EmblemHealth VIP Dual (HMO D-SNP) offered by Health Insurance Plan of Greater New York (HIP)/EmblemHealth

Annual Notice of Changes for 2025

You are currently enrolled as a member of EmblemHealth VIP Dual (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 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 **emblemhealth.com/medicare**. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Customer Service to ask us to mail you an *Evidence of Coverage.*

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 EmblemHealth VIP Dual (HMO D-SNP).
- 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 EmblemHealth VIP Dual (HMO D-SNP).
- Look in section 3 page 12 to learn more about your choices.
- 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

- This document is available for free in Spanish.
- Please contact our Customer Service number at **1-877-344-7364** for additional information. (TTY users should call **711**.) Hours are 8 am to 8 pm 7 days a week from October 1 to March 31 and 8 am to 8 pm Monday- Saturday, April 1 to September 30. This call is free.
- We can also provide information in a way that works for you (information in other alternate formats). Please call Customer Service at the number 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 EmblemHealth VIP Dual (HMO D-SNP)

- Health Insurance Plan of Greater New York (HIP) is an HMO D-SNP plan with a Medicare contract and a contract with the New York State Department of Health. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company.
- When this document says “we,” “us,” or “our,” it means HIP/EmblemHealth. When it says “plan” or “our plan,” it means EmblemHealth VIP Dual (HMO D-SNP).

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for EmblemHealth VIP Dual (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**. **If you are eligible for Medicare cost-sharing assistance under New York Medicaid you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* *Your premium may be higher than this amount. (See Section 1.1 for details.)	**$0.00**	**$0.00**
Doctor office visits	Primary care visits: **$0** copay per visit Specialist visits: **$0** copay per visit	Primary care visits: **$0** copay per visit Specialist visits: **$0** copay per visit
Inpatient hospital stays	**$0** copay for each Medicare-covered stay. Prior authorization is required.	**$0** copay for each Medicare-covered stay. Prior authorization is required.
Part D prescription drug coverage (See Section 1.5 for details.) (continued on next page)	Deductible: **$0** Copayment during the Initial Coverage Stage: Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** You pay **$0-$4.50** per prescription**.** **Tier 2 (Generic):** You pay **$0-$4.50** per prescription.	Deductible: **$0** Copayment during the Initial Coverage Stage: Your cost for a one-month supply at a network pharmacy: **Tier 1 (All Formulary Drugs):** You pay **$0** or **$1.60** or **$4.90** per generic drug prescription. You pay **$0** or **$4.80** or **$12.15** per brand drug prescription.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	**Tier 3 (Preferred Brand):** You pay **$0-$11.20** per prescription. **Tier 4 (Non-Preferred Drug):** You pay **$0-$11.20** per prescription. **Tier 5 (Specialty Tier):** You pay **$0-$11.20** per prescription. **Tier 6 (Select Care Drugs):** You pay **$0** per prescription. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.
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.)	**$8,850** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	**$9,350** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

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 (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	**$0.00**	**$0.00**

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	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. 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.	**$8,850**	**$9,350** Once you have paid **$9,350** 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

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 **emblemhealth.com/medicare**. 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* emblemhealth.com/medicare to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are no changes to our network of pharmacies for next year.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are a 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

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

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)
Advanced Care Planning	Online assistance and toolkit to help you complete Advance Care Directives **is covered.**	Online assistance and toolkit to help you complete Advance Care Directives **is not covered.**
Chiropractic Services	You pay a **$0** copay for chiropractic services. Prior authorization **is** required.	You pay a **$0** copay for chiropractic services. Prior authorization **is not** required.
Medicaid Covered Dental Services	**Not covered**	You pay a **$0** copay for Medicaid Covered Dental Services including: • Maxillofacial Prosthetics • Implant Services • Orthodontics Prior authorization is required.
Occupational Therapy	You pay a **$0** copay for occupational therapy. Prior authorization **is** required.	You pay a **$0** copay for occupational therapy. Prior authorization **is not** required.
Outpatient Blood Services	You pay a **$0** copay for outpatient blood services. Prior authorization **is** required.	You pay a **$0** copay for outpatient blood services. Prior authorization **is not** required.
Outpatient Observation Services	You pay a **$0** copay for outpatient observation services. Prior authorization **is** required.	You pay a **$0** copay for outpatient observation services. Prior authorization **is not** required.

