a mail order pharmacy for up to a 90-day supply. You pay \$70 for a 90-day supply of each covered insulin product on this tier. **Drug Tier 5:** 33% per prescription at a retail or mail order pharmacy for a 30-day supply. 60-day and 90-day supplies are not covered for drugs on Tier 5.

Cost	2024 (this year)	2025 (next year)
	Drug Tier 6: $0 per Tier 6 vaccine. Not applicable at Mail Order. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing.	**Drug Tier 6:** $0 per Tier 6 vaccine. Not applicable at Mail Order. Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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 There is no change to the plan premium for the upcoming benefit year. (You must also continue to pay your Medicare Part B premium.)	$0	$0

- 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.

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 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 costs for prescription drugs do not count toward your maximum out-of-pocket amount. There is no change to the maximum out-of-pocket amount for the upcoming benefit year.	$4,900	$4,900 Once you have paid $4,900 out-of-pocket for covered services, you will pay nothing for your covered 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 www.carepartnersct.com. 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 networks of providers for next year. **Please review the 2025 *Provider Directory* at www.carepartnersct.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory* at www.carepartnersct.com to see which pharmacies are in our network.**

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)
Cardiac rehabilitation services	You pay $0 for Medicare-covered services.	You pay $0 for Medicare-covered services. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP. Except in an emergency, prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Chiropractic services	You pay $20 for each Medicare-covered visit. You pay $20 for the initial chiropractic evaluation. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP.	You pay $20 for each Medicare-covered visit. You pay $20 for the initial chiropractic evaluation. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP. Except in an emergency, prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Dental services – Medicare-covered	You pay $45 for Medicare-covered dental services.	You pay $45 for Medicare-covered dental services. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP. Except in an emergency, prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.
DME - Medical supplies	You pay $0 for Medicare-covered medical supplies.	You pay $0 for Medicare-covered medical supplies provided as part of an office visit. You pay 20% coinsurance for all other Medicare-covered medical supplies. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Emergency care	You pay $90 for each covered emergency room (ER) visit. You will still pay this ER copay amount if you are held for observation. You do not pay this ER amount if you are admitted as an inpatient to the hospital within 24 hours for the same condition (refer to **Inpatient Hospital Care** section in your *Evidence of Coverage* for hospital cost-share that applies instead).	You pay $125 for each covered emergency room (ER) visit. If you are held for observation following the ER visit, the ER copay will be waived and you will pay the Observation copay (refer to **Outpatient hospital observation** section of your *Evidence of Coverage* for outpatient hospital observation cost-share that applies instead). You do not pay the ER or Observation copay amount if you are admitted as an inpatient to the hospital within one day for the same condition (refer to **Inpatient Hospital Care** section in your *Evidence of Coverage* for hospital cost-share that applies instead). Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Home health agency care	You pay $0 for Medicare-covered home health care services.	You pay $0 for Medicare-covered home health care services. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP. Except in an emergency, prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient diagnostic radiology services	You pay $60 per day for a Medicare-covered ultrasound. You pay $250 per day for other Medicare-covered diagnostic radiology services that are not ultrasounds. Prior authorization may be required before you receive this service.	You pay $60 per day for a Medicare-covered ultrasound. You pay $150 per day for other Medicare-covered diagnostic radiology services that are not ultrasounds. Prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient hospital observation	You pay $0 for Medicare-covered outpatient hospital observation stays. Additional cost-share may apply if you receive other outpatient services while held in observation.	You pay $310 for each Medicare-covered outpatient hospital observation stay. Additional cost-share may apply if you receive other outpatient services while held in observation. You do not pay this outpatient hospital observation copay amount if you are admitted as an inpatient to the hospital within one day for the same condition (refer to **Inpatient Hospital Care** section in your *Evidence of Coverage* for hospital cost-share that applies instead). Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient hospital services	See the following sections in this chart for applicable details and changes: **Observation services**, see "Outpatient hospital observation" in this chart. **Outpatient surgery**, see "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" in this chart. **Radiological services**, see "Outpatient diagnostic radiology services" in this chart.	See the following sections in this chart for applicable details and changes: **Observation services**, see "Outpatient hospital observation" in this chart. **Outpatient surgery**, see "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" in this chart. **Radiological services**, see "Outpatient diagnostic radiology services" in this chart.

