Vermont Blue advantage
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Vermont Blue Advantage Group PPO℠

Benefits-at-a-Glance Medical Services and Prescription Drugs

Vermont State Teachers' Retirement System PPO Medicare Advantage Plans

January 1, 2024 – December 31, 2024

The information provided is a summary of your benefits, showing what we cover and what you pay. A complete list of services is found in the *Evidence of Coverage* and the *Medical Benefits Chart*.

If you have any questions about this plan's benefits, please call Vermont Blue Advantage Group PPO Customer Service (phone numbers are on the back cover of this booklet). A complete list of services is found in the *Evidence of Coverage*, which will be mailed to you prior to the date your coverage takes effect and will be available online at **www.VermontBlueAdvantage.com/VSTRS**.

Vermont Blue Advantage Group PPO has a network of doctors, hospitals, pharmacies, and other providers that participate with Medicare. You do not have to use our network providers, but all providers must participate with Medicare and must accept the member as a patient. Out-of-network/non-contracted providers are under no obligation to treat Vermont Blue Advantage Group PPO members, except in emergency situations.

For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **www.VermontBlueAdvantage.com/VSTRS**.

To join Vermont Blue Advantage Group PPO, you must meet all of the following requirements:

- Have both Medicare Part A and Medicare Part B.
- Be a United States citizen or lawfully present in the United States.
- Live in our geographic service area of the United States and its territories. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Vermont Blue Advantage is a PPO plan with a Medicare contract. Enrollment in Vermont Blue Advantage depends on contract renewal.
Vermont Blue Advantage® is an independent licensee of the Blue Cross and Blue Shield Association.

Vermont Blue Advantage Group PPO

Vermont State Teachers' Retirement System PPO Medicare Advantage Plans

Cost-sharing Table	**JY** Medical & Prescription Drugs	**Comprehensive** Medical & Prescription Drugs	**VSTRS 65** Medical only
Premium	In addition to the Medicare Part B premium, you may also be required to pay a premium contribution as defined by your employer, union group, or third-party advisor. For premium contribution questions please contact the Vermont State Teachers' Retirement office toll-free at **1-800-642-3191**, TTY: **711**, Monday through Friday 7:45 a.m.to 4:30 p.m. Eastern time.		
Medical Deductible *(Does not include prescription drugs)*	**In- and out-of-network combined:** $100 deductible applies to certain services as shown below	**In- and out-of-network combined:** $300 deductible applies to most services as shown below	**In- and out-of-network combined:** $0
Maximum Out-of-Pocket Responsibility *(Does not include prescription drugs)* All medical and hospital care services below apply to this annual amount, except for worldwide urgent care, emergency care, and emergency transportation.	**In- and out-of-network combined:** $600 annually	**In- and out-of-network combined:** $600 annually	Not applicable

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Ambulance Services Medically necessary transport: coverage applies to each one-way trip			
• Emergency ambulance in U.S. and its territories	20% coinsurance, after deductible, for emergency transport	20% coinsurance, after deductible, for emergency transport	$0 copay for emergency transport
• Non-emergency ambulance in U.S. and its territories **Authorization required for non-emergency air ambulance.*	20% coinsurance, after deductible, for non-emergency transport	20% coinsurance, after deductible, for non-emergency transport	$0 copay for non-emergency transport
Caregiver Support	This benefit is built into the plan at no additional cost. **MyCareAdvocate™** On-demand, personalized guidance from expert Care Advocates providing caregivers with information, coaching, assistance, and emotional support to reduce caregiver stress. Topics can include healthcare, living arrangements, financial concerns, legal resources, and more. To access MyCareAdvocate, call **1-877-960-3510**, 8 a.m. to 7 p.m. Eastern time, Monday through Friday. TTY: **711**. **MyCareDesk®** Online comprehensive caregiver support, with resources and guidance to empower caregivers navigating complex topics like senior living, in-home care, health, finances, legal topics, and healthy living. To access MyCareDesk visit **VBA.MyCareDesk.com**.		

