

# CCHP Senior Value Program (HMO) offered by Chinese Community Health Plan (CCHP)

## Annual Notice of Changes for 2025

You are currently enrolled as a member of *CCHP Senior Value Program (HMO)*. 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.cchphealthplan.com/Medicare](http://www.cchphealthplan.com/Medicare). You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

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

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### 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](http://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 CCHP Senior Value Program (HMO).
- 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 CCHP Senior Value Program (HMO).
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

### Additional Resources

- This document is available for free in Chinese and Spanish
- Please contact our Member Services number at 1-888-775-7888 for additional information. (TTY users should call 1-877-681-8898.) Hours are 8:00 a.m. to 8:00 p.m. during the open enrollment period (October 1 - March 31). During the non-open enrollment period (April 1 – September 30), the hours are Mondays – Fridays 8:00 a.m. to 8:00 p.m.. This call is free.
- 此文件有其它的語言版本免費提供。了解詳情請致電： 1-888-775-7888 與會員服務中心聯絡。（聽力殘障人士請電 TTY: 1-877-681-8898），10月1日至3月31日期間，每週七天，上午8時至晚上8時。4月1日至9月30日期間，週一至週五，上午8時至晚上8時。會員服務中心也有提供免費其它語言的口譯服務。
- Por favor comuníquese con nuestro número de Servicios para Miembros al 1-888-775-7888 para obtener información adicional. (Los usuarios de TTY deben llamar al 1-877-681-8898). El horario es los 7 días de la semana, de 8:00 a. m. a 8:00 p. m. durante el período de inscripción abierta (1 de octubre al 31 de marzo). Durante el período de inscripción no abierta (del 1 de abril al 30 de septiembre), el horario es de lunes a viernes de 8:00 a. m. a 8:00 p. m. Esta llamada es gratis.
- This document may be available in other formats, such as Braille, large print, or alternate formats. You may call member services at 1-888-775-7888 for more information. TTY callers should call 1-877-681-8898.
- **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](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

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**About CCHP Senior Value Program (HMO)**

- *CCHP Senior Value Program (HMO) is an HMO plan with a Medicare contract. Enrollment in CCHP Senior Value Program (HMO) depends on contract renewal.*
  - *When this document says “we,” “us,” or “our,” it means Chinese Community Health Plan. When it says “plan” or “our plan,” it means CCHP Senior Value Program (HMO).*
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***Annual Notice of Changes for 2025***  
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## Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for CCHP Senior Value Program (HMO) in several important areas. **Please note this is only a summary of costs.**

These are 2024 cost-sharing amounts and may change for 2025. CCHP Senior Value Program (HMO) will provide updated rates as soon as they are released.

Cost	2024 (this year)	2025 (next year)
<b>Monthly plan premium*</b> * Your premium may be higher or lower than this amount. See Section 2.1 for details.	\$0 per month	\$0 per month
<b>Maximum out-of-pocket amount</b> This is the <u>most</u> you will pay out of pocket for your covered services. (See Section 2.2 for details.)	\$7,550	\$7,550
<b>Doctor office visits</b>	Primary care visits: \$0-\$5 per visit Specialist visits: \$20 per visit	Primary care visits: \$0-\$5 per visit Specialist visits: \$20 per visit
<b>Inpatient hospital stays</b>	Days 1-7: \$150 copay/day (at Chinese Hospital) Days 1-7: \$315 copay/day (at all other hospitals) Days 8-90: \$0 copay/day	Days 1-7: \$150 copay/day (at Chinese Hospital) Days 1-7: \$315 copay/day (at all other hospitals) Days 8-90: \$0 copay/day