Cost	2024 (this year)	2025 (next year)
Over-the-Counter (OTC) Items	Our plan will cover **$60 per month** for Medicare-eligible over-the-counter (OTC) **items, including healthy foods and produce at participating locations.** **This amount does not roll-over month-to-month and will expire at the end of each month.**	Our plan will cover **$60 per month** for Medicare-eligible over-the-counter (OTC) **items at mail order and participating retail locations.** **This amount does not roll-over month-to-month and will expire at the end of each month.**
Physical and Speech Therapy Services	You pay a **$0** copay for physical and speech therapy services. Prior authorization **is** required.	You pay a **$0** copay for physical and speech therapy services. Prior authorization **is not** required.
Vision Care	Our plan covers up to a **$300 allowance every 2 years for one pair of routine eyeglasses or contact lenses.**	Our plan covers up to a **$300 allowance every 2 years for routine eyeglasses or contact lenses up to allowance.**
Worldwide Emergency Services	You pay a **$0** copay for one way Worldwide Emergency Services.	You pay a **$0** copay for one way Worldwide Emergency Services. **$50,000 annual limit combined with Worldwide Urgent Care and Worldwide Ground Ambulance.**
Worldwide Ground Ambulance	You pay a **$0** copay for each Worldwide Ground Ambulance trip.	You pay a **$0** copay for each Worldwide Ground Ambulance trip. **$50,000 annual limit combined with Worldwide Emergency Care and Worldwide Urgent Care.**
Worldwide Urgent Care	You pay a **$0** copay for Worldwide Urgent Care.	You pay a **$0** copay for Worldwide Urgent Care. **$50,000 annual limit combined with Worldwide Emergency Care and Worldwide Ground Ambulance.**

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

Most of the changes in the Drug List are new for the beginning of each year. However, 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.

Changes to Prescription Drug Benefits and Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **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 December 31, 2024, 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 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	The deductible is **$0**	The deductible is **$0**

Changes to Your Cost Sharing in the Initial Coverage Stage

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 row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply , look in Chapter 6, Section 5 of your *Evidence of Coverage*. Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy is: **Tier 1 (Preferred Generic):** You pay **$0-$4.50** per prescription. **Tier 2 (Generic):** You pay **$0-$4.50** per prescription. **Tier 3 (Preferred Brand):** You pay **$0-$11.20** per prescription. **Tier 4 (Non-Preferred Drug):** You pay **$0-$11.20** per prescription. **Tier 5 (Specialty Tier):** You pay **$0-$11.20** per prescription. **Tier 6 (Select Care Drugs):** You pay **$0** per prescription. Once you have paid **$8,000** out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 (All Formulary Drugs):** You pay **$0** or **$1.60** or **$4.90** per generic drug prescription. You pay **$0** or **$4.80** or **$12.15** per brand drug prescription. 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.

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)
Value-Based Insurance Design	Our plan participates in Value Based Insurance Design.	Value Based Insurance Design ended December 31, 2024.
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 **1-866-845-1803** or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in EmblemHealth VIP Dual (HMO D-SNP)

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 EmblemHealth VIP Dual (HMO D-SNP).

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 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.

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, HIP/EmblemHealth 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 EmblemHealth VIP Dual (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from EmblemHealth VIP Dual (HMO D-SNP).
- 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, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or 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.

Because you have New York State Medicaid, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also 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 and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York State, the SHIP is called Health Insurance Information Counseling and Assistance Program (HIICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HIICAP 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 HIICAP at **1-800-701-0501**. You can learn more about HIICAP by visiting their website **(www.aging.ny.gov)**.

For questions about your New York State Medicaid benefits, contact New York State Department of Health, **1-800-541-2831**, TTY **711**. Hours are Monday to Friday, 8:00 am to 8:00 pm. Saturday, 9:00 am to 1:00 pm. You can also contact New York State Long Term Care Ombudsman Program, **1-855-582-6769**, TTY **711**. Ask how joining another plan or returning to Original Medicare affects how you get your New York State Department of Health (Medicaid) coverage.

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.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about "Extra Help," 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.** New York State has a program called Elderly Pharmaceutical Insurance Coverage (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition.To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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 New York State Uninsured Care Program. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call **1-800-542-2437**. 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 **1-866-845-1803** or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from EmblemHealth VIP Dual (HMO D-SNP)

Questions? We're here to help. Please call Customer Service at **1-877-344-7364** (TTY only, call **711**). We are available for phone calls 8 am to 8 pm 7 days a week from October 1 to March 31 and 8 am to 8 pm Monday- Saturday, April 1 to September 30. 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 EmblemHealth VIP Dual (HMO D-SNP). 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 **emblemhealth.com/medicare**. 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 **emblemhealth.com/medicare**. 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, 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.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid you can call the New York State Department of Health (Medicaid) at 1-800-541-2831. TTY users should call 711.