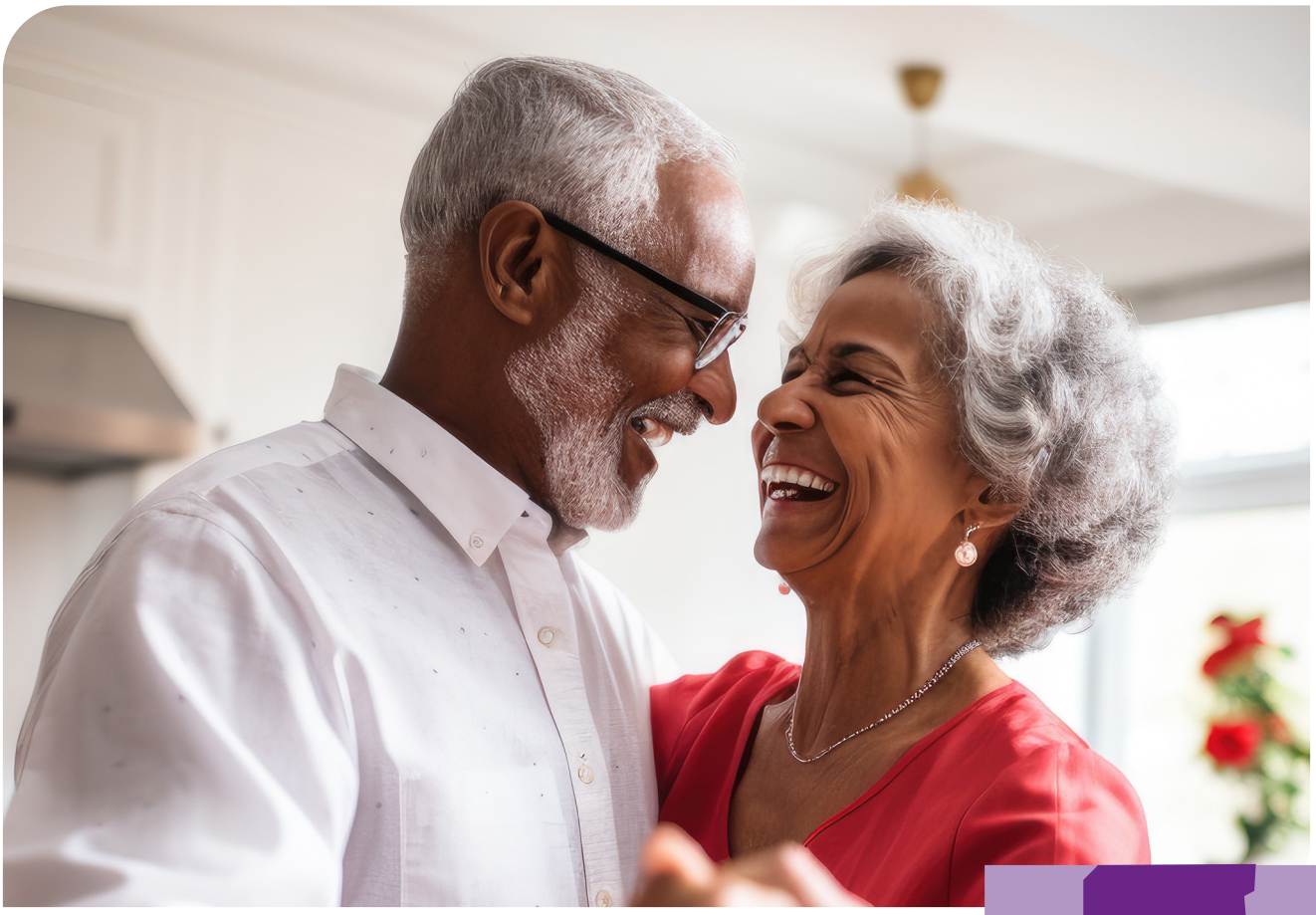
CHRISTUS Health Plan

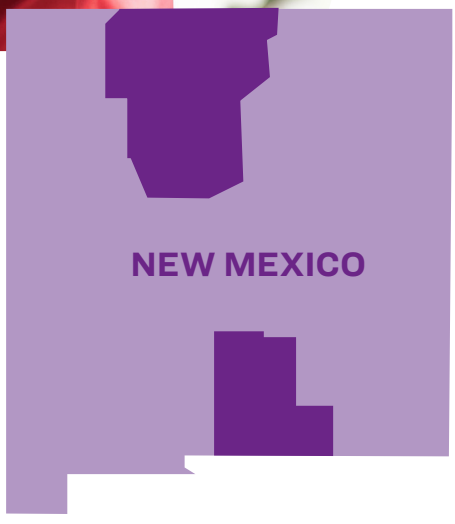
CHRISTUS HEALTH MEDICARE PLUS (HMO)
H1189-002

