2025

Annual Notice of Changes

CareFirst BlueCross BlueShield Group Advantage (PPO)

Effective January 1, 2025 - December 31, 2025

CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage PPO, Inc., an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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CareFirst BlueCross BlueShield Group Advantage (PPO) offered by CareFirst Advantage PPO, Inc. (d/b/a CareFirst BlueCross BlueShield Medicare Advantage)

Annual Notice of Changes for 2025

You are currently enrolled as a member of CareFirst BlueCross BlueShield Group Advantage. This document highlights any changes to your plan's costs and benefits for the 2025 plan year. ***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.carefirst.com/myaccount. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

You are enrolled in this plan through your employer group or union, which designates the dates each year when you can make changes to your coverage for the following plan 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.
- 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.

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers as long as the services are covered benefits, your provider is a Medicare Provider and is willing to bill CareFirst or their local BlueCross BlueShield Plan, and the services are medically necessary.

OMB Approval 0938-1051 (Expires: August 31, 2026)

Note: CareFirst BlueCross BlueShield Group Advantage will not pay any amount for the services you get from Medicare opt-out providers, even for a Medicare-covered service.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of individual 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 wish to continue as a member of CareFirst BlueCross BlueShield Group Advantage, you do not need to take any action unless your group advises otherwise.** If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2025.

- Should you choose to disenroll from your employer group offerings, you should discuss this decision with your employer group to determine what the impacts of that disenrollment would be. See your employer group Open Enrollment Materials for additional information on plan options or disenrollments.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 833-320-2664 for additional information. (TTY users should call 711). Hours are 8am-6pm EST Monday-Friday. This call is free.
- To get information from us in a way that works for you, please call Member Services. We can give you information in braille, large print, or other alternate formats if you need it.
- **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 CareFirst BlueCross BlueShield Group Advantage

- CareFirst BlueCross BlueShield Group Advantage is a PPO plan with a Medicare contract. Enrollment in CareFirst BlueCross BlueShield Group Advantage depends on contract renewal.
- When this document says "we," "us," or "our," it means CareFirst Advantage PPO, Inc.. When it says "plan" or "our plan," it means CareFirst BlueCross BlueShield Group Advantage.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for CareFirst BlueCross BlueShield Group Advantage in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium (See Section 2.1 for details.)	Contact your former employer or union for premium information.	Contact your former employer or union for premium information.
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From in-network and out-of-network providers combined: $6,000	From in-network and out-of-network providers combined: $6,000
Doctor office visits	Primary care visits: $5 copay per visit Specialist visits: $15 copay per visit	Primary care visits: $5 copay per visit Specialist visits: $15 copay per visit
Inpatient hospital stays	$50 copay per admission	$50 copay per admission
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible:$0 Copayment/Coinsurance during the Initial Coverage Stage: Preferred Generic (Tier 1): $5 Generic (Tier 2): $10 Preferred Brand (Tier 3): $20 Non-Preferred Drug (Tier 4): $40. You pay $35 per month supply of each covered insulin product on this tier.	Deductible:$0 Copayment/Coinsurance during the Initial Coverage Stage: Preferred Generic (Tier 1): $5 Generic (Tier 2): $10 Preferred Brand (Tier 3): $20 Non-Preferred Drug (Tier 4): $40. You pay $35 per month supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	Specialty (Tier 5): 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. 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.	Specialty (Tier 5): 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in CareFirst BlueCross BlueShield Group Advantage in 2025

We will automatically enroll you in 2025 CareFirst BlueCross BlueShield Group Advantage. This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through 2025 from your CareFirst BlueCross BlueShield Group Advantage plan. If you want to change to an individual plan or switch to Original Medicare, you must do so during your employer's open enrollment period. Please discuss your intent to disenroll with your former employer so they can provide you with the timing and implications of disenrolling from the plan. If you are eligible for “Extra Help,” you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium	Contact your former employer or union for premium information.	Contact your former employer or union for premium information.

Cost	2024 (this year)	2025 (next year)
(You must also continue to pay your Medicare Part B premium.)		

- 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 7 regarding "Extra Help" from Medicare.

Section 2.2 – 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	2024 (this year)	2025 (next 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 costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$6,000 Once you have paid $6,000 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 in-network or out-of-network providers for the rest of the calendar year.	$6,000 Once you have paid $6,000 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 in-network or out-of-network providers for the rest of the calendar year.

