HealthTeam Advantage Plan II (PPO) offered by Care N' Care Insurance Company of North Carolina, Inc.

Annual Notice of Changes for 2023

You are currently enrolled as a member of HealthTeam Advantage Plan II (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 www.healthteamadvantage.com. You can also review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you. (You may also call your Healthcare Concierge 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 2023 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 2023* handbook.

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

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3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in HealthTeam Advantage Plan II (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, 2023.** This will end your enrollment with HealthTeam Advantage Plan II (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 your Healthcare Concierge at 1-888-965-1965 for additional information. (TTY users should call 711.) Hours are October 1 – March 31, 8AM – 8PM Eastern, 7 days a week; April 1 – September 30, 8AM – 8PM Eastern, Monday through Friday.
- This information is also available in large print. Please call your Healthcare Concierge at 1-888-965-1965 (TTY users should call 711) if you need plan information in another format or language.
- **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 HealthTeam Advantage Plan II (PPO)

- HealthTeam Advantage Plan II (PPO), a product of Care N' Care Insurance Company of North Carolina, Inc., is a Medicare Advantage organization with a Medicare contract. Enrollment in HealthTeam Advantage Plan II (PPO) depends on contract renewal.
- When this document says "we," "us," or "our", it means Care N' Care Insurance Company of North Carolina, Inc. (HealthTeam Advantage Plan II (PPO)). When it says "plan" or "our plan," it means HealthTeam Advantage Plan II (PPO).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for HealthTeam Advantage Plan II (PPO) in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$75	$75
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $3,200 From network and out-of-network providers combined: $5,150	From network providers: $3,000 From network and out-of-network providers combined: $5,100
Doctor office visits	**In-network:** Primary care visits: $0 copay per visit Specialist visits: $20 copay per visit **Out-of-network:** Primary care visits: $30 copay per visit Specialist visits: $50 copay per visit	**In-network:** Primary care visits: $0 copay per visit Specialist visits: $15 copay per visit **Out-of-network:** Primary care visits: $30 copay per visit Specialist visits: $50 copay per visit

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	**In-network:** $250 copay per day for days 1 through 5 $0 copay per day for days 6 through 90 $0 copay for days 91 and beyond **Out-of-network:** $500 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay for days 91 and beyond	**In-network:** $200 copay per day for days 1 through 5 $0 copay per day for days 6 through 90 $0 copay for days 91 and beyond **Out-of-network:** $500 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay for days 91 and beyond
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $12 copay • Drug Tier 3: $40 copay • Drug Tier 4: $80 copay • Drug Tier 5: 33% coinsurance	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $12 copay • Drug Tier 3: $40 copay • Drug Tier 4: $80 copay • Drug Tier 5: 33% coinsurance

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$75	$75 There is no change to your monthly premium for 2023.
Optional Supplemental Benefits premium	$25 (Available for an extra premium)	No Longer Offered The Optional Supplemental Dental Rider will no longer be offered in 2023. Instead, Comprehensive Dental Service are included at no additional cost to you for 2023. Please see your *Evidence of Coverage* for full details.

- 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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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

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 Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (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 plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,200	$3,000 Once you have paid $3,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar 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 plan premium and your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$5,150	$5,100 Once you have paid $5,100 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.healthteamadvantage.com. You may also call your Healthcare Concierge for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider/Pharmacy 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 2023 *Provider/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 your Healthcare Concierge 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	2022 (this year)	2023 (next year)
Dental Services (Medicare-covered)	**In-Network** You pay a $20 copay for each Medicare-covered dental service. **Out-of-Network** You pay a $45 copay for each Medicare-covered dental service.	**In-Network** You pay a $0 copay for each Medicare-covered dental service. **Out-of-Network** You pay a $0 copay for each Medicare-covered dental service.
Dental Services (Non-Medicare-covered Comprehensive)	Non-Medicare-covered Comprehensive dental visits are not covered as a mandatory plan benefit in 2022. They are available as part of the Optional Supplemental Package for an additional premium.	Non-Medicare-covered Comprehensive dental visits are covered as a mandatory plan benefit in 2023. The Optional Supplemental Benefit package will not be offered in 2023. Comprehensive services are covered at no additional premium.
Dental Services (Preventive)	**In-Network** You pay a $0 copay for each preventive dental service. **Out-of-Network** You pay a $20 copay for each preventive dental service.	**In-Network** You pay a $0 copay for each preventive dental service. **Out-of-Network** You pay a $0 copay for covered preventive services with a maximum allowed of $750 per calendar year. Please see the full dental coverage description in your *Evidence of Coverage*. Annual maximum benefit applies to both in-network and out-of-network services.

Cost	2022 (this year)	2023 (next year)
Diabetic Services and Supplies	Monitoring devices and supplies covered are limited to Freestyle, Precision and OneTouch.	Diabetic Supplies and Services limited to those from the following manufacturers: - Blood Glucose Meter and testing supplies - One Touch - Continuous Glucose Monitor and supplies - FreeStyle Libre $0 coinsurance for preferred and 20% cost share for non-preferred. Authorization required for non-preferred. $0 copay for one pair of Medicare-covered therapeutic shoes and up to two pairs of inserts.
Hearing Aids	You pay a $499-$799 per hearing aid. Premium hearing aids are available in rechargeable style options at no additional cost. (Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. Hearing aid purchase includes a 45-day trial period.)	You pay a $499-$799 per hearing aid. Premium hearing aids are available in rechargeable style options at no additional cost. (Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. Hearing aid purchase includes a 60-day trial period.)
Inpatient Hospital Care	**In-Network** You pay a $250 copay per day for days 1 through 5 and a $0 copay per day for days 6 through 90 for Medicare-covered inpatient hospital stays.	**In-Network** You pay a $200 copay per day for days 1 through 5 and a $0 copay per day for days 6 through 90 for Medicare-covered inpatient hospital stays.

