Annual Notice of Change 2024

Care N' Care Choice Plus (PPO) H6328-002

1-877-374-7993 (TTY 711) October 1 - March 31, 8 a.m. to 8 p.m. CST, seven days a week or April 1 - September 30, 8 a.m. to 8 p.m. CST, Monday through Friday.

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cnchealthplan.com

care n care

Insurance Company, Inc.

OMB Approval 0938-1051 (Expires: February 29, 2024)

Care N' Care Choice Plus (PPO) offered by Care N' Care Insurance Company

Annual Notice of Changes for 2024

You are currently enrolled as a member of Care N' Care Choice Plus (PPO). 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 www.cnchealthplan.com. You may also call your Customer Experience Team 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 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. 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 website or review the list in the back of your *Medicare & You 2024* handbook.

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

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

- If you don't join another plan by December 7, 2023, you will stay in Care N' Care Choice Plus (PPO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Care N' Care Choice Plus (PPO).
- If you recently moved into, currently live in, or just moved out of 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.

Additional Resources

- This document is available for free in Spanish. Este documento está disponible de forma gratuita en español.
- Please contact our Customer Experience Team number at 1-877-374-7993 for additional information. (TTY users should call 711.) Hours are October 1 – March 31, 8AM to 8PM Central, 7 days a week; April 1 – September 30, 8AM to 8PM Central, Monday through Friday. This call is free.
- This information is available in a different format, including large print and Spanish. Please call your Customer Experience Team 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 Care N' Care Choice Plus (PPO)

- Care N' Care Insurance Company, Inc. is an HMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal.
- When this document says "we," "us," or "our", it means Care N' Care Insurance Company. When it says "plan" or "our plan," it means Care N' Care Choice Plus (PPO).

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 Care N' Care Choice Plus (PPO) 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.	$53	$50
Maximum out-of-pocket amounts 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.)	From network providers: $3,800 From network and out-of-network providers combined: $8,950	From network providers: $3,900 From network and out-of-network providers combined: $8,950
Doctor office visits	**In-Network** Primary care visits: $0 Copay per visit Specialist visits: $25 Copay per visit **Out-of-Network** Primary care visits: $20 Copay per visit Specialist visits: $50 Copay per visit	**In-Network** Primary care visits: $0 per visit Specialist visits: $20 Copay per visit **Out-of-Network** Primary care visits: $20 Copay per visit Specialist visits: $25 Copay per visit
Inpatient hospital stays	**In-Network** You pay a $250 copay per day for days 1-5. You pay a $0 copay per day for days 6-90.	**In-Network** You pay a $200 copay per day for days 1-5. You pay a $0 copay per day for days 6-90.

Cost	2023 (this year)	2024 (next year)
	Out-of-Network You pay a 30% Coinsurance per day for days 1- 90.	**Out-of-Network** You pay a 30% Coinsurance per day for days 1-90.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $2 copay • Drug Tier 2: $12 copay • Drug Tier 3: $45 copay *You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $97 copay • Drug Tier 5: 33% coinsurance Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • 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.)	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $2 copay • Drug Tier 2: $12 copay • Drug Tier 3: $45 copay *You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $97 copay • Drug Tier 5: 33% coinsurance Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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.)	$53	$50
Optional Dental Benefit premium	$25	Not offered (See Dental Services (Routine) in Section 1.4)

- 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 Amounts

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. 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)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,800	$3,900 Once you have paid $3,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2023 (this year)	2024 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$8,950	$8,950 Once you have paid $8,950 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers 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 www.cnchealthplan.com. You may also call your Customer Experience Team 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/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, pharmacies, etc.) 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 your Customer Experience Team 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)
Acupuncture (Medicare Covered Benefit Only; Benefit through American Specialty Health)	**In-Network:** You pay a $15 copay per visit.	**In-Network:** You pay a $20 copay per visit.