2025 Annual Notice of Changes



CHRISTUS HEALTH MEDICARE PLUS (HMO) H1189-002 COVERS MEMBERS IN THE FOLLOWING COUNTIES:

- Bernalillo
- Los Alamos
- Otero
- Rio Arriba
- Sandoval
- San Miguel
- Santa Fe
- Taos



CHRISTUS Health Plan

METHOD	MEMBER SERVICES – CONTACT INFORMATION
CALL	**844.282.3026** - Calls to this number are free. The CHRISTUS Health Plan Member Services department is available to assist you seven days a week, 8 a.m. to 8 p.m., local time, from Oct. 1 – Mar. 31, and Mon. - Fri., 8 a.m. to 8 p.m., local time, from Apr. 1 – Sept. 30. A voice response system is available after hours. Messages left will be responded to within one business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Relay New Mexico This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available to assist you seven days a week, 8 a.m. to 8 p.m., local time, from Oct. 1 – Mar. 31, and Mon. - Fri., 8 a.m. to 8 p.m., local time, from Apr. 1 – Sept. 30.
FAX	469.282.3013
WRITE	CHRISTUS Health Advantage, Attention: Member Services P.O. Box 169001 Irving | TX 75016
WEBSITE	CHRISTUShealthplan.org

THE NEW MEXICO AGING AND LONG-TERM SERVICES DEPARTMENT

The New Mexico Aging and Long-Term Services Department is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

METHOD	CONTACT INFORMATION
CALL	800.432.2080 or 505.476.4799
TTY	505.476.4937 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New Mexico Aging and Long-Term Services Department P.O. Box 27118 Santa Fe | NM 87502-7118
WEBSITE	aging.nm.gov

CHRISTUS Health Medicare Plus (HMO) offered by CHRISTUS Health Plan

Annual Notice of Changes for 2025

You are currently enrolled as a member of CHRISTUS Health Medicare Plus (HMO). 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.christushealthplan.org/member-resources/forms-documents. 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 CHRISTUS Health Medicare Plus (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 CHRISTUS Health Medicare Plus (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 Spanish.
- Please contact our Member Services number at 1-844-282-3026 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m. (CST), Monday through Friday. From October 1 – March 31, the hours are 8:00 a.m. to 8:00 p.m. (CST), 7 days a week. This call is free.
- This document is available in other formats such as braille, large print, or audio.
- **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 CHRISTUS Health Medicare Plus (HMO)

- CHRISTUS Health Medicare Plus (HMO) is an HMO with a Medicare contract. Enrollment in CHRISTUS Health Medicare Plus (HMO) depends on contract renewal.
- When this document says "we," "us," or "our," it means CHRISTUS Health Plan. When it says "plan" or "our plan," it means CHRISTUS Health Medicare Plus (HMO).

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for CHRISTUS Health Medicare Plus (HMO) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$4,400	$4,000
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $25 per visit	Primary care visits: $0 per visit Specialist visits: $25 per visit
Inpatient hospital stays	Days 1-5: $275 per day Days 6-90: $0 per day Days 91-100: $275 per day	Days 1-5: $150 per day Days 6-90: $0 per day Additional Days after 90: $0 per day
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 copayment	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copayment

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 2: $10 copayment • Drug Tier 3: $47 copayment. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 copayment • Drug Tier 5: 33% coinsurance • Drug Tier 6: $0 copayment Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs You pay nothing.	• Drug Tier 2: $5 copayment • Drug Tier 3: $47 copayment. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 copayment • Drug Tier 5: 33% coinsurance • Drug Tier 6: $0 copayment Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.) There is no change to your monthly premium for the upcoming year.	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,400	$4,000 Once you have paid $4,000 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

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.christushealthplan.org. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a customized 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.christushealthplan.org/find-a-provider to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are no changes to our network of pharmacies for next year.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Ambulance services	You pay a $110 copayment per one-way trip for Medicare-covered ambulance benefits. Copayment is waived if admitted.	You pay a $300 copayment per one-way trip for Medicare-covered ambulance benefits. Copayment is not waived if admitted.
	You pay a $110 copayment per one-way trip for Medicare-covered worldwide ambulance benefits. Copayment is waived if admitted.	You pay a $300 copayment per one-way trip for Medicare-covered worldwide ambulance benefits. Copayment is not waived if admitted.