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Chiropractic Care			
• Manual manipulation of the spine to correct subluxation	$20 copay for each Medicare-covered visit	20% coinsurance, after deductible, for each Medicare-covered visit	$0 copay for each Medicare-covered visit
• One routine office visit per year	$20 copay for each routine care visit	20% coinsurance, after deductible, for each routine care visit	$0 copay for each routine care visit
• One set of X-rays (up to 3 views) when performed by chiropractor	$0 copay for one annual set of X-rays	20% coinsurance, after deductible, for one annual set of X-rays	$0 copay for one annual set of X-rays
Diabetic Supplies			
• Diabetic supplies	$0 copay	$0 copay	$0 copay
• Diabetic shoes and inserts	$0 copay	$0 copay	$0 copay
Doctor Visits			
• Primary Care Physician (PCP)	$20 copay	20% coinsurance, after deductible	$0 copay
• Specialists	$20 copay	20% coinsurance, after deductible	$0 copay
Durable Medical Equipment/ Supplies*			
• Durable medical equipment (e.g., wheelchairs, oxygen)	20% coinsurance, after deductible	20% coinsurance, after deductible	$0 copay
• Prosthetics (e.g., braces, artificial limbs)	20% coinsurance, after deductible	20% coinsurance, after deductible	$0 copay
• Diabetic equipment or supplies	$0 copay	$0 copay	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Emergency Care In U.S. and its territories If you are admitted to the hospital within one day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$20 copay	20% coinsurance, after deductible	$0 copay
Foot Care (podiatry services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	$20 copay	20% coinsurance, after deductible	$0 copay
Hearing Services • Medicare-covered hearing exam to diagnose and treat hearing and balance issues Enhanced Hearing Services • Routine hearing exam • Hearing aid fitting and evaluation • Hearing aid You may pay less if you use an in-network NationsHearing provider.	$0 copay	20% coinsurance, after deductible	$0 copay
	In-network enhanced hearing services (routine exam, hearing aid fitting and evaluation) through NationsHearing: $0 copay once per year. **Out-of-network enhanced hearing services (routine exam, hearing aid fitting and evaluation) through non-NationsHearing:** $0 copay once per year, based on approved amount. If you see an out-of-network, non-NationsHearing network provider for your hearing exam, you are responsible for any amounts your provider charges above the plan's approved amount. This means you may end up paying more than the $0 copay for the exam.		
	In-network through NationsHearing for hearing aids: Our plan pays up to a $1,250 allowance toward one new standard (analog or basic digital) hearing aid for each ear, once per year from a NationsHearing provider.		

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Hearing Services (continued) Locate a NationsHearing provider at **www.NationsHearing.com/VBA** or call **1-877-246-6955**, 24 hours a day, 7 days a week. TTY: **711**.	**Out-of-network through non-NationsHearing for hearing aid(s):** Our plan will reimburse you up to a $1,250 allowance toward one new standard (analog or basic digital) hearing aid for each ear, once per year. You can submit receipts from an out-of-network provider for reimbursement by calling NationsHearing. Over-the-counter hearing aids purchased off-the-shelf are **not** a covered benefit. You are responsible for the difference between the plan's benefit allowance and the cost of the hearing aid(s).		
Home Health Agency Care Includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc. Custodial care is not a benefit.	$0 copay	20% coinsurance, after deductible	$0 copay
Home Infusion Therapy* • Home infusion drugs • Home infusion administration	$0 copay	20% coinsurance, after deductible	$0 copay
Inpatient Hospital Care* The copays are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row.	$0 copay Our plan covers an unlimited number of days for an inpatient hospital stay	20% coinsurance, after deductible Our plan covers an unlimited number of days for an inpatient hospital stay	$0 copay Our plan covers an unlimited number of days for an inpatient hospital stay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Medicare Part B Drugs* • COVID-19, flu, Hepatitis B, and pneumonia immunizations	$0 copay	$0 copay	$0 copay
• Other Medicare-covered immunizations	$0 copay	$0 copay	$0 copay
• Part B insulins	$0 copay	$0 copay	$0 copay
• Part B drugs, such as chemotherapy	$0 copay	20% coinsurance, after deductible	$0 copay
• Other Part B drugs *Step therapy applies to certain Part B drugs*.	$0 copay	20% coinsurance, after deductible	$0 copay
Mental Health Outpatient Services • Outpatient therapy visit	$20 copay	20% coinsurance, after deductible	$0 copay
• Outpatient non-therapy visit	$20 copay	20% coinsurance, after deductible	$0 copay
You can also use Teladoc Health® to access online behavioral health support from licensed providers such as therapists, counselors, and U.S. board-certified psychiatrists by appointment 7 days a week, 7 a.m. to 9 p.m. local time. Access your telemedicine services by visiting **www.TeladocHealth.com** or by calling **1-800-Teladoc** (835-2362), available 24 hours a day, 7 days a week, 365 days a year. TTY: **1-855-636-1578**.	$0 copay for online telemedicine visit via Teladoc Health	$0 copay for online telemedicine visit via Teladoc Health	$0 copay for online telemedicine visit via Teladoc Health

