ConnectiCare

ConnectiCare Employer Group Plan (HMO-POS) offered by ConnectiCare, Inc.

CBIA High Option (HMO-POS)

Annual Notice of Changes for 2024

You are currently enrolled as a member of ConnectiCare Employer Group Plan. Next year, there will be some changes to the plan's costs and benefits. *This document tells about the changes.*

For specific information about cost, please review your Cost Sharing Guide. To get more information about benefits, or rules please review the Evidence of Coverage, which is located on our website at **connecticare.com/medicare**.

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 authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

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

☐ Think about whether you are happy with our plan.

2. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** ConnectiCare Employer Group Plan, you may not have to do anything. Please contact your Benefit Administrator for additional information.

3. ENROLL: If you decide other coverage will better meet your needs, you can switch plans. Please contact your Benefit Administrator for additional information.

Additional Resources

- 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 large print or other alternate formats). Please call Member Services at the number listed above if you need plan information in another format.
- **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 Employer Group Plan

- ConnectiCare, Inc. is an HMO/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 Employer Group Plan.

H3528_202504CY24_M Group

Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for ConnectiCare Employer Group Plan in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	Please contact your Benefits Administrator to find out if there are any premium changes in 2024. (You must continue to pay your Medicare Part B premium.)	
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.)	**$3,400** (combined In-Network and Out-of-Network)	**$3,400** (combined In-Network and Out-of-Network)
Doctor office visits	Primary care visits: **$15** copay per visit in-network **$15** copay per visit out-of-network Specialist visits: **$30** copay per visit in-network **$30** copay per visit out-of-network	Primary care visits: **$15** copay per visit in-network **$15** copay per visit out-of-network Specialist visits: **$30** copay per visit in-network **$30** copay per visit out-of-network

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	In-Network: Days 1-7: **$250** copay per day. **$0** copay for each additional day; for each inpatient stay. Out-of-Network: Days 1-7: **$250** copay per day. **$0** copay for each additional day; for each inpatient stay. Prior authorization is required	In-Network: Days 1-7: **$250** copay per day. **$0** copay for each additional day; for each inpatient stay. Out-of-Network: Days 1-7: **$250** copay per day. **$0** copay for each additional day; for each inpatient stay. Prior authorization is required
Part D prescription drug coverage (See Section 1.6 for details.) (continued on next page)	Deductible: **$0** Copayment during the Initial Coverage Stage: Drug Tier 1: **$5** copayment. Drug Tier 2: **$5** copayment. Drug Tier 3: **$40** copayment. You pay **$35** per one-month supply of each covered insulin product on this tier. Drug Tier 4: **$80** copayment. Drug Tier 5: **$80** copayment. Drug Tier 6: **$0** copayment. Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs.	Deductible: **$0** Copayment during the Initial Coverage Stage: Drug Tier 1: **$5** copayment. Drug Tier 2: **$5** copayment. Drug Tier 3: **$40** copayment. You pay **$35** per one-month supply of each covered insulin product on this tier. Drug Tier 4: **$80** copayment. Drug Tier 5: **$80** copayment. Drug Tier 6: **$0** copayment. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	• For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	Please contact your Benefits Administrator to find out if there are any premium changes in 2024.	

- 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 5 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	2023 (this year)	2024 (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.	**$3,400** (combined in-network and out-of-network)	**$3,400** (combined in-network and out-of-network) Once you have paid **$3,400** out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

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 2024 *Provider Directory* 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 2024 *Pharmacy Directory* 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	2023 (this year)	2024 (next year)
Cardiac Rehabilitation Services	You pay a **$0** copay for Medicare-covered cardiac rehabilitation services.	You pay a **$0** copay for Medicare-covered cardiac rehabilitation services. **You have the option of getting these services through an in-person visit or by telehealth with a network provider who offers the service by telehealth.**

Cost	2023 (this year)	2024 (next year)
Remote Access Technologies/ Teladoc®	You pay a **$45** copay for each covered Teladoc® service.	You pay a **$0** copay for each covered Teladoc® service.

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, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

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 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, please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (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.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (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.** Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage* or refer to your Benefit Summary. **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."**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic):** You pay **$5** per prescription **Tier 2 (Generic):** You pay **$5** per prescription **Tier 3 (Preferred Brand):** You pay **$40** per prescription You pay **$35** per one-month supply of each covered insulin product on this tier **Tier 4 (Non-Preferred Drug):** You pay **$80** per prescription **Tier 5 (Specialty Tier):** You pay **$80** per prescription **Tier 6 (Select Care Drugs):** You pay **$0** per prescription Once have paid **$7,400** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic):** You pay **$5** per prescription **Tier 2 (Generic):** You pay **$5** per prescription **Tier 3 (Preferred Brand):** You pay **$40** per prescription You pay **$35** per one-month supply of each covered insulin product on this tier **Tier 4 (Non-Preferred Drug):** You pay **$80** per prescription **Tier 5 (Specialty Tier):** You pay **$80** per prescription **Tier 6 (Select Care Drugs):** You pay **$0** per prescription Once have paid **$8,000** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in ConnectiCare Employer Group Plan

To stay in ConnectiCare Employer Group Plan, please contact your Benefits Administrator to find out how you can stay enrolled in our ConnectiCare Employer Group Plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 please contact your Benefits Administrator for additional information.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, please contact your Benefits Administrator for additional information. The change will take effect on January 1, 2024.

SECTION 4 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 5 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, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or 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 (applications).
- **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. 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, or how to enroll in the program, please call CADAP at 1-800-424-3310.

SECTION 6 Questions?

Section 6.1 – Getting Help from ConnectiCare Employer Group Plan

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 to September 30. Calls to these numbers are free.

Read your *2024 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 2024. For details, look in the *2024 Evidence of Coverage* for ConnectiCare Employer Group Plan or refer to your Benefit Summary. 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 and Pharmacy Directory) and our *List of Covered Drugs (Formulary/"Drug List")*.

Section 6.2 – 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 2024*

Read the *Medicare & You 2024* 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.