Cost	2022 (this year)	2023 (next year)
Inpatient Services in a Psychiatric Hospital	**In-Network** You pay a $250 copay per day for days 1 through 5 and a $0 copay per day for days 6 through 90 for Medicare-covered inpatient mental health stays.	**In-Network** You pay a $200 copay per day for days 1 through 5 and a $0 copay per day for days 6 through 90 for Medicare-covered inpatient mental health stays.
Outpatient Mental Health Specialty Services	**In-Network** You pay a $20 copay for each Medicare-covered individual therapy visit and $20 copay for each group therapy visit.	**In-Network** You pay a $15 copay for each Medicare-covered individual therapy visit and $15 copay for each group therapy visit.
Outpatient Psychiatrist Services	**In-Network** You pay a $20 copay for each Medicare-covered individual therapy visit with a psychiatrist and $20 copay for each group therapy visit.	**In-Network** You pay a $15 copay for each Medicare-covered individual therapy visit with a psychiatrist and $15 copay for each group therapy visit.
Physical & Speech Therapy Services	**In-Network** You pay a $20 copay for each Medicare-covered physical therapy visit. You pay a $20 copay for each Medicare-covered speech therapy visit.	**In-Network** You pay a $15 copay for each Medicare-covered physical therapy visit. You pay a $15 copay for each Medicare-covered speech therapy visit.
Podiatry Services (Medicare-covered)	**In-Network** You pay a $20 copay for each Medicare-covered podiatry visit.	**In-Network** You pay a $15 copay for each Medicare-covered podiatry visit.
Remote Access Technologies	You pay a $0 copay for services provided by MDLive.	MDLive is no longer covered for remote access technologies. Please contact your provider directly for telehealth services.

Cost	2022 (this year)	2023 (next year)
Specialist Visits	**<u>In-Network</u>** You pay a $20 copay for each Medicare-covered specialist visit.	**<u>In-Network</u>** You pay a $15 copay for each Medicare-covered specialist visit.
Vision Care (Non-Medicare-covered Eyewear)	**<u>In-Network</u>** You pay a $0 copay (1 pair of eyeglasses per year; frame allowance of $100.)	**<u>In-Network</u>** You pay a $0 copay (1 pair of eyeglasses per year; frame allowance of $200.)

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 in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

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 your Healthcare Concierge 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 your Healthcare Concierge 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	2022 (this year)	2023 (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	2022 (this year)	2023 (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 that provides standard cost sharing.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Preferred Generics:** You pay \$0 per prescription. **Generics:** You pay \$12 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Preferred Generics:** You pay \$0 per prescription. **Generics:** You pay \$12 per prescription.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued) 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*. 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.	**Preferred Brands:** You pay $40 per prescription. **Non-Preferred Drugs:** You pay $80 per prescription. **Specialty Drugs:** You pay 33% of the total cost. ______________ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	**Preferred Brands:** You pay $40 per prescription. **Non-Preferred Drugs:** You pay $80 per prescription. **Specialty Drugs:** You pay 33% of the total cost. ______________ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

SECTION 2 Administrative Changes

Description	2022 (this year)	2023 (next year)
Mail Order Pharmacy	Elixir is the Mail Order Pharmacy.	Elixir Mail Order Pharmacy and Wesley Long Outpatient Pharmacy will be the options for all Mail Order pharmacy. Amazon Pill Pack is an option 30-day mail order supply only.

Description	2022 (this year)	2023 (next year)
Pharmacy Benefit Manager	The Pharmacy Benefit manager is Elixir.	The Pharmacy Benefit manager is RxAdvance/ nirvanaHealth.
Service Area	The service area for this plan is Alamance, Davidson, Davie, Forsyth, Guilford, Randolph, and Rockingham counties.	The service area for this plan is Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Randolph, Rockingham, Stokes, and Yadkin counties.
Third Party Administrator	The Third Party Administrator for enrollment and claims processing is Beacon Health Solutions.	The Third Party Administrator for enrollment and claims processing is nirvanaHealth.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in HealthTeam Advantage Plan II (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 HealthTeam Advantage Plan II (PPO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 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 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, HealthTeam Advantage offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HealthTeam Advantage Plan II (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from HealthTeam Advantage Plan II (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact your Healthcare Concierge 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, 2023.

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, 2023, 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, 2023.

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 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 North Carolina, the SHIP is called the North Carolina Seniors' Health Insurance Information Program (SHIIP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The SHIIP 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 SHIIP at 1-855-408-1212. You can learn more about SHIIP by visiting their website (www.ncdoi.com/SHIIP/).

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, 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).
- **Help from your state's pharmaceutical assistance program.** North Carolina has a program called Medication Assistance Programs (MAP) and NC MedAssist that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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 North Carolina AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-877-466-2232.

SECTION 7 Questions?

Section 7.1 – Getting Help from HealthTeam Advantage Plan II (PPO)

Questions? We're here to help. Please call your Healthcare Concierge at 1-888-965-1965. (TTY only, call 711.) We are available for phone calls October 1 – March 31, 8AM – 8PM Eastern, 7 days a week; April 1 – September 30, 8AM – 8PM Eastern, Monday through Friday. Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for HealthTeam Advantage Plan II (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 www.healthteamadvantage.com. You can also review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call your Healthcare Concierge to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.healthteamadvantage.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy 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 2023*

Read the *Medicare & You 2023* 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.