

BlueCross Total Value Lowcountry (PPO) offered by BlueCross BlueShield of South Carolina

Annual Notice of Changes for 2025

You are currently enrolled as a member of BlueCross Total Value Lowcountry. 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.SCBluesMedAdvantage.com. You may also call Customer Service 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 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.

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

Additional Resources

- Please contact our Customer Service number at 1-855-204-2744 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm, Eastern Time, Monday through Friday. Our automated phone system handles calls received after 8 pm and on Saturdays, Sundays, and holidays. From October 1 through March 31, we are available 8 am to 8 pm, Eastern Time, seven days a week. This call is free.
- Customer Service has free language interpreter services available for non-English speakers. This information is available in alternate formats, including large print. Please call Customer Service if you need plan information in other 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 BlueCross Total Value Lowcountry

- BlueCross Total Value Lowcountry is a Medicare Advantage Preferred Provider Organization plan with a Medicare contract. Enrollment in BlueCross Total Value Lowcountry depends on contract renewal.
 - When this document says "we," "us," or "our," it means BlueCross BlueShield of South Carolina. When it says "plan" or "our plan," it means BlueCross Total Value Lowcountry.
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Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025.....	4
SECTION 1 Changes to Benefits and Costs for Next Year	7
Section 1.1 – Changes to the Monthly Premium.....	7
Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts.....	7
Section 1.3 – Changes to the Provider and Pharmacy Networks	8
Section 1.4 – Changes to Benefits and Costs for Medical Services.....	9
Section 1.5 – Changes to Part D Prescription Drug Coverage.....	14
SECTION 2 Administrative Changes.....	18
SECTION 3 Deciding Which Plan to Choose.....	19
Section 3.1 – If you want to stay in BlueCross Total Value Lowcountry.....	19
Section 3.2 – If you want to change plans.....	19
SECTION 4 Deadline for Changing Plans.....	20
SECTION 5 Programs That Offer Free Counseling about Medicare.....	20
SECTION 6 Programs That Help Pay for Prescription Drugs	21
SECTION 7 Questions?.....	22
Section 7.1 – Getting Help from BlueCross Total Value Lowcountry	22
Section 7.2 – Getting Help from Medicare	22

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for BlueCross Total Value Lowcountry 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 amounts This is the <u>most</u> you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: \$7,900 From network and out-of-network providers combined: \$11,300	From network providers: \$9,350 From network and out-of-network providers combined: \$14,000
Doctor office visits	Primary care visits from in-network providers: \$0 per visit Primary care visits from out-of-network providers: \$40 per visit Specialist visits from in-network providers: \$30 per visit Specialist visits from out-of-network providers: \$55 per visit	Primary care visits from in-network providers: \$0 per visit Primary care visits from out-of-network providers: \$40 Copay per visit Specialist visits from in-network providers: \$17 - \$47 per visit Specialist visits from out-of-network providers: \$55 per visit

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	<p>In-Network You pay \$350 per day for days 1 through 4. You pay \$0 per day for days 5 through 90.</p> <p>Out-of-Network 50% Coinsurance per admission</p>	<p>In-Network You pay \$465 per day for days 1 through 2. You pay \$0 per day for days 3 through 90.</p> <p>Out-of-Network 40% Coinsurance per admission</p>
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Deductible: \$95 except for covered insulin products and most adult Part D vaccines.</p> <p>Copayment/Coinsurance Standard Retail during the Initial Coverage Stage (30-day supply):</p> <ul style="list-style-type: none"> • Drug Tier 1: \$5 • Drug Tier 2: \$15 • Drug Tier 3: \$47 <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 4: \$100 • Drug Tier 5: 31% • Drug Tier 6: \$5 <p>Copayment/Coinsurance Preferred Retail during the Initial Coverage Stage (30-day supply):</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 • Drug Tier 2: \$10 • Drug Tier 3: \$42 <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 4: \$100 • Drug Tier 5: 31% 	<p>Deductible: \$200 except for covered insulin products and most adult Part D vaccines.</p> <p>Copayment/Coinsurance Standard Retail during the Initial Coverage Stage (30-day supply):</p> <ul style="list-style-type: none"> • Drug Tier 1: \$5 • Drug Tier 2: \$15 • Drug Tier 3: 25% <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 4: 42% <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 5: 30% <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 6: \$5 <p>Copayment/Coinsurance Preferred Retail during the Initial Coverage Stage (30-day supply):</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 • Drug Tier 2: \$10 • Drug Tier 3: 21%

Cost	2024 (this year)	2025 (next year)
	<ul style="list-style-type: none"> • Drug Tier 6: \$0 <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. 	<p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 4: 40% <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 5: 30% <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 6: \$0 <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, you pay nothing for your covered Part D drugs.

