LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Mailing Address: PO Box 512218, Los Angeles, CA 90051-0218
www.lacers.org | lacers.services@lacers.org | Mail Stop 175
(800) 779-8328 | RTT (888) 349-3996 | Fax (213) 473-7297

2025 Medical Plan Enrollment Form

(for Anthem Blue Cross/SCAN Health Plan/UnitedHealthcare ONLY)

1. SUBSCRIBER INFORMATION

Last Name	First Name, Middle Initial	Birth Date	Daytime Phone Number
Street Address	**City**	**State**	**Zip Code**
Retirement Effective Date:	**Email Address:**		

Status	Gender	Social Security Number	Medicare Beneficiary Identifier
☐ Single ☐ Domestic Partnership ☐ Married ☐ Divorced ☐ Widow(er)	☐ Male ☐ Female		

2. MEDICAL PLANS: *Additional form(s) required if you and/or your dependent(s) has Medicare.*

Anthem Blue Cross

☐ HMO (California only*)

☐ PPO

☐ Medicare Preferred PPO Plan (Medicare Advantage with Rx)

☐ Medicare Supplement Plan (Medicare Supplement with Rx)

SCAN Health Plan

☐ California*

UnitedHealthcare Medicare Advantage HMO

☐ California*

☐ Arizona*

☐ Nevada*

DUAL CARE HMO PLANS (California only*)**

☐ Anthem Blue Cross HMO & SCAN Health Plan

☐ Anthem Blue Cross HMO & UnitedHealthcare Medicare Advantage HMO

***Anthem Blue Cross HMO will cover the individual(s) under age 65 or over age 65 with Medicare Part B only*

* *Available only within authorized zip code service areas.*

3. LIST SELF AND ANY ELIGIBLE DEPENDENTS TO BE ENROLLED IN THE MEDICAL PLAN

Last Name, First Name, Middle Initial	Social Security Number	Medicare Beneficiary Identifier	Gender	Relationship	Birth Date (mm/dd/yy)
			☐ M ☐ F	**SELF**	
			☐ M ☐ F		

If you have additional eligible dependents to add, continue listing at the top of Page 2.

Primary Care Physician Anthem Blue Cross HMO, SCAN Health Plan, UnitedHealthcare Medicare Advantage HMO subscribers

Continue to Page 2

FOR OFFICE USE ONLY			
INITIALS	YEARS OF SERVICE	MEDICAL SUB/PART	EFFECTIVE DATE

3. LIST ADDITIONAL ELIGIBLE DEPENDENTS TO BE ENROLLED IN THE MEDICAL PLAN *(continued)*

Last Name, First Name, Middle Initial	**Social Security Number**	**Medicare Beneficiary Identifier**	**Gender**	**Relationship**	**Birth Date** (mm/dd/yy)
			☐ M ☐ F		
			☐ M ☐ F		

Primary Care Physician Anthem Blue Cross HMO, SCAN Health Plan, UnitedHealthcare Medicare Advantage HMO subscribers

4. IMPORTANT INFORMATION

- Your first retirement payment or the first monthly payment following a health plan change may have more than one monthly deduction.
- **Your retirement or survivor documents must be completed and/or submitted within 90 days**, otherwise your coverage may be terminated and you will not be eligible for coverage until the next annual Open Enrollment period.
- **Health plan enrollment and health subsidy eligibility is based on currently available information and is subject to change**. LACERS reserves the right to make corrections to your health plan premium subsidy and eligibility upon receipt of any additional information received subsequent to your retirement date or eligible Survivor set-up. The amounts of City Service/Service Credit/Health Service Credit have not been verified and is subject to change.
- ***New Retirees who are eligible for Medicare:*** LACERS will enroll you and your eligible dependent(s) in the corresponding non-Medicare plan. Until all required forms and documents are received and processed by LACERS, the associated non-Medicare plan premiums and deductions will reflect in your retirement payment for a limited time period. Failure to enroll in Medicare and/or failure to submit proof to LACERS in a timely manner will result in the termination of the LACERS subsidy and medical plan coverage.
- ***LACERS Medicare requirement:*** LACERS requires that Retired Members, Eligible Surviving Spouses/Domestic Partners, and eligible dependents enroll in and maintain Medicare Part B, and, if eligible at no cost, Medicare Part A. Medicare-enrollees responsible for paying their Medicare premiums, Income-Related Monthly Adjustment Amount (IRMAA), and penalties assessed by Centers for Medicare & Medicaid Services (CMS). Failure to maintain Medicare enrollment may result in the termination of your LACERS subsidy, medical plan coverage, and, if applicable, Retiree's basic Medicare Part B reimbursement.
- ***CMS single Medicare plan requirement:*** CMS only allows enrollment in a single Medicare Advantage plan or Medicare Part D Prescription Drug plan. Enrolling in a non-LACERS Medicare plan or non-LACERS Medicare Part D prescription plan will cause your LACERS subsidy and medical coverage to be terminated.
- **LACERS reserves the right to terminate your dependent's health plan coverage** should we discover your dependent is no longer eligible to participate in a LACERS health plan, including any Medicare non-compliance reason, e.g., lapse of Part B or enrolled in another plan.
- Pursuant to LACERS Board Rules, LACERS has the right to recover benefits paid when the Member or dependent was ineligible by offsetting against any benefits payable.
- For more information about Medicare, please contact the Centers for Medicare and Medicaid Services (CMS) or the Social Security Administration (SSA).