Cost	2023 (this year)	2024 (next year)
	Out- of -Network: You pay a $40 copay per visit.	**Out- of -Network:** You pay a $55 copay per visit.
Additional Telehealth Services	**In-Network:** You pay a $0 copay per visit for Services by a Primary Care Physician. You pay a $25 copay per visit for Individual or Group Mental Health Specialty Services. You pay a $25 copay per visit for Services by a Physician Specialist limited to Allergy & Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gynecology, OB/GYN, Infectious Diseases, Nephrology, Neurology, and Ophthalmology. Other Medicare-covered benefits not listed are not covered with Additional Telehealth Services. **Out- of -Network:** Not Covered	**In-Network:** You pay a $0 copay per visit for Services by a Primary Care Physician (including Other Healthcare Professionals functioning as a Primary Care Physician) and Urgently Needed Services. You pay a $25 copay per visit for Individual or Group Mental Health or Psychiatric Services. You pay a $20 copay per visit for Services by a Physician Specialist (including Other Healthcare Professionals functioning as a Physician Specialist). Other Medicare-covered benefits not listed are not covered with Additional Telehealth Services. **Out- of -Network:** Not Covered

Cost	2023 (this year)	2024 (next year)
Chiropractic Services	**In-Network:** You pay a $15 copay per visit. **Out-of-Network:** You pay a $30 copay per visit.	**In-Network:** You pay a $20 copay per visit. **Out-of-Network:** You pay a $55 copay per visit.
Dental Services (Routine) (Supplemental benefit through DentaQuest)	**In-Network:** You pay a $0 copay for routine preventive Dental Services. An optional supplemental benefits dental rider including Comprehensive Dental Services is offered for an additional monthly premium of $25. **Out- of -Network:** You pay a $0 copay for routine preventive Dental Services.	**In-Network:** You pay a $0 copay up to a $3,000 benefit maximum for combined Preventive and Comprehensive Dental Services. Once the benefit maximum is reached, you pay 100% of the claim cost. The optional supplemental benefit dental rider is <u>not</u> offered. **Out- of -Network:** You pay a $0 copay for the in-network allowed amount for combined Preventive and Comprehensive Dental Services up to the benefit maximum of $3,000. Once the benefit maximum is reached, you pay 100% of claim costs.

Cost	2023 (this year)	2024 (next year)
	An optional supplemental benefits dental rider including Comprehensive Dental Services is offered for an additional monthly premium of $25.	Out-of-network services are based on the in-network allowed amount. Your provider can charge you the difference between the allowed amount and the billed amount. The optional supplemental benefit dental rider is <u>not</u> offered. *Services may require prior authorization.*
Diagnostic Procedures and Tests	**In-Network:** You pay a $50 copay for a diagnostic colonoscopy. You pay a $50 copay for a diagnostic mammogram. **Out- of -Network:** You pay a $175copay for a diagnostic colonoscopy. You pay a $175 copay for a diagnostic mammogram.	**In-Network:** You pay a $0 copay for a diagnostic colonoscopy. You pay a $0 copay for a diagnostic mammogram. **Out- of -Network:** You pay a $175 copay for a diagnostic colonoscopy. You pay a $75 copay for a diagnostic mammogram.

Cost	2023 (this year)	2024 (next year)
Hearing Services - Hearing Aids (Supplemental benefit through TruHearing)	**In-Network:** You pay $699 copay per Advanced aid. You pay $999 copay per Premium aid. Standard aid is not covered. (Benefit limited to one aid per ear per year) This in-network non-Medicare covered supplemental benefit is included in your maximum out-of-pocket (MOOP) calculations. **Out-of-Network:** Not Available Must use a TruHearing provider	**In-Network:** You pay $499 copay per Standard aid. You pay $699 copay per Advanced aid. You pay $999 copay per Premium aid. (Benefit limited to one aid per ear per year) **Out-of-Network:** Not Available. Must use a TruHearing provider
Hearing Services – Routine Hearing Exams (Supplemental benefit through TruHearing)	**In-Network:** You pay a $45 copay per exam (one exam per year). This in-network non-Medicare covered supplemental benefit is included in your maximum out-of-pocket (MOOP) calculations. **Out-of-Network:**	**In-Network:** You pay a $0 copay per exam (one exam per year). **Out-of-Network:**