Cost	2024 (this year)	2025 (next year)
Routine chiropractic services	You pay a $20 copayment per visit for routine chiropractic visits, limited to 36 visits per year.	You pay a $20 copayment per visit for routine chiropractic visits, limited to 24 visits per year.
Dental services	You pay a $0 copayment per preventive service: • Oral exams: 1 exam every 6 months • Prophylaxis: 1 visit every 6 months for teeth cleaning • Fluoride treatment: 1 visit every 6 months • X-rays: Once every 6 months	You pay a $0 copayment per preventive service: • Oral exams: 2 visits every year • Prophylaxis: 3 visits every year for teeth cleaning • Fluoride treatment: 2 visits every year • X-rays: Once every year • Unlimited other preventive dental services • Unlimited diagnostic dental services
	Combined preventive and comprehensive annual maximum of $2,000.	Combined preventive and comprehensive annual maximum of $2,000.
	You pay a $20 copayment per comprehensive dental services up to the annual maximum.	You pay a $20 copayment per comprehensive dental services up to the annual maximum.
	Covered comprehensive dental services are non-routine, diagnostic, restorative, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery, other services.	Covered comprehensive dental services are restorative, endodontics, periodontics, extractions, implant services, prosthodontics, other oral/maxillofacial surgery, adjunctive general services.

Cost	2024 (this year)	2025 (next year)
Dental services (continued)	You pay a $25 copayment per Medicare-covered dental visit.	You pay a $25 copayment per Medicare-covered dental visit.
Emergency care	You pay a $65 copayment for Medicare-covered emergency room visits. Copayment waived if admitted within 24 hours.	You pay a $125 copayment for Medicare-covered emergency room visits. Copayment waived if admitted within 24 hours.
Emergency care worldwide	You pay a $65 copayment for Medicare-covered worldwide emergency room visits. Copayment waived if admitted.	You pay a $125 copayment for Medicare-covered worldwide emergency room visits. Copayment is not waived if admitted.
Hearing services	You pay a $25 copayment for Medicare-covered hearing services per exam. You pay a $35 copayment per routine hearing exam, limit 1 per year. Fittings/evaluations for hearing aids are not covered.	You pay a $25 copayment for Medicare-covered hearing services per exam. You pay a $0 copayment per routine hearing exam, limit 1 per year. You pay a $0 copayment for unlimited fittings/evaluations for hearing aids.
Prescription hearing aids	$1,000 hearing aid allowance per ear every 2 years.	You pay a $395 - $1,595 copayment per hearing aid per year. Copayment depends on hearing aid technology level.

Cost	2024 (this year)	2025 (next year)
Hearing services (continued)		
Over-the-Counter (OTC) hearing aids	OTC hearing aids are not covered.	You pay a $95 - $295 copayment per hearing aid per year through a contracted vendor. Copayment depends on hearing aid technology level. Prescription and OTC hearing aids have a combined limit of 2 per year.
Inpatient hospital stays	You pay a: • $275 copayment per day for days 1-5 • $0 copayment per day for days 6-90 • $275 copayment per day for days 91-100 100-day limit with an additional 60 reserve days.	You pay a: • $150 copayment per day for days 1-5 • $0 copayment per day for days 6-90 • $0 copayment for unlimited additional days after 90 days.
Other health care providers	You pay a $0 copayment for other Medicare-covered health care provider visits.	You pay a $0 copayment for other Medicare-covered primary care provider visits. You pay a $25 copayment for Medicare-covered visits to providers other than primary care providers.

Cost	2024 (this year)	2025 (next year)
Outpatient blood services	You pay a $150 copayment per unit for Medicare-covered blood services.	You pay a $0 copayment per unit for Medicare-covered blood services.
Outpatient hospital surgery and observation services	You pay a $250 copayment for Medicare-covered outpatient hospital and observation services.	You pay a $0 copayment for a diagnostic colonoscopy at an outpatient hospital. You pay a $300 copayment for Medicare-covered surgery provided at an outpatient hospital. You pay a $300 copayment for Medicare-covered outpatient hospital observation services.
Outpatient surgery or services provided at ambulatory surgical centers	You pay a $100 copayment for Medicare-covered outpatient services at ambulatory surgical centers.	You pay a $0 copayment for a diagnostic colonoscopy at an ambulatory surgical center. You pay a $275 copayment for Medicare-covered surgery provided at an ambulatory surgery center.
Outpatient therapeutic radiological services	You pay a $20 copayment for Medicare-covered therapeutic radiological services.	You pay a 20% coinsurance for Medicare-covered therapeutic radiological services.