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4. IMPORTANT INFORMATION *(continued)*

- Please review the LACERS Health Benefits Guide and the medical plan's Evidence of Coverage (EOC) for more information about your LACERS health benefits.

I have read and understand the information provided above.

Member's Signature **Date**

5. MEMBER AUTHORIZATION

I understand this election will remain in effect as long as I remain eligible, or until I make another election during the Open Enrollment period. I hereby authorize: 1) LACERS to deduct from my retirement allowance my share of the monthly premiums as may be established from time to time in the service agreement; and 2) any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay claims under the plan selected. I want to enroll myself and those dependents listed above in the plan elected. **I understand that it is my responsibility to report any change in the eligibility of my dependents**. I understand that the benefits or services of the elected plan are coordinated with those provided by any other group hospital or medical benefit or service plan. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees, and providers) may be subject to binding arbitration. I understand that LACERS will select the earliest coverage date possible for me unless I notify them otherwise.

I understand that certain LACERS medical plans require enrollment in Medicare Parts A & B, or Part B only if not eligible for premium-free Part A. Should I fail to provide sufficient proof of proper Medicare enrollment and/or the required forms to enroll in a LACERS Senior (Medicare) Plan, I hereby authorize LACERS to enroll me and/or any dependents I have identified in a comparable non-Medicare plan, and I assume any increased premiums associated with that non-Medicare plan.

Member's Signature **Date**

SUBMIT COMPLETED FORMS TO LACERS

SECURE DOCUMENT UPLOAD: **lacers.org/secure-document-upload**
EMAIL: **LACERS.health@lacers.org**
MAIL: **LACERS, Attn: Health Benefits Administration**
PO Box 512218, Los Angeles, CA 90051-0218
DROP OFF/VISIT: **977 N. Broadway, Los Angeles, CA 90012-1728**
FAX: **(213) 473-7284**

ADA NOTICE

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.

Anthem

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LA CITY EMPLOYEES' RETIREMENT SYSTEM

Anthem BC Health Insurance Company Group-Sponsored Health Plan Enrollment Election Form

All fields on this form are required unless noted with an asterisk*		
Group sponsor name: **LACERS**		Group #: **CA039GRS**
Plan you will join: Anthem Medicare Preferred (PPO) with Senior Rx Plus		Requested effective date of coverage: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y) Generally the effective date of enrollment will be the first of the month following the enrollment receipt date, unless a future date is requested and is allowed.
FIRST name:	LAST name:	MIDDLE initial:
Birthdate: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ M ☐ F	Phone number: ( ) ☐ Cell ☐ Other
Permanent residence street address (Do not enter a P.O. Box):		
City:	State:	ZIP code:
Mailing address, if different from your permanent address (P.O. Box allowed):		
Street address:	City:	State: ZIP code:

Email address:_____

Your email address will be used for communications only from Anthem BC Health Insurance Company. We will not share your email address. Thank you for providing your email address and phone number. We will only use this information to occasionally contact you by email, phone call, or text with Important Plan Information.

In addition, may we also contact you about additional products and services that might interest you by email.

Please know you can change your preference at any time by visiting www.anthem.com/ca or contacting customer service.

Your Medicare information:

Medicare Number: _____

Note: The Medicare Number is required to complete your enrollment. If you do not provide your Medicare Beneficiary ID from your ID card, your enrollment into the plan may be delayed.