Cost	2023 (this year)	2024 (next year)
	Not Available. Must use a TruHearing provider	Not Available. Must use a TruHearing provider
Inpatient Hospital Services (Acute)	**In-Network:** You pay a $250 copay per day for days 1-5. You pay a $0 copay per day for days 6-90. You pay a $0 copay per day for days 91 and beyond (supplemental benefit). * *This in-network non-Medicare covered supplemental benefit is included in your maximum out-of-pocket (MOOP) calculations. **Out- of -Network:** You pay a 30% coinsurance per stay for days 1-90. You pay a 30% coinsurance per stay for days 91 and beyond (supplemental benefit). *Services require prior authorization.*	**In-Network:** You pay a $200 copay per day for days 1-5. You pay a $0 copay per day for days 6-90. You pay a $0 copay per day for days 91 and beyond (supplemental benefit) . **Out- of -Network:** You pay a 30% coinsurance per stay for days 1-90. You pay a 30% coinsurance per stay for days 91 and beyond (supplemental benefit). *Services require prior authorization.*
Inpatient Services in a Psychiatric Hospital	**In-Network:** You pay a $250 copay per day for days 1-5.	**In-Network:** You pay a $250 copay per day for days 1-5.

Cost	2023 (this year)	2024 (next year)
	You pay a $0 copay per day for days 6-90. **Out- of -Network:** You pay 30% coinsurance per stay for days 1-90. *Inpatient Services in a Psychiatric Hospital are <u>not</u> covered after 90 days. *Services require prior authorization*	You pay a $0 copay per day for days 6-90. You pay a $0 copay per day for days 91 and beyond (supplemental benefit) **Out- of -Network:** You pay 30% coinsurance per stay for days 1-90. You pay a 30% coinsurance per stay for days 91 and beyond (supplemental benefit). *Services require prior authorization*
Mental Health Specialty Services (Services provided by State-licensed clinical psychologists and clinical social workers and other professionals authorized by the State to furnish mental health services.)	**In-Network:** You pay a $25 copay for each individual or group therapy visit. **Out- of -Network:** You pay a $55 copay for each individual or group therapy visit. *Services require prior authorization.*	**In-Network:** You pay a $25 copay for each individual or group therapy visit. **Out- of -Network:** You pay a $55 copay for each individual or group therapy visit.
Other Health Care Professional Services	**In-Network:**	**In-Network:**

Cost	2023 (this year)	2024 (next year)
(Nurse practitioner, physician's assistant or other non-physician health care professional as allowed by Medicare)	You pay a $0 copay per visit for Other Health Care Professional Services in a primary care physician office. You pay a $25 copay per visit for Other Health Care Professional Services in a physician specialist office. **Out- of -Network:** You pay a $20 copay per visit for Other Health Care Professional Services in a primary care physician office. You pay a $50 copay per visit for Other Health Care Professional Services in a physician specialist office.	You pay a $0 copay per visit for Other Health Care Professional Services in a primary care physician office. You pay a $20 copay per visit for Other Health Care Professional Services in a physician specialist office. **Out- of -Network:** You pay a $20 copay per visit for Other Health Care Professional Services in a primary care physician office. You pay a $25 copay per visit for Other Health Care Professional Services in a physician specialist office.
Outpatient Hospital Services	**In-Network:** You pay a $275 copay per visit. **Out- of -Network:** You pay a $350 copay per visit.	**In-Network:** You pay a $200 copay per visit. **Out- of -Network:** You pay a $350 copay per visit.

