

Provider Partners North Carolina Community Plan (HMO I-SNP) offered by Provider Partners Health Plans

Annual Notice of Changes for 2025

You are currently enrolled as a member of *Provider Partners North Carolina Community Plan*. 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.pphealthplan.com. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

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

What to do now

1. ASK: Which changes apply to you

- ☐ Check the changes to our benefits and costs to see if they affect you.
 - Review the changes to medical care costs (doctor, hospital).
 - Review the changes to our drug coverage, including coverage restrictions and cost sharing.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
 - Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
 - Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.
- ☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.
- ☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.
- ☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

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

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

- If you don't join another plan by December 7, 2024, you will stay in *Provider Partners North Carolina Community Plan*.
- 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 *Provider Partners North Carolina Community Plan*.
- 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

- Please contact our Member Services number at 1-800-405-9681 for additional information. (TTY users should call 711.) Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31: 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30. This call is free.
- *This material may be available in an alternate format such as braille and 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 Provider Partners North Carolina Community Plan

- *Provider Partners North Carolina Community Plan is a Health Maintenance Organization (HMO) Special Needs Plan (SNP) with a Medicare contract. Enrollment in Provider Partners Medicare Community Plan depends on contract renewal.*
- When this document says "we," "us," or "our," it means *Provider Partners Health Plans*. When it says "plan" or "our plan," it means *Provider Partners North Carolina Community Plan*.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for *Provider Partners North Carolina Community Plan* 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 2.1 for details.	\$0	\$0
Maximum out-of-pocket amount This is the <u>most</u> you will pay out of pocket for your covered services. (See Section 2.2 for details.)	\$1,500	\$3,750
Doctor office visits	Primary care visits: 0% of the total cost per visit Specialist visits: 20% of the total cost per visit	Primary care visits: 0% of the total cost per visit Specialist visits: 20% of the total cost per visit
Inpatient hospital stays	\$1,632 deductible for each benefit period. Days 1–60: \$0 copay for each benefit period. Days 61–90: \$408 copay per day of each benefit period. Days 91–150: \$816 copay per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: You pay all costs.	\$1,676 deductible for each benefit period. Days 1–60: \$0 copay for each benefit period. Days 61–90: \$419 copay per day of each benefit period. Days 91–150: \$838 copay per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: You pay all costs.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: \$545 except for covered insulin products and most adult Part D vaccines. <i>Coinsurance during the Initial Coverage Stage:</i> <ul style="list-style-type: none"> Drug Tier 1: 25% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. <i>Catastrophic Coverage:</i> <ul style="list-style-type: none"> During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. 	Deductible: \$590 except for covered insulin products and most adult Part D vaccines. <i>Coinsurance during the Initial Coverage Stage:</i> <ul style="list-style-type: none"> Drug Tier 1: 25% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. <i>Catastrophic Coverage:</i> <ul style="list-style-type: none"> During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *Provider Partners North Carolina Community Plan* in 2025

If you do nothing by December 7, 2024, we will automatically enroll you in our *Provider Partners North Carolina Community Plan*. This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through *Provider Partners North Carolina Community Plan*. If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for “Extra Help,” you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0
Medicare Part B premium reduction	<i>No reduction to standard Medicare Part B premium amount</i>	<i>Reduction is \$.60</i>

- 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 2.2 – 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	\$1,500	\$3,750
Your costs for covered medical services (such as copays and deductibles) 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.		Once you have paid \$3,750 out of pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – 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.

Updated directories are located on our website at www.pphealthplan.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 network of providers for next year. **Please review the 2025 Provider Directory www.pphealthplan.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 www.pphealthplan.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 2.4 – 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)
<i>Additional Telehealth Benefits</i>	<i>Prior authorization is not required.</i>	<i>Prior authorization may be required.</i>
<i>Annual Physical Exam</i>	<i>This benefit was not covered as a supplemental benefit under Part C.</i>	<i>This benefit is provided as a supplemental benefit under Part C. You pay 20% of the total cost.</i>
<i>Ambulatory Surgical Center (ASC) Services</i>	<i>Prior authorization is not required.</i>	<i>Prior authorization may be required.</i>
<i>Emergency Services</i>	<i>You pay 20% of the total cost (up to \$135 maximum) per visit.</i>	<i>You pay 20% of the total cost (up to \$100 maximum) per visit.</i>
<i>Fitness Benefit</i>	<i>You pay \$0 to utilize services at in-network facilities.</i>	<i>This benefit <u>is no</u> longer covered.</i>
<i>Medicare Part B Rx Drugs and Home Infusion Drugs</i>	<i>Prior authorization is required for billed charges in excess of \$1,500.</i>	<i>Prior authorization may be required.</i>
<i>Non- Medicare service categories that are subject to Maximum out of pocket</i>	<i>Annual Physical exam did not count towards the maximum out of the pocket.</i>	<i>Annual Physical exam will count towards the maximum out of the pocket.</i>
<i>Other Medicare-Covered Preventative Services</i>	<i>You pay 20% of the total cost for Medicare - covered Diabetes Self-Management Training.</i>	<i>You pay 0% for Medicare-covered Diabetes Self-Management Training.</i>