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Mental Health Inpatient Services Inpatient therapy visit	$0 copay	20% coinsurance, after deductible	$0 copay
	If your hospital stay is longer than 90 days, our plan provides for up to 100 additional days of coverage, subject to the Medicare lifetime limit of 190 days. This limitation does not apply to inpatient psychiatric services furnished in a psychiatric unit of a general hospital. A benefit period starts the day you go into an inpatient psychiatric hospital. It ends when you go for 60 days in a row without inpatient psychiatric hospital care. No prior hospital stay is required. Copays, deducible and coinsurance restart as new benefit period begins.		
Nurse Advice Line Speak to a nurse anytime day or night by calling our 24-hour Nurse Line at **1-833-968-1766**. TTY: **711**.	$0 copay	$0 copay	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Online/Telehealth Visits with Your Doctor Telehealth visits with your regular primary care physician specialist or mental health provider. Remote access technologies give you the opportunity to meet with your regular health care providers through electronic forms of communication, such as online. This does not replace an in-person visit but allows you to meet with your regular health care providers when it is not possible for you to meet with them in the office.	$20 copay	20% coinsurance, after deductible	$0 copay
Online/Telemedicine Visits with Teladoc® Health When you can't get in to see your regular provider or need an appointment fast, you can also use Teladoc Health's online telemedicine services. Teleadoc Health provides online urgent care, behavioral health support and nutritional counseling. Online behavioral health support from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists by appointment 7 days a week, 7 a.m. to 9 p.m. To access telemedicine services through our plan-approved vendor, visit **www.TeladocHealth.com** or call **1-800-Teladoc** (835-2362), available 24 hours a day, 7 days a week, 365 days a year. TTY: **1-855-636-1578**.	$0 copay for urgent care, mental health and nutrition counseling telemedicine visits Get urgent general medical services from U.S. board-certified doctors without an appointment for: • Sore throat, coughs, fevers • Ear and sinus infections • Headache • Allergies • Pink eye • Bronchitis • Nutrition counseling Use your smartphone, computer, or tablet anywhere in the United States to meet with doctors and behavioral health care providers when it's convenient for you. Prescriptions can be sent to your local pharmacy. Certain medications cannot be prescribed online, including controlled substances.		

Cost-sharing Table	JY **Medical & Prescription Drugs** In- and out-of-network	Comprehensive **Medical & Prescription Drugs** In- and out-of-network	VSTRS 65 **Medical only** In- and out-of-network
Note: Services with * may require prior authorization.			
Outpatient Diagnostic Tests and Therapeutic Services* • X-rays • Low-tech diagnostic radiological services • High-tech diagnostic radiological services such as CT, MRI, MRA, and PET • Therapeutic radiological services • Lab services • Blood • Outpatient diagnostic procedures and tests	$0 copay	20% coinsurance, after deductible	$0 copay
Outpatient Hospital Services* Ambulatory surgical and non-surgical services Outpatient hospital	$0 copay	20% coinsurance, after deductible	$0 copay
Outpatient Substance Abuse Individual or group therapy visit	$20 copay	20% coinsurance, after deductible	$0 copay
Physical Therapy Available in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities. Limited to 30 visits per calendar year, including evaluations.	$0 copay	20% coinsurance, after deductible	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered.	$0 copay Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual physical exam • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, flexible sigmoidoscopy, guaiac-based fecal occult blood test, fecal immunochemical test, or DNA based colorectal screening) • Depression screening • Diabetes screening and diabetes self-management training • Glaucoma screening • Health and wellness education programs • HIV screening • Immunizations, including COVID-19, flu, Hepatitis B, and pneumonia immunizations • Intensive behavioral therapy for obesity • Medical nutrition therapy services • Medicare Diabetes Prevention Program • Prostate cancer screenings • Screening and intensive behavioral therapy for obesity • Screening for lung cancer with low dose computed tomography • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Tobacco use cessation counseling (for people with no sign of tobacco-related disease) • “Welcome to Medicare” preventive visit (one-time)		

