BlueMedicare Saver Choice (PPO) offered by Arkansas Blue Medicare

Annual Notice of Changes for 2024

You are currently enrolled as a member of BlueMedicare Saver Choice (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.arkbluemedicare.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.**

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.

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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 BlueMedicare Saver Choice (PPO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with BlueMedicare Saver Choice (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

- Please contact our Customer Service number at **1-844-463-1088** for additional information. (TTY users should call **711**.) Hours are 8:00 a.m. to 8:00 p.m. Central, Monday through Friday (April 1 through September 30). From October 1 through March 31, our hours are 8:00 a.m. to 8:00 p.m. Central, seven days a week. This call is free.
- This information is available in large print.
- **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 BlueMedicare Saver Choice (PPO)

- Arkansas Blue Medicare offers HMO, PFFS, PPO, and PDP plans with a Medicare contract. Enrollment in Arkansas Blue Medicare depends on contract renewal.
- When this document says "we," "us," or "our," it means Arkansas Blue Medicare. When it says "plan" or "our plan," it means BlueMedicare Saver Choice (PPO).

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for BlueMedicare Saver Choice (PPO) in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $5,000 From network and out-of-network providers combined: $8,950	From network providers: $5,000 From network and out-of-network providers combined: $9,550
Doctor office visits	**In-Network** Primary care visits: $0 copay per visit Specialist visits: $30 copay per visit **Out-of-Network** Primary care visits: $30 copay per visit Specialist visits: 40% of the total cost	**In-Network** Primary care visits: $0 copay per visit Specialist visits: $30 copay per visit **Out-of-Network** Primary care visits: $30 copay per visit Specialist visits: 40% of the total cost

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In-Network** For each Medicare-covered hospital stay: $375 copay per day for days 1–5; $0 copay per day for days 6–90 For additional days after reaching the Medicare-covered benefit limit, you pay a $0 copay. A transfer from one facility (e.g., an acute care or long-term care hospital) to another facility is treated as one admission. **Out-of-Network** For each Medicare-covered hospital stay: 40% of the total cost	**In-Network** For each Medicare-covered hospital stay: $325 copay per day for days 1–5; $0 copay per day for days 6–90 Additional days are not covered. A transfer from one facility (e.g., an acute care or long-term care hospital) to another facility is treated as a new admission. **Out-of-Network** For each Medicare-covered hospital stay: 40% of the total cost

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $250 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $15 copay • Drug Tier 3: $47 copay You pay $0 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 copay You pay $0 per month supply of each covered insulin product on this tier. • Drug Tier 5: 29% of the total cost • Drug Tier 6: $0 copay 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	Deductible: $250 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $15 copay • Drug Tier 3: $47 copay You pay $20 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 copay You pay $20 per month supply of each covered insulin product on this tier. • Drug Tier 5: 29% of the total cost You pay $20 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under

Cost	2023 (this year)	2024 (next year)
	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).	our enhanced benefit. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

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

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

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

Cost	2023 (this year)	2024 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,000	$5,000 Once you have paid $5,000 out-of-pocket for covered services, you will pay nothing for your covered 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 costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$8,950	$9,550 Once you have paid $9,550 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

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

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated Directories are located on our website at **www.arkbluemedicare.com**. You may also call Customer Service 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 Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2023 (this year)	2024 (next year)
Ambulance services	**In- and Out-of-Network** You pay a $265 copay per one-way ground ambulance trip.	**In- and Out-of-Network** You pay a $325 copay per one-way ground ambulance trip.
Ambulatory surgical center services	**In-Network** You pay a $0 copay for diagnostic colonoscopies. You pay a $225 copay per visit for all other services.	**In-Network** You pay a $275 copay per visit for all services, including visits for diagnostic colonoscopies.

