MCS Classicare Hero (HMO) *offered by* MCS Advantage, Inc. (MCS Classicare)

Annual Notice of Changes for 2024

You are currently enrolled as a member of MCS Classicare Hero (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.mcsclassicare.com. You may also call our Call Center to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

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

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

   - If you don't join another plan by December 7, 2023, you will stay in MCS Classicare Hero (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, 2024**. This will end your enrollment with MCS Classicare Hero (HMO).
   - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Call Center number at 787-620-2530 (Metro Area), 1-866-627-8183 (Toll Free) for additional information. (TTY users should call 1-866-627-8182). Hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. This call is free.
- This information is available in different formats including, large print, braille, and audio CD. Please call our Call Center at the numbers listed above if you need plan information in another format or language.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About MCS Classicare Hero (HMO)

- MCS Classicare is a product subscribed by MCS Advantage, Inc. (MCS Classicare). MCS Classicare is an HMO plan with a Medicare contract. Enrollment in MCS Classicare depends on contract renewal.
- When this document says "we," "us," or "our", it means MCS Advantage, Inc. (MCS Classicare). When it says "plan" or "our plan," it means MCS Classicare Hero (HMO).

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Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for MCS Classicare Hero (HMO) 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 amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,400	$3,400
Doctor office visits	Primary care visits: $11 copayment per visit Specialist visits: $20 copayment per visit	Primary care visits: $11 copayment per visit Specialist visits: $20 copayment per visit
Inpatient hospital stays	$100 copayment for each inpatient hospital stay for Special Network (SN) Providers $200 copayment per each inpatient hospital stay for General Network (GN) Providers	$100 copayment for each inpatient hospital stay for Special Network (SN) Providers $200 copayment per each inpatient hospital stay for General Network (GN) Providers
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $5 copayment	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $5 copayment

Cost	2023 (this year)	2024 (next year)
	• Drug Tier 2: $10 copayment • Drug Tier 3: $30 copayment • Drug Tier 4: 25% coinsurance • Drug Tier 5: 33% coinsurance • Drug Tier 6: $5 copayment Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.).	• Drug Tier 2: $10 copayment • Drug Tier 3: $30 copayment • Drug Tier 4: 25% coinsurance • Drug Tier 5: 33% coinsurance • Drug Tier 6: $5 copayment 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.

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
Part B Premium Reduction (Your Part B monthly premium is reduced by the amounts shown.)	$100	$164.90

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

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.mcsclassicare.com. You may also call our Call Center for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Providers and Pharmacies 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 *Providers and Pharmacies 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 our Call Center 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)
Over-the-Counter (OTC) Items		
	You are eligible for $100 every month ($1,200 annually) to be used toward the purchase of over-the-counter (OTC) products.	You are eligible for $20 every month ($240 annually) to be used toward the purchase of over-the-counter (OTC) items. **At the end of the policy year, the plan will not provide any remaining balance of your benefit.** Please review your Evidence of Coverage (EOC) for more information about your Over-the-Counter (OTC) Items benefit.

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI)	To be eligible for additional benefits you must have been diagnosed with one or more of the chronic conditions identified by the health plan and meet certain eligibility criteria: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Crohn's disease; Ulcerative colitis; Anemia; Chronic obstructive pulmonary disease (COPD); Severe mental retardation; Moderate to Severe Autism; Rheumatologic disease; Hx of cancer (Personal history of cancer); Hypertension; Valvular heart disease; Cerebrovascular disease; Chronic viral hepatitis C; Chronic liver disease; Neurodegenerative disease; Obesity; Malnutrition and Cachexia; Chronic kidney disease; Colostomy status; Non-pressure chronic ulcer.	To be eligible for additional benefits you must have been diagnosed with one or more of the chronic conditions identified by the health plan and meet certain eligibility criteria: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Crohn's disease; Ulcerative colitis; Chronic anemia; Chronic obstructive pulmonary disease (COPD); Severe mental retardation; Moderate to Severe Autism; Hypertension; Valvular heart disease; Cerebrovascular disease; Chronic viral hepatitis; Chronic liver disease; Neurodegenerative disease; Obesity; Chronic Malnutrition and Cachexia; Chronic kidney disease; Non-pressure chronic ulcer.

Cost	2023 (this year)	2024 (next year)
Te Paga Card	Members with one or more of the chronic conditions previously mentioned may use their OTC allowance ($100 monthly, $1,200 annually) to purchase both OTC and additional items with your Te Paga card. All other members must use their allowance only for the purchase of over-the-counter (OTC) items.	Members with one or more of the chronic conditions previously mentioned may use their OTC allowance ($20 monthly, $240 annually) to purchase both OTC and additional items with your Te Paga card. All other members must use their allowance for the purchase of over-the-counter (OTC) items. **At the end of the policy year, the plan will not provide any remaining balance of your benefit.** Please review your Evidence of Coverage (EOC) for more information about goods and services available for purchase with your Te Paga Card.
Home Assistance	You pay a $0 copay for Home Assistance services, which include: yard clean-up, hairstyling (wash, cut, and dry), basic plumbing, locksmith services, electrical repairs, pest control, preventive home cleaning/ disinfection, pet grooming, and technology assistance.	You pay a $0 copay for Home Assistance services, which include: yard clean-up, hairstyling (wash, cut, and dry), basic plumbing, locksmith services, electrical repairs, pest control, preventive home cleaning/ disinfection, and technology assistance.
Dental Services		

