Medica Advantage with SSM Value (HMO-POS) offered by Medica Central Health Plan

Annual Notice of Changes for 2024

You are currently enrolled as a member of SSM Health Plan Integrity. Next year, there will be changes to the plan's costs and benefits. ***Please see page 8 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 https://central.medica.com/medicare. You may also call the Customer Care Center 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 our plan.
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with our plan.
   - 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

- Please contact our Customer Care Center number at 1-877-301-3326 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm, seven days per week. However, please note that our automated phone system may answer your call during all Federal holidays and weekends from April 1 to September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day. This call is free.
- The Customer Care Center has free language interpreter services available for non-English speakers.
- This information is available for free in other formats. Please call the Customer Care Center if you need plan information in another format.
- **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 Medica Advantage with SSM Value

- Medica Central Health Plan is an HMO/HMO-POS with a Medicare Contract. Enrollment in Medica Central Health Plan depends on contract renewal. Medica Central Health Plan markets under the name Medica.
- When this document says "we," "us," or "our," it means Medica Central Health Plan. When it says "plan" or "our plan," it means Medica Advantage with SSM Value.

Form Approved
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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 **1-877-317-2410 (TTY: 711).** 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 **1-877-317-2410.** 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 **1-877-317-2410**。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 **1-877-317-2410**。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 **1-877-317-2410.** 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 **1-877-317-2410.** 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 quí vị cần thông dịch viên xin gọi **1-877-317-2410** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-877-317-2410.** Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-877-317-2410**번으로 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 **1-877-317-2410.** 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 بمساعدتك. هذه خدمة مجانية فوري، ليس عليك سوى الاتصال بنا على **1 877 317-2410**. سيقوم شخص ما يتحدث العربية.

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 **1-877-317-2410**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 **1-877-317-2410.** 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 **1-877-317-2410.** 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 **1-877-317-2410.** 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 **1-877-317-2410.** 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ございます。通訳をご用命になるには、**1-877-317-2410**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。

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats such as large print, audio, and braille.
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your identification card. If you believe that we have failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 800-368-1019, TTY: 800-537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for our plan 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 2.1 for details.)	$0	$0
Monthly Part B Premium Reduction (You must also continue to pay your Medicare Part B premium.)	$35	$15
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 2.2 for details.)	$2,500 for in-network and $5,000 for in-network and out-of-network services combined	$4,500 for in-network services and $8,200 for in-network and out-of-network services combined
Doctor office visits	**Primary care visits:** **In-Network:** $0 copay per visit. **Out-of-Network:** $50 copay per visit **Specialist visits:** **In-Network:** $35 copay per visit. **Out-of-Network:** $50 copay per visit	**Primary care visits:** **In-Network:** $0 copay per visit. **Out-of-Network:** 40% of the total cost per visit **Specialist visits:** **In-Network:** $35 copay per visit. **Out-of-Network:** 40% of the total cost per visit
Inpatient hospital stays	**In-Network:** $325 copay each day for days 1 - 7	**In-Network:** $325 copay each day for days 1 - 7

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays (continued)	$0 per day for days 8 to discharge. Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days. **Out-of-Network:** $500 copay each day for days 1 - 7 $0 each day for days 8 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days.	$0 per day for days 8 to discharge. Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days. **Out-of-Network:** 40% coinsurance each day for days 1 - 7 $0 each day for days 8 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days.
Part D prescription drug coverage (See Section 2.5 for details.) You pay $30 per prescription at preferred pharmacies and $35 per prescription at standard retail pharmacies for insulins covered by our formulary. To find out which insulins are covered, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call the Customer Care Center.	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: **Preferred Pharmacy cost sharing:** • Drug Tier 1: $2 • Drug Tier 2: $8 • Drug Tier 3: $42 You pay $30 per month supply of each covered insulin product on this tier. • Drug Tier 4: $95 • Drug Tier 5: 33%	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: **Preferred Pharmacy cost sharing:** • Drug Tier 1: $0 • Drug Tier 2: $8 • Drug Tier 3: $42 You pay $30 per month supply of each covered insulin product on this tier. • Drug Tier 4: $95 • Drug Tier 5: 33%

