BlueMedicare Classic Plus (HMO) offered by *Arkansas Blue Medicare*

Annual Notice of Changes for 2025

You are currently enrolled as a member of BlueMedicare Classic Plus (HMO). 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the **www.medicare.gov/plan-compare** website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

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

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

- If you don't join another plan by December 7, 2024, you will stay in BlueMedicare Classic Plus (HMO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with BlueMedicare Classic Plus (HMO).
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Customer Service number at **1-844-463-1088** 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, braille, or audio.
- **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 Classic Plus (HMO)

- 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 Classic Plus (HMO).

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for BlueMedicare Classic Plus (HMO) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium	$0 Monthly Medicare Part B premium reduction not covered.	$0 We will reduce your monthly Medicare Part B premium by $4.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$6,200	$6,200
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $35 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $35 copay per visit
Inpatient hospital stays	For each Medicare-covered hospital stay: $350 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 one admission.	For each Medicare-covered hospital stay: $375 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.

Cost	2024 (this year)	2025 (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: $3 copay • Drug Tier 2: $10 copay • Drug Tier 3: $47 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 36% of the total cost You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 29% of the total cost You pay $35 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 our enhanced benefit. You pay nothing.	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: $5 copay • Drug Tier 3: $47 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 36% of the total cost You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 30% of the total cost You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: Not covered Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium	$0 Monthly Medicare Part B premium reduction not covered.	$0 We will reduce your monthly Medicare Part B premium by $4.

- 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 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 services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,200	$6,200 Once you have paid $6,200 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

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 2025 *Provider Directory* at www.arkbluemedicare.com 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 2025 *Pharmacy Directory* at www.arkbluemedicare.com 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	2024 (this year)	2025 (next year)
Ambulatory surgical center services	You pay a $275 copay per visit.	You pay a $250 copay per visit.
Cardiac rehabilitation services	Prior authorization is required for cardiac rehabilitation services.	Prior authorization is not required for cardiac rehabilitation services.
Chiropractic services	You pay a $20 copay per visit.	You pay a $15 copay per visit.

Cost	2024 (this year)	2025 (next year)
Dental (supplemental)	You have an annual maximum of $2,000 for preventive and comprehensive dental services.	You have an annual maximum of $3,500 for preventive and comprehensive dental services.
Dental Xtra℠	This benefit is covered.	This benefit is not covered.
Diabetic supplies	Prior authorization is required for diabetic supplies (CGMs).	Prior authorization is not required for diabetic supplies (CGMs).
Diabetic therapeutic shoes/inserts	You pay 20% of the total cost for diabetic therapeutic shoes and inserts.	You pay a $0 copay for diabetic therapeutic shoes and inserts.
Emergency services	You pay a $120 copay per visit.	You pay a $125 copay per visit.
Eyewear (supplemental)	You have a combined allowance of $100 for contact lenses, eyeglasses, and upgrades every year. Contact lenses and eyeglasses (lenses and frames) are limited to one per year up to the annual allowance.	You have a combined allowance of $150 for contact lenses, eyeglasses, and upgrades every year. Contact lenses and eyeglasses (lenses and frames) are unlimited up to the annual allowance.
Inpatient hospital stays	You pay a $350 copay per day for days 1–5 and a $0 copay per day for days 6–90.	You pay a $375 copay per day for days 1–5 and a $0 copay per day for days 6–90.

Cost	2024 (this year)	2025 (next year)
Inpatient psychiatric stays	You pay a $350 copay per day for days 1–5 and a $0 copay per day for days 6–90.	You pay a $375 copay per day for days 1–5 and a $0 copay per day for days 6–90.
Intensive cardiac rehabilitation services	Prior authorization is required for intensive cardiac rehabilitation services.	Prior authorization is not required for intensive cardiac rehabilitation services.
Occupational therapy services	You pay a $35 copay per visit.	You pay a $40 copay per visit.
Outpatient diagnostic radiological services	You pay a $295 copay per visit for outpatient diagnostic radiological services, excluding mammograms and ultrasounds. You pay a $0 copay for diagnostic DEXA scans.	You pay a $325 copay per visit for outpatient diagnostic radiological services, excluding mammograms and ultrasounds. You pay a $325 copay for diagnostic DEXA scans.
Outpatient hospital observation	You pay a $295 copay per stay.	You pay a $325 copay per stay.
Outpatient hospital services	You pay a $295 copay per visit.	You pay a $325 copay per visit.
Over-the-counter (OTC) items	You receive $50 per calendar quarter for OTC items.	You receive $80 per calendar quarter for OTC items.
Skilled nursing facility (SNF) care	You pay a $0 copay per day for days 1–20 and a $203 copay per day for days 21–100.	You pay a $0 copay per day for days 1–20 and a $214 copay per day for days 21–100.

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, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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.

Starting in 2025, we may immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we may decide to keep the brand name drug or original biological product on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month's supply of your brand name drug or biological product at a network pharmacy. If you are taking the brand name drug or biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of the drug types that are discussed throughout this chapter, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: **https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients**. You may also contact Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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, 2024, please call Customer Service and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3 (Preferred Brand), 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 $3 cost sharing for drugs on Tier 1 (Preferred Generic), $10 cost sharing for drugs on Tier 2 (Generic), $0 cost sharing for drugs on Tier 6 (Select Care Drugs), and the full cost of drugs on Tier 3 (Preferred Brand), 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), $5 cost sharing for drugs on Tier 2 (Generic), and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (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**. The costs in this chart 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, 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. Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic):** You pay $3 per prescription. Your cost for a one-month mail-order prescription is $3. **Tier 2 (Generic):** You pay $10 per prescription. Your cost for a one-month mail-order prescription is $10. **Tier 3 (Preferred Brand):** You pay $47 per prescription. **Tier 4 (Non-Preferred Drug):** You pay 36% of the total cost. **Tier 5 (Specialty Tier):** You pay 29% of the total cost. Your cost for a one-month mail-order prescription is 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. Your cost for a one-month mail-order prescription is $0. **Tier 2 (Generic):** You pay $5 per prescription. Your cost for a one-month mail-order prescription is $5. **Tier 3 (Preferred Brand):** You pay $47 per prescription. **Tier 4 (Non-Preferred Drug):** You pay 36% of the total cost. **Tier 5 (Specialty Tier):** You pay 30% of the total cost. Your cost for a one-month mail-order prescription is 30% of the total cost.

Stage	2024 (this year)	2025 (next year)
	Tier 6 (Select Care Drugs): You pay $0 per prescription. Your cost for a one-month mail-order prescription is $0. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	**Tier 6 (Select Care Drugs):** Not covered. _____ Once you have paid $2,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January–December). To learn more about this payment option, please contact us at **1-844-280-5833** or visit **Medicare.gov**.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in BlueMedicare Classic Plus (HMO)

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 Classic Plus (HMO).

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 2025 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 2025* 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 Classic Plus (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from BlueMedicare Classic Plus (HMO).
- 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, 2025.

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

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

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

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

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
    - **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**, 24 hours a day, 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.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the 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.**

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January–December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at **1-844-280-5833** or visit **Medicare.gov**.

SECTION 7 Questions?

Section 7.1 – Getting Help from BlueMedicare Classic Plus (HMO)

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 *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for BlueMedicare Classic Plus (HMO). 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 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (**https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf**) or by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.