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Rehabilitation Services • Cardiac rehabilitation/intensive cardiac services • Pulmonary rehabilitation • Occupational therapy visit: limited to 30 visits per calendar year, including evaluations • Speech and language therapy: limited to 30 visits per calendar year, including evaluations	$0 copay	20% coinsurance, after deductible	$0 copay
Renal Dialysis Services for Kidney Disease Home health care visits, equipment, dialysis, and supplies	$0 copay	20% coinsurance, after deductible	$0 copay
Skilled Nursing Facility (SNF) • Days 1-99 • Day 100 and above*	$0 copay $0 copay	20% coinsurance, after deductible 20% coinsurance, after deductible	$0 copay You pay all costs.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	$0 copay	20% coinsurance, after deductible	$0 copay

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Urgently Needed Services In U.S. and its territories	$20 copay	20% coinsurance, after deductible	$0 copay
You can use Teladoc Health to access urgent telemedicine services by visiting **www.TeladocHealth.com** or calling **1-800-Teladoc** (835-2362), available 24 hours a day, 7 days a week, 365 days a year. TTY: **1-855-636-1578**.	$0 copay for urgent care online telemedicine visit via Teladoc Health.	$0 copay for urgent care online telemedicine visit via Teladoc Health.	$0 copay for urgent care online telemedicine visit via Teladoc Health.
Vision Services Original Medicare covers limited vision services, including:			
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay	$0 copay	$0 copay
• Eyeglasses or contact lenses, after cataract surgery	$0 copay	20% coinsurance, after deductible	$0 copay
• Diabetic retinopathy screening	$0 copay	$0 copay	$0 copay
Enhanced Vision Services We offer additional enhanced vision benefits not covered by Original Medicare, including: • Enhanced (non-Medicare covered) supplemental routine eye exam • Enhanced vision benefit has an allowance toward materials, including elective contact lenses, frames, or complete glasses (lenses and frames)	**In-network** $0 copay for one supplemental routine eye exam every 12 months through a VSP Choice Network provider. **Out-of-Network** $0 copay for one supplemental routine eye exam every 12 months through an out-of-network non-VSP Choice Network provider. If you see a non-VSP provider, you are responsible for any amounts your provider charges above the plan's approved amount. This means you may end up paying more than the $0 copay for the exam.		

Cost-sharing Table	JY Medical & Prescription Drugs In- and out-of-network	Comprehensive Medical & Prescription Drugs In- and out-of-network	VSTRS 65 Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Enhanced Vision Services (continued) You may pay less if you use an in-network provider. To locate an in-network VSP Choice Network provider, call **1-855-492-9028** from 8 a.m. to 8 p.m. 7 days a week. TTY: **1-800-428-4833**. You can also visit **www.vsp.com**. You can submit receipts from a non-VSP provider for reimbursement. Learn more at **www.vsp.com/claims/submit-oon-claim**.	**In-and Out-of-Network** $200 allowance toward materials every 12 months through a VSP Choice Network provider or an out-of-network non-VSP Choice Network provider. You are responsible for any charges above the plan's benefit allowance.		
Worldwide Emergency Coverage If you need care when you're outside of the United States, you have coverage for emergency medical care, emergency transportation, and urgent care only.	There is a combined $50,000 lifetime plan coverage limit for emergency and urgent care services outside the U.S. and its territories. You are responsible for the difference between the approved amount and the provider's charge.		
• Worldwide emergency medical care	$0 copay	$0 copay	$100 copay
• Worldwide emergency transportation (ambulance)	$0 copay	$0 copay	$100 copay
• Worldwide urgent care	$0 copay	$0 copay	$50 copay