Cost	2024 (this year)	2025 (next year)
Outpatient rehabilitation services	You pay $30 for each Medicare-covered physical therapy, occupational therapy, or speech/language therapy visit. You pay $0 for a post-outpatient surgical procedure physical therapy or occupational therapy consultation prior to discharge. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP.	You pay $25 for each Medicare-covered physical therapy, occupational therapy, or speech/language therapy visit. You pay $0 for a post-outpatient surgical procedure physical therapy or occupational therapy consultation prior to discharge. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP. Except in an emergency, prior authorization may be required before you receive services. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay $0 for Medicare-covered colonoscopies. You pay $270 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an ambulatory surgical center. You pay $370 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital. Before you receive services from out-of-network providers, you must first obtain a referral from your PCP. A referral is not required to out-of-network hospital outpatient facilities and ambulatory surgical centers. Except in an emergency, prior	You pay $0 for Medicare-covered colonoscopies. You pay $210 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an ambulatory surgical center. You pay $310 per day for other outpatient procedures and services, including, but not limited to, diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital. Before you receive services from out-of-network providers, you must first obtain a referral from your PCP. A referral is not required to out-of-network hospital outpatient facilities and ambulatory surgical centers. Except in an emergency, prior

Cost	2024 (this year)	2025 (next year)
	authorization may be required before you receive services.	authorization may be required before you receive services. Please refer to your *Evidence of Coverage* for more information.
Over-the-Counter (OTC) for Medicare Items	You receive $67 credit per calendar quarter to use toward Medicare-approved Over-the-Counter (OTC) items. You are responsible for purchases of Medicare-approved OTC items that exceed this quarterly benefit limit. Any unused balance at the end of a calendar quarter will not roll over into the following calendar quarter.	You receive $140 credit per calendar quarter to use toward Medicare-approved Over-the-Counter (OTC) items. You are responsible for purchases of Medicare-approved OTC items that exceed this quarterly benefit limit. Any used balance at the end of a calendar quarter will not roll over into the following calendar quarter. Do not throw out your current OTC card. You will continue to use your current OTC card to access your OTC benefits in 2025. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Pulmonary rehabilitation services	You pay $0 for Medicare-covered services.	You pay $0 for Medicare-covered services. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP. Except in an emergency, prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.
Skilled nursing facility (SNF) care	For each admission you pay $0 for days 1-20 of a benefit period, and $178 per day for days 21-59 of a benefit period, and $0 for days 60-100 of a benefit period.	For each admission you pay $0 for days 1-20 of a benefit period, and $203 per day for days 21-100 of a benefit period. Except in an emergency, prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Supervised Exercise Therapy (SET)	You pay $0 for Medicare-covered Supervised Exercise Therapy services.	You pay $0 for Medicare-covered Supervised Exercise Therapy services. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP. Except in an emergency, prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Telehealth - Remote Patient Monitoring services	You pay $0 for remote patient monitoring services rendered by your PCP or Specialist.	You pay $0 for remote patient monitoring services rendered by your PCP or Specialist. Before you receive service from out-of-network providers, you must first obtain a referral from your PCP. Except in an emergency, prior authorization may be required before you receive this service. Please refer to your *Evidence of Coverage* for more information.
Urgently needed care	You pay $45 for each Medicare-covered urgent care visit. This copayment is not waived if you are admitted as an inpatient to the hospital within 24 hours for the same condition.	You pay $40 for each Medicare-covered urgent care visit. This copayment is not waived if you are admitted as an inpatient to the hospital within one day for the same condition. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Vision - Diabetic retinopathy	You pay $0 for an annual diabetic retinopathy screening by an optometrist or a specialist. Before you receive services from an out-of-network ophthalmologist for diagnosis and/ or treatment of a medical condition of the eye, you must first obtain a referral from your PCP. No referral is required to see an optometrist, but you must use a provider in the EyeMed Vision Care network.	You pay $15 or $45 for an annual diabetic retinopathy screening by an optometrist or a specialist, depending on the type of vision service you receive. Before you receive services from an out-of-network ophthalmologist for diagnosis and/ or treatment of a medical condition of the eye, you must first obtain a referral from your PCP. No referral is required to see an optometrist, but you must use a provider in the EyeMed Vision Care network. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Vision - Eyewear benefit	You receive an annual allowance toward the purchase of standard eyeglasses (prescription lenses, frames, or a combination of lenses and frames) and/or contact lenses.	You receive an annual allowance toward the purchase of standard eyeglasses (prescription lenses, frames, or a combination of lenses and frames) and/or contact lenses, including upgrades. The annual allowance may be used to purchase upgrades for Medicare-covered and/or therapeutic eyewear as well as routine/corrective eyewear.
	The allowance is $150 per calendar year for purchases from EyeMed Vision Care participating providers, or $90 per calendar year for purchases from non-EyeMed Vision Care participating providers.	The allowance is $300 per calendar year for purchases from EyeMed Vision Care participating providers, as well as from non-EyeMed Vision Care participating providers. Please refer to your *Evidence of Coverage* for more information.

Cost	2024 (this year)	2025 (next year)
Wellness Allowance	The plan reimburses you up to $175 per calendar year towards certain health and wellness education programs. Please refer to your *Evidence of Coverage* for details of covered items, activities, and programs.	The plan reimburses you up to $500 per calendar year towards certain health and wellness education programs. The following additional items, activities, and programs will be covered: • Certain home fitness equipment • Alternative therapies • Fitness tracking devices and heart rate monitors • Massage therapy • Additional types of fitness clubs and classes Please refer to your *Evidence of Coverage* for more information.