Please read and answer these important questions
1. Are you the retiree? ☐ Yes ☐ No If "yes," retirement date (month/date/year): _____ If "no," name of retiree:_____ Retiree Medicare ID #:_____
2. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No
3. Do you have other medical insurance? ☐ Yes ☐ No If "yes," what is the name of the health plan (e.g., Aetna, Humana, Cigna)? _____ What are the effective dates of coverage? _____
4. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No If "yes," please provide the following information: Name of institution:_____ Address (number and street) and phone number of institution:_____ _____
5. Will you have other prescription drug coverage (like VA or TRICARE) in addition to this plan? ☐ Yes ☐ No Name of other coverage: Member number for this coverage: Group number for this coverage: _____ _____ _____
This document may be available in an alternate format, such as large print. Please call the First Impressions Welcome Team at **1-833-848-8729**, TTY: **711**, , for additional information or questions you may have.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Race*		**Ethnicity***
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean	☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ I choose not to answer	☐ Not of Hispanic, Latino/a, or Spanish Origin ☐ Puerto Rican ☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Mexican, Mexican American, Chicano/a ☐ Cuban ☐ I choose not to answer

What is your gender? Select one.*	**Which of the following best represents how you think of yourself?** Select one.*
☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term:_____ ☐ I choose not to answer	☐ Lesbian or gay ☐ Straight, that is, not gay or lesbian ☐ Bisexual ☐ I use a different term:_____ ☐ I don't know ☐ I choose not to answer

IMPORTANT: Read and sign below:
• I must keep Medicare Part A and Part B to stay in the plan I have selected. • **Release of information:** By joining this Medicare Advantage (Part D) prescription drug plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Anthem BC Health Insurance Company will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. • The information on this enrollment election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. • I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. • I understand that when my Anthem Medicare Preferred (PPO) with Senior Rx Plus coverage begins, I must get all of my medical and prescription drug benefits from Anthem BC Health Insurance Company. Benefits and services authorized by Anthem BC Health Insurance Company and contained in my Anthem Medicare Preferred (PPO) with Senior Rx Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem BC Health Insurance Company will pay for benefits or services.** • I understand that as a member of this plan, I have the right to ask about the plan's decision regarding payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree. • I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan or Medicare Part D prescription drug plan. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform the plan of any other prescription drug coverage that I have or may obtain in the future. • I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this enrollment election form means that I have read and understand the contents of this enrollment election form. If signed by an authorized representative (as described above), this signature certifies that: 1. This person is authorized under state law to complete this enrollment election form, and 2. Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you are the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

HIPAA authorization
If you would like to authorize an individual to have the ability to speak with us and/or obtain protected health information (PHI) on your account, please complete the HIPAA (Health Insurance Portability and Accountability Act) Member Authorization Form located at www.anthem.com/ca/forms. This form is valid for one year from the signature date. • A printed form can be requested by contacting Member Services at the telephone number on the back of your ID card. **Sign and return it to the address on the form.** • If you wish to continue having the authorized representative on your account, a new form is required annually. • If you have a durable healthcare power of attorney document, it can also be returned with the HIPAA form.

Please return this enrollment election form to:

Los Angeles City Employees' Retirement System (LACERS)

Attn: Health Benefits Administration Division

P.O. Box 512218

Los Angeles, CA 90051-0218

Please refer to the Anthem BC Health Insurance Company *Evidence of Coverage* for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team number listed in this document to request interpreter services.

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

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PRINT

RESET

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MEDICARE INFORMATION ACKNOWLEDGEMENT

For Retired LACERS Members and Dependents Over Age 64

(Only this page to be returned to LACERS)

Member: _____ SSN (Last 4 digits): _____

I have received the literature listed below that outlines the procedures for obtaining Medicare. I understand I must read it carefully. If I have questions, I may contact LACERS Health Staff at (800) 779-8328 or LACERS.health@lacers.org.

- Medicare Information Sheet (Parts A and B)
- Medicare Part D Information Sheet

_____ Initial

I understand that to continue participating in a LACERS medical plan, I, and/or my dependents, must submit proof of Medicare to LACERS by age 65. I also understand that it is my responsibility to:

- Telephone Social Security at (800) 772-1213 to make an appointment at a local office to apply for Medicare insurance coverage
- Submit proof of Medicare coverage to LACERS before my and/or my dependent's 65th birthday
- Review LACERS Health Benefits Guide and change medical plans as necessary upon turning age 65
- Complete a senior plan enrollment or election form for my selected medical plan upon turning age 65
- Submit proof of Medicare Part A, only if I qualify to receive it premium-free
- Maintain Medicare Part B by paying the premiums to Social Security every three months or by a deduction from my Social Security check
- Not enroll in Medicare Part D separately from my LACERS medical plan (if I enroll separately, my LACERS medical plan will be terminated)

_____ Initial

I was informed that if I fail to enroll in/maintain Medicare (Parts A and B or B only) I will:

- Lose my LACERS medical plan coverage for myself and any dependent(s)
- Lose my LACERS medical subsidy
- Lose my Part B Reimbursement (if I have both Medicare Parts A and B)

Los Angeles Administrative Code §4.1111(f)

_____ Initial

I was informed that if my dependent(s) fail to enroll in/maintain Medicare (Parts A and B or B only) they will lose their LACERS medical plan coverage.