Cost	2024 (this year)	2025 (next year)
<i>Occupational Therapy Services</i>	<i>Prior authorization is required. There is no prior authorization required if service rendered in a contracted nursing home facility.</i>	<i>Prior authorization may be required. Prior authorization <u>is</u> required if service is rendered in a contracted nursing home facility.</i>
<i>Other Health Care Professional Services</i>	<i>Prior authorization is not required.</i>	<i>Prior authorization may be required.</i>
<i>Outpatient Diagnostic and Therapeutic Radiological Services</i>	<i>Prior authorization is not required on all Therapeutic Radiological Services.</i>	<i>Prior authorization may be required on all Therapeutic radiological services.</i>
<i>Outpatient Diagnostic Procedures, Tests and Lab Services</i>	<i>Prior authorization is not required.</i>	<i>Prior authorization may be required for outpatient diagnostic procedures and tests. Prior authorization is not required for lab services.</i>
<i>Over the Counter (OTC) Benefit</i>	<i>Limited to \$255 allowance every quarter for specific over-the-counter drugs and other health-related products, as listed in the OTC catalog.</i>	<i>Limited to \$50 allowance every quarter for specific over-the-counter drugs and other health-related products, as listed in the OTC catalog.</i>
<i>Physician Specialist Services</i>	<i>Prior authorization is not required.</i>	<i>Prior authorization may be required.</i>

Cost	2024 (this year)	2025 (next year)
<i>Physical Therapy and Speech Therapy</i>	<i>Prior authorization is required. There is no prior authorization required if service rendered in a contracted nursing home facility.</i>	<i>Prior authorization may be required. Prior authorization <u>is</u> required if service is rendered in a contracted nursing home facility.</i>

Cost	2024 (this year)	2025 (next year)
<i>Special Supplemental Benefits for the Chronically Ill (SSBCI)*</i>	<i>This benefit <u>is not</u> covered.</i>	<p><i>The Grocery benefit provides a monthly allowance of \$60. Funds are loaded every month onto a restricted spend debit card** for use at participating retail locations. Members can purchase healthy foods and prepared meals. Any unused funds do not rollover to the next period.</i></p> <p><i>*These are special supplemental benefits, not all members will qualify. Members that have been diagnosed with one of the following chronic conditions AND meet certain criteria may be eligible for these benefits: cardiovascular disorders, chronic heart failure, dementia, diabetes and chronic and disabling mental health conditions. Other conditions may also make you eligible for these benefits.</i></p> <p><i>** The &more Benefits Prepaid Mastercard® is issued by Avidia Bank, pursuant to a license from Mastercard Inc. Use of this card is subject to the terms and conditions of the Cardholder Agreement.</i></p>
<i>Transportation Services</i>	<i>You pay \$0 for 36 one-way trips.</i>	<i>You pay \$0 for 14 one-way trips.</i>

Cost	2024 (this year)	2025 (next year)
<i>Urgently Needed Services</i>	<i>You pay 20% of the total cost (up to \$65 maximum) per visit.</i>	<i>You pay 20% of the total cost (up to \$45 maximum) per visit.</i>

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

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

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately add new restrictions.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month’s supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website:

<https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients>.

You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get “Extra Help” Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive “Extra Help” and you haven’t received this insert by 9/30/2024, please call Member Services and ask for the *LIS Rider*.