Additional Benefits	JY **Medical & Prescription Drugs** In- and out-of-network	**Comprehensive** **Medical & Prescription Drugs** In- and out-of-network	**VSTRS 65** Medical only In- and out-of-network
Note: Services with * may require prior authorization.			
Contraceptive Devices	$0 copay	20% coinsurance, after deductible	$0 copay
Gradient Compression Stockings	20% coinsurance, after deductible	20% coinsurance, after deductible	$0 copay
Private Duty Nursing	20% coinsurance, after deductible, with an annual coverage limit of 14 hours	20% coinsurance, after deductible, with an annual coverage limit of 14 hours	Not a covered benefit
Weight Loss Surgery*	$0 copay	20% coinsurance, after deductible	$0 copay
Wigs, Wig Stand, Adhesive* Wigs must be prescribed by a physician and medically necessary.	20% coinsurance, after deductible	20% coinsurance, after deductible	$0 copay

Prescription Benefits				
Stage 1: Deductible	**JY and Comprehensive:** Because there is no deductible for the plan, this payment stage does not apply to you. **VSTRS 65:** Prescription drugs are not a covered benefit.			
Stage 2: Initial Coverage	**JY and Comprehensive: Y**ou pay the following until your out-of-pocket costs reach $600. See Chapter 6 of the *Evidence of Coverage* for information on how Medicare counts your out-of-pocket costs. **VSTRS 65:** Prescription drugs are not a covered benefit.			
Tiers (includes specialty drugs limited to a 30-day supply)	**Retail network pharmacy** **30-day supply**	**Mail-order network pharmacy** **30-day supply**	**Retail network pharmacy** **90-day supply**	**Mail-order network pharmacy** **90-day supply**
Tier 1: Generic	**JY:** $5 **Comprehensive:** $5	**JY:** $5 **Comprehensive:** $5	**JY:** $15 **Comprehensive:** $15	**JY:** $10 **Comprehensive:** $10
Tier 2: Preferred Brand	**JY:** $20 **Comprehensive:** $20	**JY:** $20 **Comprehensive:** $20	**JY:** $60 **Comprehensive:** $60	**JY:** $40 **Comprehensive:** $40
Tier 3: Non-Preferred Drug	**JY:** $45 **Comprehensive:** $45	**JY:** $45 **Comprehensive:** $45	**JY:** $135 **Comprehensive:** $135	**JY:** $90 **Comprehensive:** $90
Stage 3 and 4: Coverage Gap & Catastrophic Stages: Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.				
Stage 3: Coverage Gap	**JY and Comprehensive:** This stage doesn't apply. You continue to pay your Stage 2 copay amounts until you reach Catastrophic Coverage. **VSTRS 65:** Prescription drugs are not a covered benefit.			
Stage 4: Catastrophic Coverage	**JY and Comprehensive:** $0 copay. **VSTRS 65:** Prescription drugs are not a covered benefit.			

JY and Comprehensive: Part D insulin is covered 100%. You will have no out-of-pocket costs for Part D insulin drugs.

For more information on the phases of the benefit, please call us or access our *Evidence of Coverage* online at **www.VermontBlueAdvantage.com/VSTRS**.

If your plan includes prescription benefits, your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to your formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website (**www.VermontBlueAdvantage.com/VSTRS**).

If your plan includes prescription benefits, your plan also covers additional non-Medicare covered medications not listed in your drug formulary.

If your plan includes prescription benefits, you must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's pharmacy directory at our website (**www.VermontBlueAdvantage.com/VSTRS**). Costs may differ based on pharmacy type.

See our plan's provider directory at our website (**www.VermontBlueAdvantage.com/VSTRS**) or call us and we will send you a copy of the provider directory.

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For more information

A complete list of services is found in the *Evidence of Coverage*, which will be mailed to you prior to the date your coverage takes effect and will be available online at **www.VermontBlueAdvantage.com/VSTRS**.

If you are not yet enrolled in the Vermont Blue Advantage plan, call the transitional call center toll-free **1-800-344-6690**, Monday through Friday, 7 a.m. to 4:30 p.m. Eastern time. TTY: **1-800-535-2227**.

Once you are enrolled, call toll-free **1-800-572-0280**, Monday through Friday, 8 a.m. to 8 p.m. Eastern time, with weekend hours October 1 to March 31. TTY: **711**.

This document is available in other formats such as audio CD and large print. This document may be available in a non-English language. For additional information, call us at **1-800-572-0280**. TTY: **711**.

To learn more about Original Medicare, you can order a copy of the "Medicare & You" handbook at www.medicare.gov, or you can call Medicare at **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, 7 days a week. TTY: **1-877-486-2048**.

Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.