Saint Mary's ATRIO Choice Rx (PPO) offered by ATRIO Health Plans

Annual Notice of Changes for 2024

You are currently enrolled as a member of Saint Mary's ATRIO Choice Rx (PPO). 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 atriohp.com. 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 authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

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

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

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

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2023, you will stay in Saint Mary's ATRIO Choice Rx (PPO).
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Saint Mary's ATRIO Choice Rx (PPO).
   - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-877-672-8620 for additional information. (TTY users should call 711.) Hours are daily from 8am to 8pm local time. This call is free.
- This information is available in braille, large print, or other alternate formats.
- **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 Saint Mary's ATRIO Choice Rx (PPO)

- ATRIO Health Plans is a PPO, HMO, and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal.
- When this document says "we," "us," or "our", it means ATRIO Health Plans. When it says "plan" or "our plan," it means Saint Mary's ATRIO Choice Rx (PPO).

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Saint Mary's ATRIO Choice Rx (PPO) in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $3,400 From network and out-of-network providers combined: $5,450	From network providers: $3,500 From network and out-of-network providers combined: $5,500
Doctor office visits	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $20 copay per visit **Out-of-Network:** Primary care visits: $50 copay per visit Specialist visits: $50 copay per visit	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $25 copay per visit **Out-of-Network:** Primary care visits: $50 copay per visit Specialist visits: $50 copay per visit

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In-Network:** $0 to $100 copay per day for days 1-5; $0 copay per day for days 6-90 (copay will depend on hospital facility) **Out-of-Network:** 50% of the total cost per stay	**In-Network:** $0 to $200 copay per day for days 1-5; $0 copay per day for days 6-90 (copay will depend on hospital facility) **Out-of-Network:** $300 copay per day for days 1-5; $0 copay per day for days 6-90
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $12 copay • Drug Tier 3: $35 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% of the total cost • Drug Tier 6: $0 copay	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $12 copay • Drug Tier 3: $47 copay You pay $35 copay per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 copay • Drug Tier 5: 33% of the total cost • Drug Tier 6: $0 copay

Cost	2023 (this year)	2024 (next year)
	Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs).	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$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 Amounts

Cost	2023 (this year)	2024 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,500 Once you have paid $3,500 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.

Cost	2023 (this year)	2024 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$5,450	$5,500 Once you have paid $5,500 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at atriohp.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 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* to see which pharmacies are in our network**.

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2023 (this year)	2024 (next year)
Dental Services	**In-Network**	**In-Network**
	Plan provides an annual allowance of $1,250 towards preventive and comprehensive dental services at any provider through a Flex Card.	$2,500 maximum plan coverage amount every year for in- and out-of-network preventive dental services. This amount is combined with the non-Medicare-covered comprehensive dental services benefit. Coverage allowance through a Flex Card.
	Prior authorization is required for Medicare-covered dental services.	No prior authorization required for Medicare-covered dental services.
	Prior authorization is required for non-Medicare-covered non-routine comprehensive dental services.	No prior authorization required for non-Medicare-covered non-routine comprehensive dental services.
Emergency Care	**In and Out-of-Network**	**In and Out-of-Network**
	You pay $110 copay for each visit for Medicare-covered emergency care services.	You pay $135 copay for each visit for Medicare-covered emergency care services.
Fitness Benefit	$250 maximum plan coverage amount every year for the fitness benefit.	$480 maximum plan coverage amount every year for the fitness benefit. Coverage amount through a Flex Card.
Hearing Services	**In-Network**	**In-Network**
	You pay $699 to $999 copay for hearing aids – all types (2 hearing aids every year).	$1,500 maximum plan allowance every year (both ears combined) for hearing aids. (unlimited hearing aids).

Cost	2023 (this year)	2024 (next year)
Hearing Services (continued)	**Out-of-Network**	**Out-of-Network**
	You pay $0 copay for each routine hearing exam (1 routine hearing exam every year).	Routine hearing exams benefit is not covered.
	You pay $0 copay for each routine hearing aid fitting/evaluation visit (unlimited fitting/evaluation for hearing aids visits every year).	Routine hearing aid fitting/evaluation benefit is not covered.
Inpatient Hospital Care	**In-Network**	**In-Network**
	For Medicare-covered inpatient hospital stays, you pay $0 to $100 per day days 1-5. $0 copay per day for days 6-90 (copay will depend on hospital facility).	For Medicare-covered inpatient hospital stays, you pay $0 to $200 copay per day for days 1-5; $0 copay per day for days 6-90 (copay will depend on hospital facility).
	Out-of-Network	**Out-of-Network**
	For Medicare-covered inpatient hospital stays, you pay 50% of the total cost per stay.	For Medicare-covered inpatient hospital stays, you pay $300 copay per day for days 1-5; $0 copay per day for days 6-90.

Cost	2023 (this year)	2024 (next year)
Medicare Part B Prescription Drugs	**In-Network**	**In-Network**
	You pay 20% of the total cost for Medicare Part B insulin drugs.	You pay 0% to 20% of the total cost for Medicare Part B insulin drugs but your cost share is limited to $35 per month.
	You pay 20% of the total cost for Medicare Part B chemotherapy and radiation drugs.	You pay 0% to 20% of the total cost for Medicare Part B chemotherapy and radiation drugs.
	You pay 20% of the total cost for other Medicare Part B drugs.	You pay 0% to 20% of the total cost for other Medicare Part B drugs.
	Step therapy may be required for Part B to Part B and Part D to Part B drugs.	Step therapy may be required for Part B to Part B and Part D to Part B drugs and Part D to D drugs. For a complete list of Part B Prescription Drugs that require step therapy, please visit atriohp.com.
	No prior authorization required for other Medicare Part B prescription drugs.	Prior authorization may be required for other Medicare Part B prescription drugs.
	Out-of-Network	**Out-of-Network**
	50% coinsurance for all Part B covered drugs. No limit specifically for a one-month supply of Part B covered insulin.	0-50% coinsurance for all Part B covered drugs. $35 limit specifically for a one-month supply of Part B covered insulin.