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

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

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your drugs until you have reached the yearly deductible. The deductible doesn’t apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is \$545.	The deductible is \$590.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>The costs in this chart are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.</p> <p>For information about the costs for a long-term supply look, in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is:</p> <p>Tier 1:</p> <p>You pay 25% of the total cost.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is:</p> <p>Tier 1:</p> <p>You pay 25% of the total cost.</p> <p>Once you have paid \$2,000, out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

Changes to the Catastrophic Coverage Stage

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

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

SECTION 3 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	<p>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).</p> <p>To learn more about this payment option, please contact us at 1-800-405-9681 (TTY 711) or visit Medicare.gov.</p>
Pharmacy Benefit Manager Update	For 2024, your part D, Pharmacy Benefit Manager (PBM) was going by the name Elixir. This name was referenced in your prescription mailings and on documents found on the website.	In 2025, your Pharmacy Benefit Manager changed their name to MedImpact.

Part D Mailing Address Update

Coverage Decisions for Part D prescription drugs are to be mailed to:
Elixir C/O Provider Partners Health Plans
7835 Freedom Avenue
NW North Canton, OH 44720

Part D Appeals are to be mailed to: Elixir C/O Provider Partners Health Plans
7835 Freedom Avenue
NW North Canton, OH 44720
Attn: Appeals Department

Part D Complaints/ Grievances are to be mailed to: Elixir C/O Provider Partners Health Plans
7835 Freedom Avenue
NW North Canton, OH 44720 Attn: Grievance Department
Fax: 1-877-503-7231

Pharmacy Payment Requests are to be mailed to: Elixir C/O Provider Partners Health Plans
7835 Freedom Avenue
NW North Canton, OH 44720

Claims are to be mailed to: Elixir C/O Provider Partners Health Plans
7835 Freedom Avenue
NW North Canton, OH 44720

Direct Member

Coverage Decisions for Part D prescription drugs are to be mailed to:
MedImpact C/O Provider Partners Health Plans
10181 Scripps Gateway Ct,
San Diego, CA 92131

Part D Appeals are to be mailed to: MedImpact C/O Provider Partners Health Plans
10181 Scripps Gateway Ct,
San Diego, CA 92131

Part D Complaints/ Grievances are to be mailed to: MedImpact C/O Provider Partners Health Plans
10181 Scripps Gateway Ct,
San Diego, CA 92131
Attn: Grievance Department
Fax: 1-877-503-7231

Pharmacy Payment Requests are to be mailed to: MedImpact C/O Provider Partners Health Plans
10181 Scripps Gateway Ct,
San Diego, CA 92131

Claims are to be mailed to: MedImpact C/O Provider Partners Health Plans
10181 Scripps Gateway Ct,
San Diego, CA 92131

Direct Member Reimbursements are to

Description	2024 (this year)	2025 (next year)
	Reimbursements are to be mailed to: Elixir C/O Provider Partners Health Plans 7835 Freedom Avenue NW North Canton, OH 44720 Attention: DMR Department	be mailed to: MedImpact C/O Provider Partners Health Plans 10181 Scripps Gateway Ct, San Diego, CA 92131 Attention: DMR Department
Service Areas covered	Davie, Forsyth, Gaston, Guilford	Cabarrus, Davie, Forsyth, Gaston, Guilford, Lincoln

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in *Provider Partners North Carolina Community Plan*

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 *Provider Partners North Carolina Community Plan*.

Section 4.2 – 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 2.1 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 6), or call Medicare (see Section 8.2).

As a reminder, *Provider Partners Health Plan, Inc.* 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 *Provider Partners North Carolina Community Plan*.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from *Provider Partners North Carolina Community Plan*.
- 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 5 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 6 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 *North Carolina*, the SHIP is called *Medicare and Seniors’ Health Insurance Information Program (SHIIP)*.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *Medicare and Seniors' Health Insurance Information Program (SHIIP)* 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 *Medicare and Seniors' Health Insurance Information Program (SHIIP)* at 1-855-408-1212. You can learn more about *Medicare and Seniors' Health Insurance Information Program (SHIIP)* by visiting their website <https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip>.

SECTION 7 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.
- **Help from your state’s pharmaceutical assistance program.** *North Carolina* has a program called *NC MedAssist* 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. 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 *North Carolina HIV Medication Program*. 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 1-877-466-2232 or 1-919-733-9161. 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 1-800-405-9681 (TTY 711) or visit Medicare.gov.

SECTION 8 Questions?

Section 8.1 – Getting Help from *Provider Partners North Carolina Community Plan*

Questions? We're here to help. Please call Member Services at 1-800-405-9681. (TTY only, call 711). We are available for phone calls. Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31: 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through 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 Provider Partners North Carolina Community Plan*. 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.pphealthplan.com. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you. 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.pphealthplan.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 8.2 – 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.