Cost	2023 (this year)	2024 (next year)
Dental (supplemental)	**<u>In-Network</u>** You pay 50% of the total cost for restorative services and periodontics. You pay a $20 copay for extractions. You pay a $20 copay for denture adjustments. You pay 50% of the total cost for denture repairs and relines. **<u>In- and Out-of-Network</u>** Extractions are limited to two per calendar year.	**<u>In-Network</u>** You pay 20% of the total cost for restorative services and periodontics. You pay 20% of the total cost for extractions. You pay 20% of the total cost for prosthodontics (denture adjustments, repairs, and relines), other oral/maxillofacial surgery, and other services. **<u>In- and Out-of-Network</u>** Extractions are unlimited per calendar year.
Dental Xtra[SM]	**<u>Out-of-Network</u>** You pay a $0 copay.	**<u>Out-of-Network</u>** You pay a 50% of the total cost.
Diabetic supplies and services	**<u>In-Network</u>** Lifescan (i.e., OneTouch) and Ascensia (i.e., Contour) are our preferred manufacturers for diabetic testing supplies.	**<u>In-Network</u>** Lifescan (i.e., OneTouch) and Roche (i.e., Accu-Chek) are our preferred manufacturers for diabetic testing supplies.
Emergency services	**<u>In- and Out-of-Network</u>** You pay a $110 copay per visit.	**<u>In- and Out-of-Network</u>** You pay a $120 copay per visit.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In-Network** You pay a $375 copay per day for days 1–5 and a $0 copay per day for days 6–90. For additional days after reaching the Medicare-covered benefit limit, you pay a $0 copay. A transfer from one facility (e.g., an acute care or long-term care hospital) to another facility is treated as one admission.	**In-Network** You pay a $325 copay per day for days 1–5 and a $0 copay per day for days 6–90. Additional days are not covered. A transfer from one facility (e.g., an acute care or long-term care hospital) to another facility is treated as a new admission.
Inpatient psychiatric stays	**In-Network** You pay a $350 copay per day for days 1–5 and a $0 copay per day for days 6–90. A transfer from one facility (e.g., an acute care or long-term care hospital) to another facility is treated as one admission.	**In-Network** You pay a $325 copay per day for days 1–5 and a $0 copay per day for days 6–90. A transfer from one facility (e.g., an acute care or long-term care hospital) to another facility is treated as a new admission.
Medicare Part B drugs	**In-Network** You pay 20% of the total cost for Part B chemotherapy/radiation and other Part B drugs. Prior authorization is required for Part B insulin products.	**In-Network** You pay 0%–20% of the total cost for Part B chemotherapy/radiation and other Part B drugs. Prior authorization is not required for Part B insulin products.
Outpatient diagnostic procedures/tests	**In-Network** You pay a $20 copay per diagnostic procedure/test except for spirometry and home-based sleep studies.	**In-Network** You pay a $100 copay per diagnostic procedure/test except for spirometry and home-based sleep studies.

Cost	2023 (this year)	2024 (next year)
Outpatient diagnostic radiological services	**In-Network** You pay a $0 copay for diagnostic mammograms regardless of location. You pay a $30 copay for services performed in a professional office setting or freestanding radiological clinic. You pay a $275 copay for services performed in an outpatient location.	**In-Network** You pay a $25 copay for diagnostic mammograms regardless of location. You pay a $25 copay for ultrasounds regardless of location. You pay a $295 copay for all other diagnostic radiological services regardless of location.
Outpatient hospital services	**In-Network** You pay a $275 copay per visit.	**In-Network** You pay a $295 copay per visit.
Outpatient lab services	**In-Network** You pay a $0 copay per visit for genetic testing.	**In-Network** You pay 20% of the total cost per visit for genetic testing.
Outpatient observation services	**In-Network** You pay a $275 copay per stay.	**In-Network** You pay a $295 copay per stay.
Outpatient rehabilitation services	**In-Network** Prior authorization is not required for occupational, physical, or speech therapy visits.	**In-Network** Prior authorization is required for occupational, physical, and speech therapy visits after 30 visits.