Cost	2024 (this year)	2025 (next year)
<p>Comprehensive Dental (Non-Medicare covered)</p>	<p>In-Network: You pay 50% of the total cost.*</p> <p>Out-of-Network: You pay 50% of the total cost.*</p> <p>Non-routine services, diagnostic services, restorative services, endodontics, extractions, prosthodontics, other oral/maxillofacial surgery, periodontics, and other services (i.e., dentures, root canals). We do not cover implants.</p> <p>In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in-network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)</p> <p>*Comprehensive dental services are included in your \$2,000 preventive/comprehensive maximum coverage per year.</p>	<p>In-network: You pay 50% of the total cost.*</p> <p>Out-of-network: You pay 50% of the total cost.*</p> <p>Non-routine services, diagnostic services, restorative services, endodontics, extractions, prosthodontics, other oral/maxillofacial surgery, periodontics, and other services (i.e., dentures, root canals). We do not cover implants.</p> <p>In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in-network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)</p> <p>*Comprehensive dental services are included in your \$3,000 preventive/comprehensive maximum coverage per year.</p>
<p>Diagnostic Procedures/Tests</p>	<p>In-Network: You pay a \$0 - \$295 copay. Prior Authorization is not required.</p>	<p>In-Network: You pay a \$0 - \$150 copay. Prior Authorization is required.</p>
<p>Diagnostic Radiological Services</p>	<p>In-Network: You pay a \$0 - \$150 copay.</p>	<p>In-Network: You pay a \$0 - \$300 copay.</p>
<p>Emergency Care</p>	<p>You pay a \$100 copay.</p>	<p>You pay a \$110 copay.</p>
<p>Ground Ambulance Services</p>	<p>In-Network: You pay a \$295 copay.</p> <p>Out-of-Network: You pay a \$295 copay.</p>	<p>In-Network: You pay a \$310 copay.</p> <p>Out-of-Network: You pay a \$325 copay.</p>

Cost	2024 (this year)	2025 (next year)
Group Sessions for Mental Health Specialty Services	In-Network: You pay a \$35 copay.	In-Network: You pay a \$50 copay.
Group Sessions for Outpatient Substance Abuse	In-Network: You pay \$35 copay.	In-Network: You pay \$40 copay.
Group Sessions for Psychiatric Services	In-Network: You pay \$35 copay.	In-Network: You pay \$45 copay.
Individual Sessions for Mental Health Specialty Services	In-Network: You pay a \$35 copay.	In-Network: You pay a \$50 copay.
Individual Sessions for Outpatient Substance Abuse	In-Network: You pay \$35 copay. Out-of-Network: You pay 50% of the total cost.	In-Network: You pay \$40 copay. Out-of-Network: You pay 50% of the total cost.
Individual Sessions for Psychiatric Services	In-Network: You pay \$35 copay.	In-Network: You pay \$45 copay.
Inpatient Hospital Acute	In-Network: You pay a \$350 copay per day for days 1-4. You pay a \$0 copay per day for days 5-90. Out-of-Network: You pay 50% of the total cost.	In-Network: You pay a \$465 copay per day for days 1-2. You pay a \$0 copay per day for days 3-90. Out-of-Network: You pay 40% of the total cost.
Inpatient Hospital Psychiatric	In-Network: You pay a \$645 copay per day for days 1-3. You pay a \$0 copay per day for days 4-90.	In-Network: You pay a \$675 copay per day for days 1-3. You pay a \$0 copay per day for days 4-90.
Intensive Cardiac Rehabilitation Services	In-Network: You pay a \$55 copay. Prior Authorization is not required.	In-Network: You pay a \$45 copay. Prior Authorization is required.
Observation Services	In-Network: You pay a \$375 copay.	In-Network: You pay a \$325 copay.
Occupational Therapy Services	In-Network: You pay a \$25 copay.	In-Network: You pay a \$35 copay.

Cost	2024 (this year)	2025 (next year)
Opioid Treatment Program Service	Prior authorization is not required.	Prior authorization is required.
Other Health Care Professional Services	In-Network: You pay a \$10 - \$35 copay.	In-Network: You pay a \$10 - \$30 copay.
Outpatient Hospital Services	In-Network: You pay a \$0 - \$350 copay.	In-Network: You pay a \$0 - \$295 copay.
Outpatient X-Ray Services	In-Network: You pay 20% of the total cost.	In-Network: You pay a \$10 copay.
Over-the-Counter (OTC) Items	The benefit is \$30 every 3 months (per quarter) for a total of \$120 per year.	The benefit is \$60 every 3 months (per quarter) for a total of \$240 per year.
Partial Hospitalization Partial hospitalization provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care. Your care plan must state that you require at least 20 hours of therapeutic services per week. You get treatment during the day with no overnight stay.	In-Network: You pay a \$55 copay. Prior Authorization is not required.	In-Network: You pay a \$80 copay. Prior Authorization is required.
Physical Therapy and Language Therapy Services	In-Network: You pay a \$25 copay.	In-Network: You pay a \$15 copay.
Physician Specialist Services	In-Network: You pay a \$30 copay.	In-Network: You pay a \$17 - \$47 copay.
Podiatry Services	In-Network: You pay a \$35 copay.	In-Network: You pay a \$40 copay.