_____ Initial

Signature: _____ Date: _____

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MEDICARE PARTS A & B INFORMATION SHEET

LACERS Medicare Enrollment Requirement for Retirees & Dependents Turning Age 65

In order to qualify for a LACERS medical subsidy and be eligible for coverage in a LACERS-sponsored medical plan at age 65 or older, the Los Angeles Administrative Code Sections 4.1111(f), 4.1112(h) and/or 4.1115(d) and the LACERS Board of Administration Rules require you (the Retired Member), and, on their turning 65, your Eligible Surviving Spouse/Domestic Partner (Survivor) and dependents to:

- Enroll in Medicare Part B and provide LACERS with proof of the Medicare Part B enrollment (e.g., a copy of the Medicare card or entitlement letter from Social Security);
- Enroll in Medicare Part A if eligible for it premium-free (i.e., at no cost to the enrollee);
- Complete a Senior Enrollment Form (contact LACERS for these forms); and
- Pay your Medicare Part B premiums on time (Medicare will charge you and/or your Survivor or dependent(s) directly for the Medicare Part B premiums).

LACERS recommends that enrollment in Medicare Part B occur three months prior to turning age 65 to avoid any lapse of LACERS medical coverage.

You are not required to purchase Medicare Part A if you are not eligible for it premium free. However, you may be eligible for premium-free Medicare Part A through your spouse's eligibility for Medicare Part A or your earnings history with Social Security. Contact Social Security at (800) 772-1213 or TTY (800) 325-0778. They will assist you in enrolling in Medicare and in determining your eligibility and accrued credits for Medicare Part A.

You can also apply online by visiting **www.ssa.gov/benefits/medicare** to create a secured account and accessing the Social Security online retirement application.

Failure to enroll in Medicare Part B or pay your Medicare Part B premiums on time will result in the termination of your LACERS medical subsidy and medical coverage.

Retiring after Age 65

If you are retiring from City service after age 65, and/or your dependent(s) are over age 65, Medicare allows you and/or those dependents to defer enrollment in Medicare Part B until you retire. This is known as the Special Enrollment Period. You must complete additional forms (available at LACERS) when you retire and apply for Medicare.

Medicare & Living Outside the United States

You may not need to enroll in Medicare if you reside permanently outside the U.S. and its territories. However, if you later decide to reside in the U.S., Social Security may penalize you if you did not enroll in Medicare by age 65 or allowed your Medicare premiums to lapse. Contact Social Security regarding Medicare rules, regulations or penalties that may affect your medical plan coverage.

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Medicare Part B Reimbursement for Retired Members with Medicare Parts A & B

The Los Angeles Administrative Code (Sections 4.1105, 4.1113 and 4.1128) states that qualified Retired Members enrolled in Medicare Parts A and B who are participating in a LACERS Senior medical plan or the Medical Plan Premium Reimbursement Program (MPRP) may be entitled to reimbursement of their **basic** Medicare Part B premiums by LACERS. The Medicare Part B basic premium does not include the IRMAA portion of your premium, as is further discussed below.

LACERS beneficiaries, such as a spouse, domestic partner, or Eligible Survivor, are not eligible for reimbursement of any portion of their Medicare Part B premiums.

LACERS does not reimburse Members for Medicare Part B premiums if they are enrolled in the Anthem Blue Cross PPO Out-of-Country plan.

Also, Members will not be eligible to receive reimbursement of their Medicare Part B premiums from LACERS if their LACERS medical coverage is terminated due to a lapse in payment of their Medicare Part B premiums.

Medicare Part B Reimbursement & IRMAAs

Because of federal legislation that became effective in 2007, higher-income earning Medicare enrollees are now required to pay higher Medicare Part B premiums that consist of the Part B basic premium rate plus an Income-Related Monthly Adjustment Amount (IRMAA).

LACERS does not apply your medical subsidy toward or reimburse you for any Medicare-related IRMAA costs.

> Failure to pay your IRMAAs will result in the termination of your LACERS medical subsidy and medical coverage.

Termination of your LACERS Medical Plan

If you default on your Medicare Part B premiums and are terminated from your LACERS health plan, your dependents health coverage will also be terminated and your (and your dependents') Medicare Part D prescription drug coverage that LACERS includes in its medical plans will also be cancelled. Your LACERS medical subsidy will terminate, and your Medicare Basic Part B premium reimbursement will also terminate. Additionally, Social Security may assess lifetime penalties when you re-enroll in Medicare Part B and Part D.