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	• Drug Tier 6: $0 **Standard Pharmacy cost sharing:** • Drug Tier 1: $7 • Drug Tier 2: $13 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 • Drug Tier 5: 33% • Drug Tier 6: $0 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.)	• Drug Tier 6: $0 **Standard Pharmacy cost sharing:** • Drug Tier 1: $7 • Drug Tier 2: $13 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 • Drug Tier 5: 33% • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 We Are Changing the Plan's Name

On January 1, 2024, our plan name will change from SSM Health Plan Integrity to Medica Advantage with SSM Value.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly plan premium (You must continue to pay your Medicare Part B premium)	$0	$0
Monthly Part B Premium Reduction (You must also continue to pay your Medicare Part B premium.)	$35	$15

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

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your network maximum out-of-pocket amount.	$2,500 for in-network and $5,000 for in-network and out-of- network services combined	$4,500 for in-network services and $8,200 for in-network and out-of-network services combined

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount (continued)		Once you have paid $4,500 for in-network services or $8,200 for in-network and out-of-network services combined 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 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at https://central.medica.com/medicare. You may also call the Customer Care Center 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 the Customer Care Center so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2023 (this year)	2024 (next year)
Acupuncture for Chronic Low Back Pain: Medicare-Covered	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay a $50 copay	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay 40% of the total cost
Annual Physical Exam	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $30 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost
Cardiac Rehabilitation Services	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay 40% of the total cost
Cardiac Rehabilitation Services: Intensive Cardiac Rehab	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $40 copay **Out-of-Network:** You pay 40% of the total cost
Chiropractic Services: Medicare-Covered	**In-Network:** You pay a $20 copay **Out-of-Network:** You pay a $50 copay	**In-Network:** You pay a $20 copay **Out-of-Network:** You pay 40% of the total cost
Chiropractic Services: Routine Care	**In-Network:** You pay a $20 copay per visit for 12 visits every calendar year **Out-of-Network:** You pay a $50 copay per visit for combined 12 visits every calendar year	**In-Network:** You pay a $20 copay per visit for 12 visits every calendar year **Out-of-Network:** You pay 40% of the total cost per visit for combined 12 visits every calendar year

Cost	2023 (this year)	2024 (next year)
Chiropractic Services: Therapeutic Services	**In-Network:** You pay a $20 copay per visit for 6 visits every calendar year **Out-of-Network:** You pay a $50 copay per visit for combined 6 visits every calendar year	**In-Network:** You pay a $20 copay per visit for 6 visits every calendar year **Out-of-Network:** You pay 40% of the total cost per visit for combined 6 visits every calendar year
Dental: Comprehensive Medicare-covered	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay a $50 copay	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay 40% of the total cost
Dental: Maximum Plan Benefit Coverage Amount	**In-Network:** We cover $1,000 every calendar year **Out-of-Network:** Included in limit	**In-Network:** We cover $300 every calendar year Additional $500 coverage included in FlexSpend benefit. **Out-of-Network:** Included in limit
Emergency Care in the U.S.	**In-Network:** You pay a $100 copay **Out-of-Network** You pay a $100 copay	**In-Network:** You pay a $120 copay **Out-of-Network** You pay a $120 copay
FlexSpend Benefit	Not Covered	$500 yearly Allowance on a prepaid debit card to spend on dental services, vision services, eyewear, hearing services and hearing aids.
Hearing Services: Hearing Aid Coverage	**In-Network:** max plan coverage $750	**In-Network:** $500 coverage included in FlexSpend benefit.