Cost	2024 (this year)	2025 (next year)
Over-the-Counter (OTC) items	You receive a $150 allowance every quarter for over-the-counter drugs and items purchased from Convey. Nicotine Replacement Therapy (NRT) and Naloxone are not covered as part of this benefit.	You receive a $205 allowance every quarter for over-the-counter drugs and items purchased from Convey. Nicotine Replacement Therapy (NRT) and Naloxone are not covered as part of this benefit.
Routine podiatry services	You pay a $0 copayment for unlimited routine foot care services.	You pay a $0 copayment for routine foot care services, limited to 6 visits per year.
Skilled Nursing Facility (SNF)	You pay a: • $0 copayment for days 1-20 • $150 copayment for days 21-100	You pay a: • $0 copayment for days 1-20 • $214 copayment for days 21-100
Transportation services	You pay a $0 copayment for 24 round-trips to a plan approved health-related location per year. Up to 100 miles per one-way trip.	You pay a $0 copayment for 48 one-way trips to a plan approved health-related location per year. Up to 100 miles per one-way trip.

Cost	2024 (this year)	2025 (next year)
Urgently needed services	You pay a $25 copayment for Medicare-covered urgent coverage visits. Copayment is not waived if admitted to a hospital. You pay a $65 copayment for Medicare-covered worldwide urgent coverage visit. Copayment is waived if admitted. Telehealth urgent care is not covered.	You pay a $25 copayment for Medicare-covered urgent coverage visits. Copayment is not waived if admitted to a hospital. You pay a $125 copayment for Medicare-covered worldwide urgent coverage visit. Copayment is not waived if admitted. You pay a $0 copayment for telehealth urgent care.
Vision care	You pay a $0 copayment for Medicare-covered eye exams. You pay a $0 copayment for routine eye exams. $225 allowance per year for 1 pair of eyeglasses (frames / lenses) or contacts.	You pay a $25 copayment for Medicare-covered eye exams. You pay a $0 copayment for routine eye exams. $300 allowance per year for 1 pair of eyeglasses (frames / lenses) or contacts.

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 Member Services (see the back cover) or visiting our website (www.christushealthplan.org).

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 didn't receive this insert with this packet, please call Member Services and ask for the *LIS Rider*.

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

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

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. 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 is: **Tier 1 (Preferred Generic):** You pay $4 per prescription. **Tier 2 (Generic):** You pay $10 per prescription. **Tier 3 (Preferred Brand):** You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier.	Your cost for a one-month supply is: **Tier 1 (Preferred Generic):** You pay $0 per prescription. **Tier 2 (Generic):** You pay $5 per prescription. **Tier 3 (Preferred Brand):** You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier.

Stage	2024 (this year)	2025 (next year)
	Tier 4 (Non-Preferred Brand): You pay $100 per prescription. **Tier 5 (Specialty):** You pay: 33% of the total costs. **Tier 6 (Select Care):** You pay $0 per prescription. _____ Once your total drug costs have reached $5,030 you will move to the next stage (the Coverage Gap Stage).	**Tier 4 (Non-Preferred Brand):** You pay $100 per prescription. **Tier 5 (Specialty):** You pay 33% of the total costs. **Tier 6 (Select Care):** You pay $0 per prescription. _____ Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

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

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

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

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 1-844-282-3026 or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in CHRISTUS Health Medicare Plus (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 CHRISTUS Health Medicare Plus (HMO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 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, CHRISTUS Health Plan offers other Medicare health plans and Medicare prescription drug 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 CHRISTUS Health Medicare Plus (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from CHRISTUS Health Medicare Plus (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 New Mexico, the SHIP is called New Mexico Aging and Long-Term Services Department.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. New Mexico Aging and Long-Term Services Department 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 New Mexico Aging and Long-Term Services Department at 1-800-432-2080 or 505-476-4799. You can learn more about New Mexico Aging and Long-Term Services Department by visiting their website (https://nmaging.state.nm.us/).