CMS Medicare One Plan Requirement

In addition to Parts A and B, Medicare and LACERS offer supplemental plans. The Centers for Medicare & Medicaid Services (CMS) allows you to have only one Medicare Advantage plan. If you enroll in a Medicare Advantage plan outside of your LACERS medical plan, you may lose your LACERS medical coverage, even if the plan is from the same insurance company but sponsored by a different organization (e.g., the Los Angeles County Employees' Retirement Association Kaiser Permanente Senior Advantage plan).

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MEDICARE PART D INFORMATION SHEET

Medicare Part D is a federal program that subsidizes the prescription drugs costs of Medicare enrollees in the United States. It became effective January 1, 2006 as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Medicare Part D & Your LACERS Medical Plan

Medicare Part D is included as part of your LACERS medical plan, in an amount that and equals or exceeds the Standard Benefit under Medicare Part D and that satisfies the Medicare creditable coverage requirement.

Medicare Part D Enrollment Requirements

For Medicare-eligible subscribers in Kaiser Permanente Senior Advantage, SCAN, or UnitedHealthcare Medicare Advantage HMO: You are enrolled automatically in Medicare Part D when you enroll in your LACERS medical plan.

For Medicare-eligible subscribers in Anthem Blue Cross HMO, PPO, or Anthem Blue Cross Medicare Preferred PPO Plan: You must complete a form to assign your Medicare Part D to your LACERS medical plan. Contact LACERS for the appropriate form.

Termination of Your LACERS Plan

Do not enroll in Medicare Part D separately from your LACERS medical plan. Enrolling or dis-enrolling in Medicare Part D on your own or through another group plan will cause your medical subsidy to be terminated and may cause your LACERS medical coverage to be terminated.

Exception: If you are enrolled the LACERS' Medical Premium Reimbursement Program (MPRP) and your non-LACERS medical plan does not include Medicare Part D, you may enroll in supplemental Medicare Part D insurance in order to maintain creditable coverage (i.e., the Standard Benefit under Medicare Part D).

In addition, if you default on paying your Medicare Part B premiums and are terminated from your LACERS health plan, your and your dependents' Medicare Part D will also be cancelled. The Social Security Administration may assess lifetime penalties when you re-enroll in Medicare Part D.

Medicare & Living Outside the United States

You may not need to enroll in Medicare if you reside permanently outside the U.S. and its territories. However, if you later decide to reside in the U.S., Social Security may penalize you if you did not enroll in Medicare by age 65 or allowed your Medicare premiums to lapse.

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Contact Social Security regarding Medicare rules, regulations or penalties that may affect your medical plan coverage.

Medicare Part D Income-Related Monthly Adjustment Amounts (IRMAAs)

On January 1, 2011, as part of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, higher income-earning Medicare enrollees must now pay an Income-Related Monthly Adjustment Amount (IRMAA) for their Medicare Part D prescription drug coverage. Social Security will notify you about your Medicare premiums and if you are required to pay Medicare Part D IRMAAs.

If you receive Social Security benefits, Social Security will deduct your IRMAA from your Social Security check. If you do not receive a Social Security check, the Centers for Medicare and Medicaid Services (CMS) will bill you directly for your IRMAAs.

In addition, if you are enrolled in the LACERS' Medical Premium Reimbursement Program, LACERS may reimburse you for the supplemental Medicare Part D basic premiums you pay in order to maintain creditable Medicare Part D coverage. However, your LACERS reimbursement will not include any IRMAAs.

Reminder

Although the Medicare Part D *basic* premium is already included in the senior plan premiums of LACERS' medical plans, the IRMAA portion of Medicare Part D is not. You must pay any Medicare Part B and Part D IRMAAs assessed by Social Security. Because LACERS requires you to maintain your Medicare enrollment in order to continue receiving your medical plan premium subsidy, failure to pay your IRMAAs will result in the termination of your LACERS medical subsidy and medical benefits.

Medicare Part D Low Income Subsidy

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call CMS (the Centers for Medicare & Medicaid Services) at 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048, 24 hours a day/7 days a week; or the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday, TTY users should call 1-800-325-0778; or your state Medicaid office.

Consider the Medicare Easy Pay Program to avoid a lapse in coverage. To sign up, visit **www.medicare.gov/basics/costs/pay-premiums/medicare-easy-pay**

Call 1-800-MEDICARE or 1-800-633-4227 for more information.