Cost	2023 (this year)	2024 (next year)
	Services require prior authorization.	*Services require prior authorization.*
Outpatient Observation Services	**In-Network:** You pay a $275 copay per visit. **Out-of-Network:** You pay a $350 copay per visit.	**In-Network:** You pay a $200 copay per visit. **Out-of-Network:** You pay a $350 copay per visit.
Over-the-Counter (OTC) Items (Benefit through Medline)	**In-Network:** You pay a $0 copay for OTC items. You receive $60 every quarter (3 months) to spend on plan-approved OTC items. **Out- of -Network:** Not available. Must use a preferred vendor for this benefit.	**In-Network:** You pay a $0 copay for OTC items. You receive $90 every quarter (3 months) to spend on plan-approved OTC items. **Out- of -Network:** Not available. Must use a preferred vendor for this benefit.
Physician Specialist	**In-Network:** You pay a $25 copay per visit.	**In-Network:** You pay a $20 copay per visit.

Cost	2023 (this year)	2024 (next year)
	Out- of -Network: You pay a $50 copay per visit.	**Out- of -Network:** You pay a $25 copay per visit.
Psychiatric Services Physician (Individual/Group sessions)	**In-Network:** You pay a $25 copay per visit. **Out-of-Network:** You pay a $55 copay per visit. *Services require prior authorization.*	**In-Network:** You pay a $25 copay per visit. **Out-of-Network:** You pay a $55 copay per visit.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	**In-Network:** You pay a $0 copay per visit. **Out-of-Network:** You pay a $20 copay per visit.	**In-Network:** You pay a $10 copay per visit. **Out-of-Network:** You pay a $20 copay per visit.

Cost	2023 (this year)	2024 (next year)
Texas Health Care at Home	Hospital services in the home allows for certain health care services to be provided outside of a traditional hospital setting and within your home. **In-Network:** You pay a $250 copay for days 1-5. You pay a $0 copay for days 6-90. **Services require prior authorization.** **Out-of-Network:** You pay a 30 % coinsurance per day for days 1-90. *Services require prior authorization.*	Medicare covered services under the Texas Health Care at Home benefit design will continue to be provided according to the coverage guidelines established by Medicare. Covered services include "Inpatient Hospital Care" and "Home Health Agency Care". Please see these benefit sections in the Evidence of Coverage for further details. **In-Network:** Inpatient Hospital Care: You pay a $200 copay per day for days 1-5. You pay a $0 copay per day for days 6-90. You pay a $0 copay per day for 91 and beyond (supplemental benefit). Home Health Agency Care: There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered Home Health Agency Care. **Out-of-Network:** Inpatient Hospital Care: You pay a 30% coinsurance per day for days 1-90.

Cost	2023 (this year)	2024 (next year)
		You pay a 30% coinsurance for days 91 and beyond. Home Health Agency Care: You pay a $40 copay per visit. *Services require prior authorization.*
Vision Care (Supplemental Benefit through EyeMed)	**In-Network:** You pay a $0 copay for a routine eye exam. You pay a $0 copay for prescription eyewear. Your benefit is limited to a $100 allowance toward the purchase of covered eyewear. Medically necessary contact lenses are not covered. This in-network non-Medicare covered supplemental benefit is included in your maximum out-of-pocket (MOOP) calculations. **Out- of -Network:** You pay a $40 copay for a routine eye exam. You pay a $30 copay for prescription eyewear. Your benefit is limited to a $100 maximum reimbursement	**In-Network:** You pay a $0 copay for a routine eye exam. You pay a $0 copay for prescription eyewear. Your benefit is limited to a $150 allowance toward the purchase of covered eyewear. You pay a $0 copay for Medically necessary contact lenses. **Out- of -Network:** You have a $50 maximum reimbursement limit for a routine eye exam. You have a $150 maximum reimbursement limit toward

Cost	2023 (this year)	2024 (next year)
	limit toward the purchase of covered eyewear. Medically necessary contact lenses are not covered.	the purchase of covered eyewear. You have a $210 maximum reimbursement limit toward the purchase of Medically necessary contact lenses.
Worldwide Emergency and Urgent Care Coverage	You pay a $90 copay for each visit. Coverage limited to $75,000 per year for worldwide emergency/urgent care services outside the United States. This non-Medicare covered supplemental benefit is included in your maximum out-of-pocket (MOOP) calculations.	You pay a $90 copay for each visit. Coverage limited to $75,000 per year for worldwide emergency/urgent care services outside the United States.