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.
- **Help from your state's pharmaceutical assistance program.** New Mexico has a program called New Mexico Drug Card 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. 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 New Mexico HIV Services Program. For information on eligibility criteria, covered drugs, or how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call 1-505-938-7100 Monday through Friday from 8:00 a.m. to 5:00 p.m. (MST) or go to their website

(https://www.nmhealth.org). 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 1-844-282-3026 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from CHRISTUS Health Medicare Plus (HMO)

Questions? We're here to help. Please call Member Services at 1-844-282-3026. (TTY only, call 711). We are available for phone calls 8:00 a.m. to 8:00 p.m. (CST), Monday through Friday. From October 1 – March 31, the hours are 8:00 a.m. to 8:00 p.m. (CST), 7 days a week. 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 CHRISTUS Health Medicare Plus (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.christushealthplan.org/member-resources/forms-documents. 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.christushealthplan.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (*Formulary/"Drug List"*).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

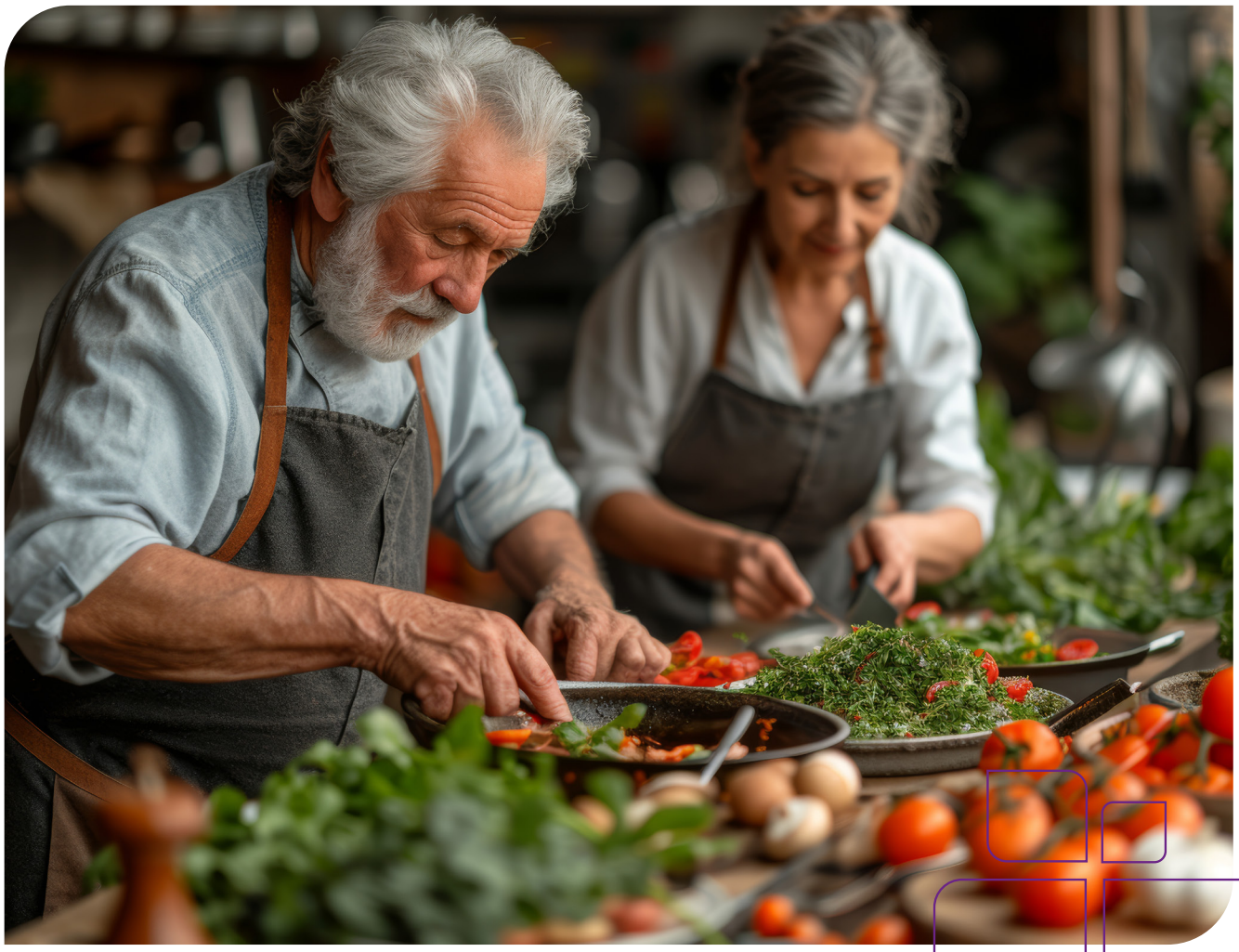
You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



CHRISTUS® Health Plan

844.282.3026 | TTY 711

Oct. 1 – Mar. 31, 7 days a week, 8 a.m. – 8 p.m., local time

Apr. 1 – Sept. 30, Mon. – Fri., 8 a.m. – 8 p.m., local time

CHRISTUShealthplan.org