Cost	2023 (this year)	2024 (next year)
Comprehensive dental services	Up to $3,300 for all in-network covered services every year.	Up to $3,400 for all in-network covered services every year.
Hearing Services		
Hearing aids	Up to $2,000 for both ears combined every year for hearing aids.	Up to $1,000 per ear every year for hearing aids.
Vision Care		
Additional routine eyewear	Up to $600 every year for all additional routine eyewear.	Up to $725 every year for all additional routine eyewear.
Medicare Part B prescription drugs - Insulins	Insulin drugs were not mentioned separately in the 2023 Evidence of Coverage.	You pay 0% - 10% of the total cost, maximum $35 copayment for insulin drugs.
Colorectal Cancer Screening (preventive screening)	You pay 20% of the total cost if your doctor finds and removes a polyp or other tissue during a colonoscopy or flexible sigmoidoscopy. This procedure is considered a 'diagnostic' test; and is therefore subject to a plan cost sharing payment. You pay 20% of the total cost in a hospital outpatient setting for the diagnostic exam.	You pay 15% of the total cost if your doctor finds and removes a polyp or other tissue during a colonoscopy or flexible sigmoidoscopy. This procedure is considered a 'diagnostic' test; and is therefore subject to a plan cost sharing payment. You pay 15% of the total cost in a hospital outpatient setting for the diagnostic exam.
Prior Authorizations		
Partial Hospitalization Services	Preauthorization required through MCS Solutions.	Prior Authorization is <u>not</u> required.
Outpatient mental health care • Services provided by a	Preauthorization required through MCS Solutions.	Prior Authorization is <u>not</u> required.

Cost	2023 (this year)	2024 (next year)
psychiatrist (Medicare-covered Individual and Group sessions) • Services provided by other mental health care providers (Only for Medicare-covered group session)		
Outpatient diagnostic tests and therapeutic services and supplies • Radiation (radium and isotope) therapy including technician materials and supplies	Prior Authorization is required.	Prior Authorization is not required.
Home infusion therapy	Prior Authorization is not required.	Prior Authorization is required.
Hearing Services • Hearing Aids	Prior Authorization is not required.	Prior Authorization is required.

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 our Call Center for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.**

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	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** 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 Drugs :** You pay $5 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1: Preferred Generic Drugs:** You pay $5 per prescription.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)		
	Tier 2: Generic Drugs: You pay $10 per prescription.	**Tier 2: Generic Drugs:** You pay $10 per prescription.
	Tier 3: Preferred Brand Drugs: You pay $30 per prescription.	**Tier 3: Preferred Brand Drugs:** You pay $30 per prescription.
	Tier 4: Non-Preferred Brand Drugs: You pay 25% of the total cost.	**Tier 4: Non-Preferred Brand Drugs:** You pay 25% of the total cost.
	Tier 5: Specialty Tier Drugs: You pay 33% of the total cost.	**Tier 5: Specialty Tier Drugs:** You pay 33% of the total cost.
	Tier 6: Select Diabetic Drugs (Select Insulins): You pay $5 per prescription.	**Tier 6: Select Care Drugs:** You pay $5 per prescription.
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."	_____ 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 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in MCS Classicare Hero (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 MCS Classicare Hero (HMO).

Section 2.2 – 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 4), or call Medicare (see Section 6.2). As a reminder, MCS Advantage, Inc. (MCS Classicare) offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from MCS Classicare Hero (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from MCS Classicare Hero (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact our Call Center if you need more information on how to do so.

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

SECTION 3 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 4 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 Puerto Rico, the SHIP is called Programa Estatal de Asistencia Sobre Seguros de Salud.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Programa Estatal de Asistencia Sobre Seguros de Salud 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 Programa Estatal de Asistencia sobre Seguros de Salud at 1-877-725-4300 (Metro Area), 1-800-981-0056 (Mayagüez Area) or 1-800-981-7735 (Ponce Area). You can learn more about Programa Estatal de Asistencia sobre Seguros de Salud by visiting their website (https://agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx).

SECTION 5 Programs That Help Pay for Prescription Drugs

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

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

Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office (applications).

- **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 Health Insurance Assistance Program (HIAP) - Ryan White Part B / ADAP Program - Puerto Rico Department of Health. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Health Insurance Assistance Program (HIAP) - Ryan White Part B / ADAP Program - Puerto Rico Department of Health at 787-765-2929, exts. 5106, 5136, 5137, or 5149.

SECTION 6 Questions?

Section 6.1 – Getting Help from MCS Classicare Hero (HMO)

Questions? We're here to help. Please call our Call Center at 787-620-2530 (Metro Area), 1-866-627-8183 (Toll Free). (TTY only, call 1-866-627-8182). We are available for phone calls Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. 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 MCS Classicare Hero (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.mcsclassicare.com. You may also call our Call Center to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.mcsclassicare.com. As a reminder, our website has the most up-to-date information about our provider network (Providers and Pharmacies Directory) and our *List of*

Covered Drugs (Formulary/"Drug List").

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.