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. **You can get the *complete* "Drug List"** by calling your Customer Experience Team (see the back cover) or visiting our website (www.cnchealthplan.com/our-plans-2024/plan-documents-2024/).

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 your Customer Experience Team 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 by September 30, 2023, please call your Customer Experience Team 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.** 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*. 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generics:** You pay $2 per prescription **Tier 2 Generics:** You pay $12 per prescription **Tier 3 Preferred Brands:** You pay $45 per prescription **Tier 4 Non-Preferred Brands:** You pay $97 per prescription **Tier 5 Specialty Tier:** You pay 33% coinsurance of the total cost Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generics:** You pay $2 per prescription **Tier 2 Generics:** You pay $12 per prescription **Tier 3 Preferred Brands:** You pay $45 per prescription You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Brands:** You pay $97 per prescription **Tier 5 Specialty Tier:** You pay 33% coinsurance of the total cost Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap 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 Care N' Care Choice Plus (PPO)

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 Care N' Care Choice Plus (PPO).

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 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 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Care N' Care Insurance Company offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Care N' Care Choice Plus (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Care N' Care Choice Plus (PPO).

- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll . Contact your Customer Experience Team 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 3 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, 2024.

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, 2024, 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, 2024.

If you recently moved into, currently live in, or just moved out of 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.

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 Texas, the SHIP is called the Health Information Counseling and Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The Health Information Counseling and Advocacy Program (HICAP) 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 The Health Information Counseling and Advocacy Program (HICAP) at 1-800-252-9240. You can learn more about the Health Insurance Information Counseling and Advocacy Program (HICAP) by visiting their website (hhs.texas.gov/services/health/medicare).

SECTION 5 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, 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).
- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas Kidney Health Care Program (KHC) and the Texas HIV Medication Program that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **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 Texas HIV Medication Program (THMP) For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-255-1090.

SECTION 6 Questions?

Section 6.1 – Getting Help from Care N' Care Choice Plus (PPO)

Questions? We're here to help. Please call Customer Experience Team at 1-877-374-7993. (TTY only, call 711.) We are available for phone calls October 1 - March 31, 8AM – 8PM Central, 7 days a week; April 1 - September 30, 8AM – 8PM Central, Monday through Friday. 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 Care N' Care Choice Plus (PPO). 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.cnchealthplan.com. You may also call your Customer Experience Team to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.cnchealthplan.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/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 (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.

Multi-Language Insert

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 1-877-374-7993 (TTY: 711). Someone who speaks English/Language 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 1-877-374-7993 (TTY: 711). 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 1-877-374-7993 (TTY: 711) 。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 1-877-374-7993 (TTY: 711) 。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 1-877-374-7993 (TTY: 711). 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 1-877-374-7993 (TTY : 711). 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 1-877-374-7993 (TTY: 711) 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 1-877-374-7993 (TTY: 711). 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 1-877-374-7993 (TTY: 711) 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 1-877-374-7993 (TTY: 711). 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 1-877-374-7993 (TTY: 711) سيقوم [1-×××-×××-××××] بمساعدتك. هذه خدمة مجانية شخص ما يتحدث العربية.

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 1-877-374-7993 (TTY: 711) 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 1-877-374-7993 (TTY: 711). 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 1-877-374-7993 (TTY: 711). 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 1-877-374-7993 (TTY : 711). 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 1-877-374-7993 (TTY: 711). 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、1-877-374-7993 (TTY: 711)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。