Cost	2023 (this year)	2024 (next year)
Hearing Services: Hearing Aid Coverage (continued)	**Out-of-Network:** Not covered	**Out-of-Network:** Included in limit
Hearing Services: Medicare-covered Exam	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay 40% of the total cost
Home Health Services	**In-Network:** You pay a $0 copay per day **Out-of-Network:** You pay 20% of the total cost	**In-Network:** You pay a $0 copay per day **Out-of-Network:** You pay 40% of the total cost
Home Infusion Therapy	**In-Network:** You pay a $0 copay per day **Out-of-Network:** You pay 20% of the total cost	**In-Network:** You pay a $0 copay per day **Out-of-Network:** You pay 40% of the total cost
In-Home Support	**In-Network:** You pay $0 copay per visit for 120 hours yearly. **Out-of-Network:** Not Covered	**In-Network:** Not Covered **Out-of-Network:** Not Covered
Inpatient Hospital Care	**In-Network:** You pay a $325 copay each day for days 1 - 7 You pay $0 each day for days 8 to discharge. Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of	**In-Network:** You pay a $325 copay each day for days 1 - 7 You pay $0 each day for days 8 to discharge. Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of

Cost	2023 (this year)	2024 (next year)
Inpatient Hospital Care (continued)	medically necessary inpatient hospital days. **Out-of-Network:** You pay a $500 copay each day for days 1 - 7 You pay $0 each day for days 8 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days.	medically necessary inpatient hospital days. **Out-of-Network:** You pay 40% of the total cost each day for days 1 - 7 You pay $0 each day for days 8 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days.
Inpatient Psychiatric Hospital Care	**In-Network:** You pay a $325 copay each day for days 1 - 7 You pay $0 each day for days 8 - 90. Cost-sharing is applied for each inpatient stay. Coverage is limited to 90 days per benefit period. **Out-of-Network:** You pay a $500 copay each day for days 1 - 7 You pay $0 each day for days 8 - 90 Cost-sharing is applied for each inpatient stay. Coverage is limited to 90 days per benefit period.	**In-Network:** You pay a $310 copay each day for days 1 - 7 You pay $0 each day for days 8 - 90 Cost-sharing is applied for each inpatient stay. Coverage is limited to 90 days per benefit period. **Out-of-Network:** You pay 40% of the total cost each day for days 1 - 7 You pay $0 each day for days 8 - 90 Cost-sharing is applied for each inpatient stay. Coverage is limited to 90 days per benefit period.

Cost	2023 (this year)	2024 (next year)
Kidney Disease Education	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $30 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost
Medicare-Covered Preventive Services	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $30 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost
Medicare-covered preventive services includes: Abdominal aortic aneurysm screening, Annual wellness visit, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular disease risk reduction visit (therapy for cardiovascular disease), Colorectal cancer screening including barium enemas, Depression screening, Diabetes self-management training, HIV screening, Immunizations, Medical nutrition therapy, Medicare Diabetes Prevention Program (MDPP), Obesity screening and therapy to promote sustained weight loss, Prostate cancer screening exams including digital rectal exam, Screening and counseling to reduce alcohol misuse, Screening for lung cancer with low dose computed tomography (LDCT), Screening for sexually transmitted infections (STIs) and counseling to prevent STIs, Services to treat kidney disease – kidney disease education services or self-dialysis training, Smoking and tobacco use cessation (counseling to stop smoking or tobacco use), and “Welcome to Medicare” preventive visit, including EKG following welcome visit.		
Opioid Treatment Services	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Blood Services	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 20% of the total cost	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost

Cost	2023 (this year)	2024 (next year)
Outpatient Diagnostic Labs	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 20% of the total cost	**In-Network:** You pay a $0-$20 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Diagnostic Radiology Services	**In-Network:** You pay a $0-$120 copay You pay a $0 copay for diagnostic mammograms **Out-of-Network:** You pay 40% of the total cost You pay 40% of the total cost for diagnostic mammograms	**In-Network:** You pay a $0-$150 copay You pay a $0 copay for diagnostic mammograms **Out-of-Network:** You pay 40% of the total cost You pay 40% of the total cost for diagnostic mammograms
Outpatient Diagnostic Tests	**In-Network:** You pay a $10 copay **Out-of-Network:** You pay 20% - 40% of the total cost	**In-Network:** You pay a $10-$20 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Diagnostic X-Ray	**In-Network:** You pay a $20 copay **Out-of-Network:** You pay 40% of the total cost	**In-Network:** You pay a $20-$25 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Mental Health Care: Group Therapy (Non-Physician)	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $30 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Mental Health Care: Group Therapy (Psychiatrist)	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $30 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost

Cost	2023 (this year)	2024 (next year)
Outpatient Mental Health Care: Individual Therapy (Non-Physician)	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $30 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Mental Health Care: Individual Therapy (Psychiatrist)	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $30 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Rehabilitation Services: Occupational Therapy	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Rehabilitation Services: Physical Therapy and Speech Therapy	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Services Therapeutic Radiology	**In-Network:** You pay a $65 copay **Out-of-Network:** You pay a 40% coinsurance	**In-Network:** You pay a $20-$65 copay **Out-of-Network:** You pay 40% coinsurance
Outpatient Substance Abuse Services: Group Therapy	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost
Outpatient Substance Abuse Services: Individual Therapy	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 40% of the total cost

Cost	2023 (this year)	2024 (next year)
Outpatient Surgery: Ambulatory Surgical Center	**In-Network:** You pay a $0-$175 copay for screening colonoscopies that result in biopsy or removal of any growth during the procedure. Minor surgical services performed during an office visit will only be charged physician services cost-sharing. **Out-of-Network:** You pay 40% of the total cost for ambulatory surgical center services. You pay 40% of the total cost for screening colonoscopies that result in biopsy or removal of any growth during the procedure.	**In-Network:** You pay a $0-$250 copay for screening colonoscopies that result in biopsy or removal of any growth during the procedure. Minor surgical services performed during an office visit will only be charged physician services cost-sharing. **Out-of-Network:** You pay 40% of the total cost for ambulatory surgical center services. You pay 40% of the total cost for screening colonoscopies that result in biopsy or removal of any growth during the procedure.
Over-the-Counter (OTC) Program	You are eligible for a $60 credit every quarter to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail-order service.	You are eligible for a $55 credit every quarter to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail-order service.
Part B Drugs	**In-Network:** You pay 20% of the total cost for intravenous, subcutaneous, and biological Part B drugs You pay $2 - $47 copay for Part B prescription drugs received in the pharmacy	**In-Network:** You pay 0% - 20% of the total cost for intravenous, subcutaneous, and biological Part B drugs including chemotherapy You pay $0 - $47 copay for Part B prescription drugs received in the

Cost	2023 (this year)	2024 (next year)
Part B Drugs (continued)		
		pharmacy including chemotherapy
	Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance beginning on April 1, 2023.	Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance.
	For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one month supply effective July 1, 2023.	For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one month supply.
	Out-of-Network: You pay 20% of the total cost for intravenous, subcutaneous, and biological Part B drugs	**Out-of-Network:** You pay 40% of the total cost for intravenous, subcutaneous, and biological Part B drugs
	You pay 20% of the total cost for Part B prescription drugs received in the pharmacy	You pay 40% of the total cost for Part B prescription drugs received in the pharmacy
	Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance beginning on April 1, 2023.	Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance.
	For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one month supply.	For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one month supply.