Cost	2023 (this year)	2024 (next year)
Over-the-counter (OTC) items	**<u>In-Network Only</u>** You receive $40 per calendar quarter for OTC items. You can only purchase eligible OTC items online or through a catalog.	**<u>In-Network Only</u>** You receive $65 per calendar quarter for OTC items. You can purchase eligible OTC items in-store, online, and through an app or catalog using a pre-loaded debit card.
Partial hospitalization	**<u>In-Network</u>** You pay a $55 copay per visit.	**<u>In-Network</u>** You pay a $85 copay per visit.
Pulmonary rehabilitation services	**<u>In-Network</u>** You pay a $20 copay per visit.	**<u>In-Network</u>** You pay a $15 copay per visit.
Skilled nursing facility (SNF) care	**<u>In-Network</u>** You pay a $0 copay per day for days 1–20 and a $196 copay per day for days 21–100.	**<u>In-Network</u>** You pay a $0 copay per day for days 1–20 and a $203 copay per day for days 21–100.
Worldwide emergency coverage	**<u>Outside the U.S.</u>** You pay a $90 copay per visit.	**<u>Outside the U.S.</u>** You pay 20% of the total cost per visit.
Worldwide urgent coverage	**<u>Outside the U.S.</u>** You pay a $90 copay per visit.	**<u>Outside the U.S.</u>** You pay 20% of the total cost per visit.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Customer Service 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 30, 2023, please call Customer Service 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 During this stage, **you pay the full cost** of your Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is $250. During this stage, you pay $0 cost sharing for drugs on Tier 1 (Preferred Generic), $15 cost sharing for drugs on Tier 2 (Generic), $47 cost sharing for drugs on Tier 3 (Preferred Brand), $0 cost sharing for drugs on Tier 6 (Select Care Drugs), and the full cost of drugs on Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) until you have reached the yearly deductible.	The deductible is $250. During this stage, you pay $0 cost sharing for drugs on Tier 1 (Preferred Generic), $15 cost sharing for drugs on Tier 2 (Generic), $47 cost sharing for drugs on Tier 3 (Preferred Brand), $0 cost sharing for drugs on Tier 6 (Select Care Drugs), and the full cost of drugs on Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier) until you have reached the yearly deductible.

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Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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.** Most adult Part D vaccines are covered at no cost to you. 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. 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic):** You pay $0 per prescription. **Tier 2 (Generic):** You pay $15 per prescription. **Tier 3 (Preferred Brand):** You pay $47 per prescription. You pay $0 per month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Drug):** You pay $100 per prescription. You pay $0 per month supply of each covered insulin product on this tier. **Tier 5 (Specialty Tier):** You pay 29% of the total cost.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic):** You pay $0 per prescription. **Tier 2 (Generic):** You pay $15 per prescription. **Tier 3 (Preferred Brand):** You pay $47 per prescription. You pay $20 per month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Drug):** You pay $100 per prescription. You pay $20 per month supply of each covered insulin product on this tier. **Tier 5 (Specialty Tier):** You pay 29% of the total cost.

Stage	2023 (this year)	2024 (next year)
		You pay $20 per month supply of each covered insulin product on this tier.
	Tier 6 (Select Care Drugs): You pay $0 per prescription.	**Tier 6 (Select Care Drugs):** You pay $0 per prescription.
	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Paying your monthly premium	You can pay your monthly premium by check, monthly bank draft, or opting to have it withdrawn directly from your Social Security check.	You can pay your monthly premium by check, monthly bank draft, or opting to have it withdrawn directly from your Social Security check. You can also pay online through your personal BluePortal account or at www.arkbluemedicare.com/payonline.
Customer Service Phone Number	To contact Customer Service, call **1-844-201-4934** (TTY: **711**).	To contact Customer Service, call **1-844-463-1088** (TTY: **711**).

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in BlueMedicare Saver Choice (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 BlueMedicare Saver Choice (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 2024, follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (**www.medicare.gov/plan-compare**), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Arkansas Blue Medicare 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 BlueMedicare Saver Choice (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from BlueMedicare Saver Choice (PPO).
- 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, seven 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, 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 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 Arkansas, the SHIP is called Seniors Health Insurance Information Program.

It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. Seniors Health Insurance Information Program 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 Seniors Health Insurance Information Program at **1-800-224-6330**. You can learn more about Seniors Health Insurance Information Program by visiting their website (**www.shiipar.com**).

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/seven days a week;
  - The Social Security Office at **1-800-772-1213** between 8:00 a.m. and 7:00 p.m., Monday through Friday, for a representative. Automated messages are available 24 hours a day. TTY users should call **1-800-325-0778**; or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Arkansas AIDS Drug Assistance Program (Ryan White Program). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call **1-501-661-2408** or visit **https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program**.

SECTION 7 Questions?

Section 7.1 – Getting Help from BlueMedicare Saver Choice (PPO)

Questions? We're here to help. Please call Customer Service at **1-844-463-1088**. (TTY only, call **711**.) We are available for phone calls 8:00 a.m. to 8:00 p.m. Central, Monday through Friday (April 1 through September 30). From October 1 through March 31, our hours are 8:00 a.m. to 8:00 p.m. Central, seven days a week. 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 BlueMedicare Saver Choice (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.arkbluemedicare.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.arkbluemedicare.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, seven 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 booklet 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, seven days a week. TTY users should call **1-877-486-2048**.