Section 2.3 – 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.carefirst.com/myaccount starting October 15, 2024. You may also call Member Services 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 may be changes to our network of providers for next year. **Please review the 2025 *Provider Directory at* www.carefirst.com/myaccount to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There may be changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory at* www.carefirst.com/myaccount 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, you will be notified of that change. Please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2024 (this year)	2025 (next year)
Onduo Virtual Diabetes Program	Onduo was a plan benefit for plan members with diabetes.	The Onduo program will no longer be offered. The CareFirst Care Management staff can help members with diabetes navigate through their condition.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website (www.carefirst.com/myaccount). The 2025 Drug List will be posted to the website by October 15, 2024.

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 Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original 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 drug types, 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 Member Services 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 have included a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying 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 didn't receive this insert with this packet, please call Member Services 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 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	Because you have no prescription drug deductible, this payment stage does not apply to you.	Because you have no prescription drug deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (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 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 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. 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 $5 per prescription. Tier 2 - Generic: You pay $10 per prescription. Tier 3 - Preferred Brand: You pay $20 per prescription. Tier 4 - Non-Preferred Drug: You pay $40 per prescription. You pay $35 per month supply of each covered insulin product on this tier. Tier 5 - Specialty Tier: You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. _______________	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: Tier 1 - Preferred Generic: You pay $5 per prescription. Tier 2 - Generic: You pay $10 per prescription. Tier 3 - Preferred Brand: You pay $20 per prescription. Tier 4 - Non-Preferred Drug: You pay $40 per prescription. You pay $35 per month supply of each covered insulin product on this tier. Tier 5 - Specialty Tier: You pay 25% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. _______________

Stage	2024 (this year)	2025 (next year)
	Once you have paid $8,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	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 and 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 3 Administrative Changes

Description	2024 (this year)	2025 (next year)
Diabetic Supplies Prior Authorization	Prior authorization was not required for any blood glucose meter or test strip products.	There is no prior authorization for OneTouch and Accu-Chek blood glucose meter or test strip products. All other blood glucose meter or test strip products require prior authorization.
Enhanced Drug Coverage - Changes	There was no prior authorization, coverage limits or step therapy (utilization management) for enhanced drugs (non-Medicare covered drugs).	There is prior authorization, coverage limits and step therapy (utilization management) for enhanced drugs (non-Medicare covered drugs).
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works

Description	2024 (this year)	2025 (next year)
		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 888-970-0917 or visit Medicare.gov.
Medication Waste Reduction	Our prescription fill system did not account for excess accumulation of medications.	We may delay when you can refill your medications if you have extra medication on-hand.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in CareFirst BlueCross BlueShield Group Advantage

To stay in our plan, you don’t need to do anything. You will automatically be enrolled in CareFirst BlueCross BlueShield Group Advantage.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
  - Because you are enrolled in our plan through your employer group or union, you are only allowed to make plan changes at times designated by that group.
  - If you choose to enroll in a Medicare health plan or Medicare prescription drug plan that is not offered by your employer group or union, you will lose coverage in our plan. If you choose to end your membership in our plan, please contact your employer group to determine how this may impact your ability to re-enroll in your employer group's health coverage.

- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from CareFirst BlueCross BlueShield Group Advantage.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from CareFirst BlueCross BlueShield Group Advantage.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send your former employer or union a written request to disenroll. Contact your former employer or union if you need more information on how to do so.
  - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

Please reach out to your employer group to understand when you can make any changes to your current plan.

SECTION 6 Programs That Offer Free Counseling about Medicare

State Health Insurance Assistance Programs (SHIP) are independent government programs with trained counselors in every state.

They are state programs that get money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

A list of State Health Insurance Programs can be found in Exhibit A at the end of your 2025 *Evidence of Coverage*.

SECTION 7 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
  - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program.** State Pharmaceutical Assistance Programs (SPAP) help 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. A list of State Pharmaceutical Assistance Programs can be found in Exhibit A at the end of your 2025 *Evidence of Coverage*.
- **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 ADAP in your state. For information on eligibility criteria, covered drugs, or how to enroll in the program or if you are currently enrolled how to continue receiving assistance, contact the ADAP in your state. A list of AIDS Drug Assistance Programs can be found in Exhibit A at the end of your 2025 *Evidence of Coverage*. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and 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 888-970-0917 or visit Medicare.gov.

SECTION 8 Questions?

Section 8.1 – Getting Help from CareFirst BlueCross BlueShield Group Advantage

Questions? We're here to help. Please call Member Services at 833-320-2664. (TTY only, call 711.) We are available for phone calls 8am-6pm EST Monday-Friday. 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 CareFirst BlueCross BlueShield Group Advantage. 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.carefirst.com/myaccount. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.carefirst.com/myaccount. 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)*, which will be posted by October 15, 2024.

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read Medicare & You *2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most

frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.