Cost	2023 (this year)	2024 (next year)
Partial Hospitalization Services	**In-Network:** You pay a $0 copay per day **Out-of-Network:** You pay a $100 copay	**In-Network:** You pay a $75 copay per day **Out-of-Network:** You pay 40% of the total cost
Physician Services: Palliative Care	**In-Network:** You pay a $0 copay per visit **Out-of-Network:** You pay a $0 copay per visit	**In-Network:** You pay a $0 copay per visit **Out-of-Network:** You pay 40% of the total cost per visit
Physician Services: Primary Care Physician	**In-Network:** You pay a $0 copay per visit **Out-of-Network:** You pay a $50 copay per visit	**In-Network:** You pay a $0 copay per visit **Out-of-Network:** You pay 40% of the total cost
Physician Services: Specialist Physician	**In-Network:** You pay a $35 copay per visit **Out-of-Network:** You pay a $50 copay per visit	**In-Network:** You pay a $35 copay per visit **Out-of-Network:** You pay 40% of the total cost
Physician Services: Telehealth Services	**In-Network:** You pay a $0 - $35 copay **Out-of-Network:** You pay a $50 copay	**In-Network:** You pay a $0 - $35 copay **Out-of-Network:** You pay 40% of the total cost
Podiatry Services: Medicare-covered	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay a $50 copay	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay 40% of the total cost

Cost	2023 (this year)	2024 (next year)
Podiatry Services: Routine Footcare	**In-Network:** You pay a $35 copay per visit for 10 visits every calendar year. **Out-of-Network:** You pay a $50 copay per visit for combined 10 visits every calendar year.	**In-Network:** You pay a $35 copay per visit for 10 visits every calendar year. **Out-of-Network:** You pay 40% of the total cost per visit for combined 10 visits every calendar year.
Pulmonary Rehabilitation Services	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $15 copay **Out-of-Network:** You pay 40% of the total cost
Renal Dialysis Services	**In-Network:** You pay 20% of the total cost **Out-of-Network:** You pay 20% of the total cost	**In-Network:** You pay 20% of the total cost **Out-of-Network:** You pay 40% of the total cost
Skilled Nursing Facility	**In-Network:** You pay a $0 copay each day for days 1 - 20 You pay a $196 copay each day for days 21 - 100 Cost-sharing is applied per benefit period. Coverage is limited to 100 days per benefit period. **Out-of-Network:** You pay a $150 copay each day for days 1 - 100 Cost-sharing is applied per benefit period. Coverage is limited to 100 days per benefit period.	**In-Network:** You pay a $10 copay each day for days 1 - 20 You pay a $203 copay each day for days 21 - 100 Cost-sharing is applied per benefit period. Coverage is limited to 100 days per benefit period. **Out-of-Network:** You pay 40% of the total cost each day for days 1 - 100 Cost-sharing is applied per benefit period. Coverage is limited to 100 days per benefit period.

Cost	2023 (this year)	2024 (next year)
Supervised Exercise Therapy for Peripheral Arterial Disease	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $25 copay **Out-of-Network:** You pay 40% of the total cost
Vision Care: Medicare-Covered Exam	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay a $60 copay	**In-Network:** You pay a $35 copay **Out-of-Network:** You pay 40% of the total cost
Worldwide Emergency Coverage	**In-Network:** You pay a $100 copay **Out-of-Network** You pay a $100 copay	**In-Network:** You pay a $120 copay **Out-of-Network** You pay a $120 copay
Worldwide Urgent Coverage	**In-Network:** You pay a $100 copay **Out-of-Network** You pay a $100 copay	**In-Network:** You pay a $120 copay **Out-of-Network** You pay a $120 copay

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically. **You can get the *complete* "Drug List"** by calling the Customer Care Center (see Section 8.1) or visiting our website (https://central.medica.com/medicare).