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.**

In 2025, certain Medicare excluded drugs are covered under our enhanced drug coverage. Covered drugs include select erectile dysfunction (ED) drugs, vitamins and minerals, and cough/cold products. Tier 1 or Tier 2 copays apply depending on the drug.

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 have included 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 didn't receive this insert with this packet, 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	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

For drugs on Tiers 3 and 4, your cost-sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: 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**. For 2024, you paid a $47 copayment for drugs on Tier 3. For 2025, you will pay 25% coinsurance for drugs on this Tier. For 2024, you paid a $100 copayment for drugs on Tier 4. For 2025, you will pay 50% coinsurance for drugs on this Tier. 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 1 and Tier 2 drugs include enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, vitamins and minerals, and cough/cold products.**	Your cost for a one-month supply is: **Tier 1:** *Preferred cost-sharing:* You pay $0 per prescription. *Standard cost-sharing:* You pay $10 per prescription. Your cost for a one-month mail-order prescription is $0. **Tier 2:** *Preferred cost-sharing:* You pay $0 per prescription. *Standard cost-sharing:* You pay $15 per prescription. Your cost for a one-month mail-order prescription is $0.	Your cost for a one-month supply is: **Tier 1:** *Preferred cost-sharing:* You pay $0 per prescription. *Standard cost-sharing:* You pay $10 per prescription. Your cost for a one-month mail-order prescription is $0. **Tier 2:** *Preferred cost-sharing:* You pay $5 per prescription. *Standard cost-sharing:* You pay $15 per prescription. Your cost for a one-month mail-order prescription is $5.

Stage	2024 (this year)	2025 (next year)
	Tier 3: *Preferred cost-sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Standard cost-sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $47. You pay $35 per month supply of each covered insulin product on this tier.	**Tier 3:** *Preferred cost-sharing:* You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Standard cost-sharing:* You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25% coinsurance. You pay $35 per month supply of each covered insulin product on this tier.

Stage	2024 (this year)	2025 (next year)
	Tier 4: *Preferred cost-sharing:* You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Standard cost-sharing:* You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $100. You pay $35 per month supply of each covered insulin product on this tier.	**Tier 4:** *Preferred cost-sharing:* You pay 50% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Standard cost-sharing:* You pay 50% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 50% coinsurance. You pay $35 per month supply of each covered insulin product on this tier.
	Tier 5: *Preferred cost-sharing:* You pay 33% of the total cost. *Standard cost-sharing:* You pay 33% of the total cost. Your cost for a one-month mail-order prescription is 33% coinsurance.	**Tier 5:** *Preferred cost-sharing:* You pay 33% of the total cost. *Standard cost-sharing:* You pay 33% of the total cost. Your cost for a one-month mail-order prescription is 33% coinsurance.

Stage	2024 (this year)	2025 (next year)
	Tier 6: *Preferred cost-sharing:* You pay $0 for all Tier 6 vaccines. *Standard cost-sharing:* You pay $0 for all Tier 6 vaccines. Mail-order is not available for drugs in Tier 6.	**Tier 6:** *Preferred cost-sharing:* You pay $0 for all Tier 6 vaccines. *Standard cost-sharing:* You pay $0 for all Tier 6 vaccines. Mail-order is not available for drugs in Tier 6.
	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	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.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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 1-888-341-1507 (TTY 711) or visit Medicare.gov.
Over-the-counter (OTC) benefit	For a full list of covered items, or to check your card balance, find participating retail locations near you, or to order items online, visit **carepartnersct.com/order-otc**.	For a full list of covered items, or to check your card balance, find participating retail locations near you, or to order items online, visit **carepartnersct.com/mybenefitscenter**.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in CarePartners of Connecticut CareAdvantage Preferred

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 CarePartners of Connecticut CareAdvantage Preferred plan.

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 CarePartners of Connecticut CareAdvantage Preferred.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from CarePartners of Connecticut CareAdvantage Preferred.
- 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.

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 (https://portal.ct.gov/ads-choices).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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 1-888-341-1507 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from CarePartners of Connecticut CareAdvantage Preferred

Questions? We're here to help. Please call Member Services at 1-888-341-1507. (TTY only, call 711). We are available for phone calls from 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday – Friday from April 1 to 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 CarePartners of Connecticut CareAdvantage Preferred. 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 www.carepartnersct.com. 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 www.carepartnersct.com. 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.

CarePartners of Connecticut
MEDICARE ADVANTAGE

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-341-1507 (HMO)/1-866-632-0060 (PPO)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-341-1507 (HMO)/1-866-632-0060 (PPO)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-341-1507 (HMO)/1-866-632-0060 (PPO)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-888-341-1507 (HMO)/1-866-632-0060 (PPO)** . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-341-1507 (HMO)/1-866-632-0060 (PPO) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-341-1507 (HMO)/1-866-632-0060 (PPO). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-341-1507 (HMO)/1-866-632-0060 (PPO)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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