Cost	2024 (this year)	2025 (next year)
<p><b>Part D prescription drug coverage</b></p> <ul style="list-style-type: none"> <li>(See Section 2.5 for details.)</li> </ul>	<p>The deductible is \$0.</p> <p><b>Copayment during the initial coverage stage:</b></p> <ul style="list-style-type: none"> <li><b>Drug Tier 1:</b> Standard cost sharing: You pay \$5 copay for one month (30 day) supply.  Preferred cost sharing: You pay \$0 copay for one month (30 day) supply.</li> <li><b>Drug Tier 2:</b> Standard cost sharing: You pay \$12 copay for one month (30 day) supply.  You pay \$35 per month supply of each covered insulin product on this tier.</li> <li><b>Drug Tier 3:</b> Standard cost sharing: You pay \$47 copay for one month (30 day) supply.</li> <li><b>Drug Tier 4:</b> Standard cost sharing: You pay \$100 copay for one month (30 day) supply.</li> </ul>	<p>The deductible is \$0.</p> <p><b>Copayment during the initial coverage stage:</b></p> <ul style="list-style-type: none"> <li><b>Drug Tier 1:</b> Standard cost sharing: You pay \$0 copay for one month (30 day) supply.  Preferred cost sharing: You pay \$0 copay for one month (30 day) supply.</li> <li><b>Drug Tier 2:</b> Standard cost sharing: You pay \$3 copay for one month (30 day) supply.  You pay \$3 per month supply of each covered insulin product on this tier.</li> <li><b>Drug Tier 3:</b> Standard cost sharing: You pay \$35 copay for one month (30 day) supply.</li> <li><b>Drug Tier 4:</b> Standard cost sharing: You pay \$75 copay for one month (30 day) supply.</li> </ul>

Cost	2024 (this year)	2025 (next year)
	<ul style="list-style-type: none"> <li>• <b>Drug Tier 5:</b> Standard cost sharing: You pay 31% coinsurance for one month (30 day) supply.</li> </ul> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage). OR you have paid \$8,000-pocket threshold out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p> <p>Catastrophic Coverage: During this payment stage, the plan pays the full cost for your covered Part D drugs.</p>	<ul style="list-style-type: none"> <li>• <b>Drug Tier 5:</b> Standard cost sharing: You pay 30% coinsurance for one month (30 day) supply.</li> </ul> <p>Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs.</p> <p>Your total out-of-pocket drug costs are capped at \$2,000. The Coverage Gap Stage has been eliminated.</p>

## SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in CCHP Senior Value Program (HMO) in 2025

If you do nothing by December 7, 2024, we will automatically enroll you in our CCHP Senior Value Program (HMO). This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through CCHP Senior Value Program (HMO). 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)
<b>Monthly premium</b> (You must also continue to pay your Medicare Part B premium.)	\$0 per month	\$0 per month

- 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)
<p><b>Maximum out-of-pocket amount</b></p> <p>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.</p>	\$7,550	<p style="text-align: center;">\$7,550</p> <p>Once you have paid \$7,550 out of pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.</p>

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### Section 2.3 – Changes to the Provider and Pharmacy Networks

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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.cchphealthplan.com/Medicare](http://www.cchphealthplan.com/Medicare). You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 Provider Directory at [www.cchphealthplan.com](http://www.cchphealthplan.com) to see if your providers (primary care provider, specialists, hospitals, 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 Member Services so we may assist.

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### Section 2.4 – Changes to Benefits and Costs for Medical Services

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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)
<p><b>Hearing Services</b></p> <p>Our plan has contracted with NationsHearing to provide your non-Medicare-covered hearing services. You must obtain your hearing aids through NationsHearing. Please contact NationsHearing by phone at (877) 392-3753 (TTY: 711) or on the web at <a href="http://nationshearing.com/cchp">nationshearing.com/cchp</a> for more information or to schedule an appointment.</p>	<p>Prior Authorization and referral rules may apply.</p> <p>In-Network</p> <p>\$20 copay for Medicare covered hearing exams.</p> <p>Non-Medicare-covered hearing services: Routine hearing exam: \$0 copay</p> <p>Hearing aid fitting evaluation: \$0 copay</p> <p>Hearing aids (up to 2 per year): <u>Entry technology level:</u> \$600 copay per hearing aid <u>Basic technology level:</u> \$775 copay per hearing aid <u>Prime technology level:</u> \$1,075 copay per hearing aid <u>Advanced technology level:</u> \$1,675 copay per hearing aid <u>Premium technology level:</u> \$2,075 copay per hearing aid</p>	<p>Prior Authorization and referral rules may apply.</p> <p>In-Network</p> <p>\$20 copay for Medicare covered hearing exams.</p> <p>Non-Medicare-covered hearing services: Routine hearing exam: \$0 copay</p> <p>Hearing aid fitting evaluation: \$0 copay</p> <p>Hearing aid allowance of \$3,000 per year. This benefit allows you to receive a pair of hearing aids from a large selection of technology, many at no out-of-pocket cost.</p> <p>Hearing aid purchases must be made through NationsHearing.</p>

Cost	2024 (this year)	2025 (next year)
<b>Medicare Part B Step Therapy Prescription Drugs</b>	Not Applicable	Step therapy may be used for certain treatments or medications covered under Medicare Part B. This means you may need to try one Part B-covered treatment first before moving on to another.