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 the Customer Care Center 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 9/30/2023, please call the Customer Care Center 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 There is no deductible for Medica Advantage with SSM Value. You begin in the Initial Coverage Stage when you fill your first prescription of 2024.	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.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $7 per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost sharing:* You pay $7 per prescription.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued) in Chapter 6, Section 5 of your *Evidence of Coverage.* 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 $2 per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $13 per prescription. *Preferred cost sharing:* You pay $8 per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $42 per prescription. **Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. **Tier 6 (Part D Vaccines):** *Standard cost sharing:* You pay $0 of the total cost.	*Preferred cost sharing:* You pay $0 per prescription. **Tier 2 (Generic):** *Standard cost sharing:* You pay $13 per prescription. *Preferred cost sharing:* You pay $8 per prescription. **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $42 per prescription. **Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription. **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. **Tier 6 (Part D Vaccines):** *Standard cost sharing:* You pay $0 of the total cost.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	*Preferred cost sharing:* You pay $0 of the total cost. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	*Preferred cost sharing:* You pay $0 of the total cost. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Medica Advantage with SSM Value offers $0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy.

Medica Advantage with SSM Value offers additional gap coverage for Tier 1 drugs covered on our formulary. During the Coverage Gap stage, your out-of-pocket costs will be the same copays as in the Initial Coverage 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 3 Administrative Changes

Description	2023 (this year)	2024 (next year)
Legal entity name changes	SSM Health Plan	Medica Central Health Plan
Brand name change	WellFirst Health	Medica
Wallet Card name change	WellFirst Wallet	Health+ by Medica card

Description	2023 (this year)	2024 (next year)
Outpatient rehabilitation services – physical therapy, occupational therapy, and speech therapy	Prior authorization from the health plan is required.	Prior authorization from the health plan is NOT required.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Medica Advantage with SSM Value

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 Medica Advantage with SSM Value.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 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 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 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2). As a reminder, Medica Central 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 our plan.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact the Customer Care Center if you need more information on how to do so.

- *– or –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 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 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. The SHIP in your area is:

- Illinois: Illinois Senior Health Insurance Program (SHIP)
- Missouri: Missouri CLAIM Senior Health Insurance Program

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with 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. Call them or learn more by visiting their website:

Method	Illinois Senior Health Insurance Program (SHIP) – Contact Information
CALL	1-800-252-8966

Method	Illinois Senior Health Insurance Program (SHIP) – Contact Information
TTY	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Illinois Senior Health Insurance Program (SHIP) One Natural Resources Way, Suite 100 Springfield, IL 62702-1271
WEBSITE	www.illinois.gov/aging/ship

Method	Missouri CLAIM Senior Health Insurance Program – Contact Information
CALL	1-800-390-3330
TTY	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Missouri CLAIM Senior Health Insurance Program (SHIP) 1105 Lakeview Avenue Columbia, MO 65201
WEBSITE	www.missouriclaim.org

SECTION 7 Programs That Help Pay for Prescription Drugs

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

- "**Extra Help**" **from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, 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).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the State AIDS/HIV Drug Assistance Program **Note:** 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.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your State ADAP office listed below.

Method	Illinois: Illinois AIDS Drug Assistance Program (ADAP) – Contact Information
CALL	1-800-825-3518 Hours of operation are 8:30 am to 4 pm Monday through Friday
WRITE	Illinois ADAP 525 W Jefferson St, Floor 1 Springfield, IL 62761
WEBSITE	www.hivcareconnect.com/adap

Method	Missouri: AIDS Drug Assistance Program (ADAP) – Contact Information
CALL	1-573-751-6439 Hours of operation are 8 am to 5 pm Monday through Friday
WRITE	Missouri Department of Health and Senior Services Bureau of HIV, STD and Hepatitis PO Box 570, Jefferson City, MO 65102-0570
WEBSITE	https://health.mo.gov/living/healthcondiseases/communicable/hiv-std-hep.php

SECTION 8 Questions?

Section 8.1 – Getting Help from Medica Advantage with SSM Value

Questions? We're here to help. Please call the Customer Care Center at 1-877-301-3326. (TTY only, call 711.) We are available for phone calls 8 am to 8 pm, seven days per week. However, please note that our automated phone system may answer your call during all Federal holidays and weekends from April 1 to September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day. 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 our plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at https://central.medica.com/medicare. You may also call the Customer Care Center to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at https://central.medica.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/"Drug List")*.

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.