Cost	2024 (this year)	2025 (next year)
<p>Preventive Dental (Non-Medicare Covered)</p>	<p>In-Network: You pay a \$0 copay.*</p> <p>Out-of-Network: You pay 50% of the total cost.* 2 preventative dental visits per year. Oral exam, cleaning, 1 dental bitewing x-ray (fluoride treatment not covered).</p> <p>In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in-network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)</p> <p>*Preventive dental services are included in your \$2,000 preventive/comprehensive maximum coverage per year.</p>	<p>In-Network: You pay a \$0 copay.*</p> <p>Out-of-Network: You pay 50% of the total cost.* 2 preventative dental visits per year. Oral exam, cleaning, 1 dental bitewing x-ray (fluoride treatment not covered).</p> <p>In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in-network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)</p> <p>*Preventive dental services are included in your \$3,000 preventive/comprehensive maximum coverage per year.</p>
<p>Pulmonary Rehabilitation Services</p>	<p>In-Network: You pay a \$15 copay. Prior Authorization is not required.</p>	<p>In-Network: You pay a \$25 copay. Prior Authorization is required.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>In-Network: You pay \$0 Copay per day for days 1-20. You pay \$203 Copay per day for days 21-100.</p>	<p>In-Network: You pay \$0 Copay per day for days 1-20. You pay \$214 Copay per day for days 21-100.</p>
<p>Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services</p>	<p>In-Network: You pay a \$25 copay. Prior Authorization is not required.</p>	<p>In-Network: You pay a \$20 copay. Prior Authorization is required.</p>

drugs on this tier. For 2024 you paid a \$100 copayment (standard), \$100 copayment (preferred), and \$100 (mail-order) for drugs on Tier 4. For 2025 you will pay 42% coinsurance (standard), 40% coinsurance (preferred), and 40% coinsurance (mail-order) for drugs on this tier.

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.

Preferred cost sharing: You pay \$10 per prescription
Your cost for a one-month mail-order prescription is \$10

Tier 3 (Preferred Brand):

Standard cost sharing: You pay \$47 per prescription
Preferred cost sharing: You pay \$42 per prescription
You pay \$35 per month supply of each covered insulin product on this tier

Your cost for a one-month mail-order prescription is \$42

Tier 4 (Non-Preferred Drug):

Standard cost sharing: You pay \$100 per prescription
Preferred cost sharing: You pay \$100 per prescription
Your cost for a one-month mail-order prescription is \$100

Tier 5 (Specialty Tier):

Standard cost sharing: You pay 31% of the total cost
Preferred cost sharing: You pay 31% of the total cost
Your cost for a one-month mail-order prescription is 31% of the total cost

Tier 6 (Select Care Drugs):

Standard cost sharing: You pay \$5 per prescription
Preferred cost sharing: You pay \$0 per prescription
Your cost for a one-month mail-order prescription is \$0

Preferred cost sharing: You pay \$10 per prescription
Your cost for a one-month mail-order prescription is \$10

Tier 3 (Preferred Brand):

Standard cost sharing: You pay 25% of the total cost
Preferred cost sharing: You pay 21% of the total cost
You pay \$35 per month supply of each covered insulin product on this tier

Your cost for a one-month mail-order prescription is 21% of the total cost

Tier 4 (Non-Preferred Drug):

Standard cost sharing: You pay 42% of the total cost
Preferred cost sharing: You pay 40% of the total cost
You pay \$35 per month supply of each covered insulin product on this tier

Your cost for a one-month mail-order prescription is 40% of the total cost

Tier 5 (Specialty Tier):

Standard cost sharing: You pay 30% of the total cost
Preferred cost sharing: You pay 30% of the total cost

You pay \$35 per month supply of each covered insulin product on this tier.

Your cost for a one-month mail-order prescription is 30% of the total cost

Tier 6 (Select Care Drugs):

- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from BlueCross Total Value Lowcountry.
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Customer Service 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 South Carolina, the SHIP is called Insurance Counseling Assistance and Referrals for Elders (I-CARE).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. I-CARE 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 I-CARE at (803) 734-9900 or 1-800-868-9095. You can learn more about I-CARE by visiting their website (www.aging.sc.gov).

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 South Carolina AIDS Drug Assistance Program (administered by the South Carolina Department of Public Health). For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call 1-800-856-9954. 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 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 833-730-1719 or visit [Medicare.gov](https://www.Medicare.gov).

SECTION 7 Questions?

Section 7.1 – Getting Help from BlueCross Total Value Lowcountry

Questions? We're here to help. Please call Customer Service at 1-855-204-2744. (TTY only, call 711.) We are available for phone calls 8 am to 8 pm, Eastern Time, Monday through Friday. Our automated phone system handles calls received after 8 pm and on Saturdays, Sundays and holidays. From October 1 through March 31, we are available 8 am to 8 pm, Eastern Time, seven 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 BlueCross Total Value Lowcountry. 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.SCBluesMedAdvantage.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.SCBluesMedAdvantage.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 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.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-204-2744. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-396-0183. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-844-396-0188。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-844-725-1516。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-389-4839. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-396-0190. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-389-4838 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-396-0191. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-396-0187번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-389-4840. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-396-0189. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-725-1519 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-396-0184. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-396-0182.irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-398-6232. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-396-0186. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-844-396-0185にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。