Cost	2024 (this year)	2025 (next year)
<b>Over-the-Counter (OTC) Items</b>	\$30 Allowance per month.	\$40 Allowance per month.
	You pay \$0 out-of-pocket for an OTC Flex Card, administered by NationsBenefits.	You pay \$0 out-of-pocket for an OTC Flex Card, administered by NationsBenefits.
	Herbal Supplements are being added to the plan approved OTC items.	Herbal Supplements are being added to the plan approved OTC items.
	You can order:	You can order:
	<ul style="list-style-type: none"> <li>• Online – visit NationsOTC.com/cchp</li> <li>• By Phone – call a NationsOTC Member Experience Advisor 877-211-3132 (TTY: 711), Monday to Friday, excluding holidays.</li> <li>• By Mail – Fill out and return the order form in the NationsOTC Product Catalog.</li> </ul>	<ul style="list-style-type: none"> <li>• Online – visit NationsOTC.com/cchp</li> <li>• By Phone – call a NationsOTC Member Experience Advisor 877-211-3132 (TTY: 711), Monday to Friday, excluding holidays.</li> <li>• By Mail – Fill out and return the order form in the NationsOTC Product Catalog.</li> </ul>
	You may now also purchase OTC items at participating retail locations.	You may also purchase OTC items at participating retail locations.

**Skilled nursing facility (SNF) care**

(For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.)

Covered services include but are not limited to:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)
- Blood - including storage and administration.  
Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs

Prior Authorization and referral rules may apply.

In-Network

For SNF stays:

Days 1-20: \$0 copay per day.

Days 21-100: \$135 copay per day.

Plan covers up to 100 days each calendar year.

Prior Authorization and referral rules may apply.

In-Network

For SNF stays:

Days 1-20: \$0 copay per day.

Days 21-100: \$115 copay per day.

Plan covers up to 100 days each calendar year.

Cost	2024 (this year)	2025 (next year)
<ul style="list-style-type: none"> <li>• Use of appliances such as wheelchairs ordinarily provided by SNFs</li> <li>• Physician/Practitioner services</li> </ul> <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> <li>• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)</li> <li>• A SNF where your spouse or domestic partner is living at the time you leave the hospital</li> </ul>		

**Vision Care**

Prior Authorization and referral rules may apply.

Prior Authorization and referral rules may apply.

You are now a part of a full-service VSP vision plan. This change will give you access to greater discounts through VSP's exclusive network and negotiated pricing.

In-Network

In-Network

\$35 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye by in-network provider.

\$35 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye by in-network provider.

\$35 copay for up to one supplemental routine eye exam (eye refraction) every year from in-network VSP provider.

\$35 copay for up to one supplemental routine eye exam (eye refraction) every year from in-network VSP provider.

\$0 copay for:

- One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.
- Up to one pair of glasses every two years by VSP Provider. \$100 plan coverage limit for eye wear every two years

\$0 copay for:

- One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.
- \$0 copay for one pair of standard prescription lenses and \$100 plan allowance for frames every two years from a VSP Provider.
- \$0 copay for contact lens services and materials (in lieu of glasses) priced up to \$100 plan allowance every two years from a VSP Provider.

Cost	2024 (this year)	2025 (next year)
<b>Dental Care</b>	Not Covered	Preventive dental covered per contract with provider Delta Dental. Dental exam (limit twice per year) \$0 copay. For complete coverage details, please see your 2025 Evidence of Coverage (EOC) addendum document.

## 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. **You can get the complete Drug List** by calling Member Services (see the back cover) or visiting our website ([www.cchphealthplan.com](http://www.cchphealthplan.com)).