Cost	2023 (this year)	2024 (next year)
Other Supplemental Benefits	**In-Network** You pay $0 for your Annual Wellness Visit once every 12 months. **Out-of-Network** You pay $0 for your Annual Wellness Visit once every 12 months.	**In-Network** You pay $0 for your Annual Wellness Visit once every 12 months. **Out-of-Network** You pay $0 for your Annual Wellness Visit once every calendar year.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	**In-Network** For Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans), you pay $60 copay.	**In-Network** For Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans), you pay $0 to $60 copay. You pay $0 copay per diagnostic mammograms.
Outpatient Rehabilitation Services	**In-Network** You pay $10 copay for each Medicare-covered occupational therapy visit. You pay $10 copay for each Medicare-covered physical therapy or speech therapy visit.	**In-Network** You pay $0 copay for each Medicare-covered occupational therapy visit. You pay $0 copay for each Medicare-covered physical therapy or speech therapy visit.
Over-the-Counter Items	$100 maximum plan coverage amount every 3 months for OTC items.	$150 maximum plan coverage amount every 3 months for OTC items. Coverage amount through a Flex Card.

Cost	2023 (this year)	2024 (next year)
Personal Emergency Response System (PERS) Benefit	**In-Network** Personal emergency response system (PERS) benefit is not covered. **Out-of-Network** Personal emergency response system (PERS) benefit is not covered.	**In-Network** You pay $0 copay for the personal emergency response system (PERS) benefit. You must use our preferred vendor to use this benefit. **Out-of-Network** Personal emergency response system (PERS) benefit is not covered unless prior authorization is approved. Monthly limit of $18.50 applies.
Physician Specialist /Practitioner Services, Including Doctor's Office Visits	**In-Network** You pay $20 copay for each Medicare-covered specialist visit.	**In-Network** You pay $25 copay for each Medicare-covered specialist visit.
Urgently Needed Services	**In and Out-of-Network** You pay $30 copay for each visit for Medicare-covered urgent care services.	**In and Out-of-Network** You pay $65 copay for each visit for Medicare-covered urgent care services.
Worldwide Emergency / Urgent Services	You pay $110 copay for each emergency care visit worldwide. You pay $110 copay for each urgent care visit worldwide. No maximum plan benefit coverage amount for the worldwide benefit.	You pay $135 copay for each emergency care visit worldwide. You pay $135 copay for each urgent care visit worldwide. $250,000 maximum plan benefit coverage amount every year for the worldwide benefit.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

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

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

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

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

Changes to Prescription Drug Costs

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

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

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:
Most adult Part D vaccines are covered at no cost to you.	**Tier 1 Preferred Generic:** You pay $0 copay per prescription.	**Tier 1 Preferred Generic:** You pay $0 copay per prescription.
The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.	**Tier 2 Generic:** You pay $12 copay per prescription.	**Tier 2 Generic:** You pay $12 copay per prescription.
For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	**Tier 3 Preferred Brand:** You pay $35 copay per prescription.	**Tier 3 Preferred Brand:** You pay $47 copay per prescription. You pay $35 copay per month supply of each covered insulin product on this tier.

Stage	2023 (this year)	2024 (next year)
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."	**Tier 4 Non-Preferred Drugs:** You pay $100 copay per prescription. **Tier 5 Specialty Drugs:** You pay 33% of the total cost per prescription. **Tier 6 Select Care Drugs:** You pay $0 copay per prescription. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	**Tier 4 Non-Preferred Drugs:** You pay $100 copay per prescription. **Tier 5 Specialty Drugs:** You pay 33% of the total cost per prescription. **Tier 6 Select Care Drugs:** You pay $0 copay per prescription. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

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

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

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Saint Mary's ATRIO Choice Rx (PPO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Saint Mary's ATRIO Choice Rx (PPO).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Saint Mary's ATRIO Health Plans 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 Saint Mary's ATRIO Choice Rx (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Saint Mary's ATRIO Choice Rx (PPO).
- 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 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

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

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

If you enrolled in a Medicare Advantage Plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

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

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Nevada, the SHIP is called Nevada Medicare SHIP. It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Nevada Medicare SHIP 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 Nevada Medicare SHIP at 1-800-307-4444. You can learn more about Nevada Medicare SHIP by visiting their website (adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Nevada Medication Assistance Program (NMAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Nevada Medication Assistance Program at 1-702-486-0768 (TTY 711).

SECTION 6 Questions?

Section 6.1 – Getting Help from Saint Mary's ATRIO Choice Rx (PPO)

Questions? We're here to help. Please call Member Services at 1-877-672-8620. (TTY only, call 711.) We are available for phone calls daily from 8am to 8pm local time. Calls to these numbers are free.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for Saint Mary's ATRIO Choice Rx (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at atriohp.com. 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 atriohp.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 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.