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 on the same or a lower cost-sharing tier and 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 move it to a different cost-sharing tier or add new restrictions or both.

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 have included a separate insert, called the *Evidence of Coverage Rider for People Who Get “Extra Help” Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive “Extra Help” and you haven’t received this insert, 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)
<b>Stage 1: Yearly Deductible Stage</b>	The deductible is \$0. Because we have no deductible, this payment stage does not apply to you.	The deductible is \$0. Because we have no deductible, this payment stage does not apply to you.

## Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
<p><b>Stage 2: Initial Coverage Stage</b></p> <p>During this stage, the plan pays its share of the cost of your drugs, and <b>you pay your share of the cost.</b></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, or at a network pharmacy that offers preferred cost sharing, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p> <p>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.”</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Your cost for a one-month supply at a network pharmacy with standard cost sharing:</p> <p><b>Drug Tier 1:</b></p> <p>Standard cost sharing: You pay \$5 per prescription.</p> <p>Preferred cost sharing: You pay \$0 per prescription.</p> <p><b>Drug Tier 2:</b></p> <p>Standard cost sharing: You pay \$12 per prescription.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p><b>Drug Tier 3:</b></p> <p>Standard cost sharing: You pay \$47 per prescription.</p> <p><b>Drug Tier 4:</b></p> <p>Standard cost sharing: You pay \$100 per prescription.</p> <p><b>Drug Tier 5:</b></p>	<p>Your cost for a one-month supply at a network pharmacy with standard cost sharing:</p> <p><b>Drug Tier 1:</b></p> <p>Standard cost sharing: You pay \$0 per prescription.</p> <p>Preferred cost sharing: You pay \$0 per prescription.</p> <p><b>Drug Tier 2:</b></p> <p>Standard cost sharing: You pay \$3 per prescription.</p> <p>You pay \$3 per month supply of each covered insulin product on this tier.</p> <p><b>Drug Tier 3:</b></p> <p>Standard cost sharing: You pay \$35 per prescription.</p> <p><b>Drug Tier 4:</b></p> <p>Standard cost sharing: You pay \$75 per prescription.</p> <p><b>Drug Tier 5:</b></p>

Stage	2024 (this year)	2025 (next year)
	<p>Standard cost sharing: You pay 31% coinsurance per prescription.</p> <p>–</p> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage). OR you have paid \$8,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p> <p>During this payment stage, the plan pays the full cost for your covered Part D drugs.</p>	<p>Standard cost sharing: You pay 30% coinsurance per prescription.</p> <p>–</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). The Coverage Gap Stage has been eliminated.</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 Deciding Which Plan to Choose

### Section 3.1 – If you want to stay in CCHP Senior Value Program (HMO)

**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 CCHP Senior Value Program (HMO).

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## Section 3.2 – If you want to change plans

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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](http://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 7.2).

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

## SECTION 4 Deadline for Changing Plans

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

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

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

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

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

## SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In California, the SHIP is called Health Insurance 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. Health Insurance 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 Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. You can learn more about Health Insurance Counseling and Advocacy Program (HICAP) by visiting their website ([www.aging.ca.gov/hicap](http://www.aging.ca.gov/hicap)).

## SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
  - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State

residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California AIDS Drug Assistance Program (ADAP) – 1-415-554-9172. 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 California AIDS Drug Assistance Program (ADAP) – 1-415-554-9172. 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 visit [Medicare.gov](https://www.Medicare.gov).

## SECTION 7 Questions?

### Section 7.1 – Getting Help from CCHP Senior Value Program (HMO)

Questions? We're here to help. Please call Member Services at 1-888-775-7888. (TTY only, call 1-877-681-8898). We are available for phone calls 8:00 a.m. to 8:00 p.m. during the open enrollment period (October 1 - March 31). During the non-open enrollment period (April 1 – September 30), the hours are Mondays – Fridays 8:00 a.m. to 8:00 p.m. 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 CCHP Senior Value Program (HMO). 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.cchphealthplan.com/Medicare](https://www.cchphealthplan.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 [www.cchphealthplan.com](http://www.cchphealthplan.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).

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## Section 7.2 – Getting Help from Medicare

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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](http://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](http://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.