Cigna HealthSpring®

Cigna-HealthSpring Advantage (PPO) offered by Cigna-HealthSpring

ANNUAL NOTICE OF CHANGES FOR 2019

You are currently enrolled as a member of Cigna-HealthSpring Advantage (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **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.
- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.4 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.
- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider and Pharmacy Directory*.

☐ Think about your overall health care costs.
- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

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

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

- If you want to **keep** Cigna-HealthSpring Advantage (PPO), you don't need to do anything. You will stay in Cigna-HealthSpring Advantage (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2018**

- If you **don't join another plan by December 7, 2018,** you will stay in Cigna-HealthSpring Advantage (PPO).
- If you join another plan by December 7, 2018, your new coverage will start on January 1, 2019.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at 1-800-668-3813 for additional information. (TTY users should call 711.) Hours are October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time, Saturday 8:00 a.m. – 5:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays.
- To get information from us in a way that works for you, please call Customer Service (phone numbers are in Section 7.1 of this booklet). We can give you information in Braille, in large print, and other alternate formats if you need it.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Cigna-HealthSpring Advantage (PPO)

- Cigna-HealthSpring is contracted with Medicare for PDP plans, HMO and PPO plans in select states, and with select State Medicaid programs. Enrollment in Cigna-HealthSpring depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Cigna-HealthSpring. When it says "plan" or "our plan," it means Cigna-HealthSpring Advantage (PPO).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Cigna-HealthSpring Advantage (PPO) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium	$0	$0
Deductible	$1,000 Out-of-Network	$1,000 Out-of-Network
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.)	From network providers: $3,400 From in-network and out-of-network providers combined: $5,100	From network providers: $3,400 From in-network and out-of-network providers combined: $5,100
Doctor office visits	In-Network: Primary care visits: $10 copayment per visit Specialist visits: $35 copayment per visit Out-of-Network: Primary care visits: 50% coinsurance per visit Specialist visits: 50% coinsurance per visit	In-Network: Primary care visits: $10 copayment per visit Specialist visits: $35 copayment per visit Out-of-Network: Primary care visits: 50% coinsurance per visit Specialist visits: 50% coinsurance per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	In-Network: Days 1-5: $175 copayment per day Days 6-90: $0 copayment per day Out-of-Network: 50% coinsurance per stay	In-Network: Days 1-5: $195 copayment per day Days 6-90: $0 copayment per day Out-of-Network: 50% coinsurance per stay

Annual Notice of Changes for 2019
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Part B Premium Reduction	Cigna will reduce your monthly Medicare Part B Premium by up to $50	Cigna will reduce your monthly Medicare Part B Premium by up to $75

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network 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 from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.	$5,100	$5,100 Once you have paid $5,100 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.cignahealthspring.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2019 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage*.

Cost	2018 (this year)	2019 (next year)
Ambulance services	In-Network and Out-of-Network You pay a copayment of $150 for each one-way Medicare-covered ground ambulance trip.	In-Network and Out-of-Network You pay a copayment of $200 for each one-way Medicare-covered ground ambulance trip.
Cardiac rehabilitation services	In-Network You pay a copayment of $30 for each Medicare-covered cardiac rehabilitative therapy visit. You pay a copayment of $30 for each Medicare-covered intensive cardiac rehabilitative therapy visit. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered cardiac rehabilitative therapy visit. You pay a coinsurance of 50% for each Medicare-covered intensive cardiac rehabilitative therapy visit.	In-Network You pay a copayment of $10 for each Medicare-covered cardiac rehabilitative therapy visit. You pay a copayment of $10 for each Medicare-covered intensive cardiac rehabilitative therapy visit. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered cardiac rehabilitative therapy visit. You pay a coinsurance of 50% for each Medicare-covered intensive cardiac rehabilitative therapy visit.
Chiropractic services	In-Network You pay a copayment of $15 for each Medicare-covered chiropractic visit. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered chiropractic visit.	In-Network You pay a copayment of $20 for each Medicare-covered chiropractic visit. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered chiropractic visit.

Cost	2018 (this year)	2019 (next year)
Dental services	In-Network You pay a copayment of $35 for Medicare-covered dental services. You pay a copayment of $0 for the following preventive dental services: – one exam every six months – one bitewing X-ray every calendar year – one full mouth or panoramic X-ray every 36 months – one cleaning every six months Comprehensive dental services not covered. Out-of-Network You pay a coinsurance of 50% for Medicare-covered dental services. You pay a coinsurance of 50% for the following preventive dental services: – one exam every six months – one bitewing X-ray every calendar year – one full mouth or panoramic X-ray every 36 months – one cleaning every six months Comprehensive dental services not covered.	In-Network You pay a copayment of $35 for Medicare-covered dental services. You pay a copayment of $0 for the following preventive dental services: – one exam every six months – one bitewing X-ray every calendar year – one full mouth or panoramic X-ray every 36 months – one cleaning every six months For the following comprehensive dental services, you pay a copayment of: $10-$195 for Restorative services $10-$55 for Periodontics $35-$75 for Extractions $25-$195 for Prosthodontics and Oral Surgery Out-of-Network You pay a coinsurance of 50% for Medicare-covered dental services. You pay a coinsurance of 50% for the following preventive dental services: – one exam every six months – one bitewing X-ray every calendar year – one full mouth or panoramic X-ray every 36 months – one cleaning every six months You pay a coinsurance of 50% for the following comprehensive dental services: – Restorative services – Periodontics – Extractions – Prosthodontics and Oral Surgery In-Network and Out-of-Network There are limitations on the number of covered services within a service category. Frequency limits and cost-sharing vary depending on the type of covered service. The plan has a max coverage amount of $1,000 per year for comprehensive dental services. Members are responsible for all cost above the max coverage amount. Unused amounts do not carry forward to future benefit years.

Cost	2018 (this year)	2019 (next year)
Emergency care	In-Network and Out-of-Network You pay a copayment of $100 for Medicare-covered emergency room visits.	In-Network and Out-of-Network You pay a copayment of $120 for Medicare-covered emergency room visits.
Inpatient hospital care	In-Network You pay a copayment of: – Days 1-5: $175 per day – Days 6-90: $0 per day For each Medicare-covered hospital stay. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered hospital stay.	In-Network You pay a copayment of: – Days 1-5: $195 per day – Days 6-90: $0 per day For each Medicare-covered hospital stay. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered hospital stay.
Inpatient mental health care	In-Network You pay a copayment of: – Days 1-7: $150 per day – Days 8-90: $0 per day For each Medicare-covered Inpatient mental hospital stay. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered Inpatient mental hospital stay.	In-Network You pay a copayment of: – Days 1-7: $175 per day – Days 8-90: $0 per day For each Medicare-covered Inpatient mental hospital stay. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered Inpatient mental hospital stay.
Post-hospital meals	Not offered.	In-Network and Out-of-Network You pay a copayment of $0 for the post-hospital meal benefit.
Pulmonary rehabilitation services	In-Network You pay a copayment of $30 for each Medicare-covered pulmonary rehabilitative therapy visit. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered pulmonary rehabilitative therapy visit.	In-Network You pay a copayment of $10 for each Medicare-covered pulmonary rehabilitative therapy visit. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered pulmonary rehabilitative therapy visit.
Skilled nursing facility (SNF) care	In-Network You pay a copayment of: – Days 1-20: $20 per day – Days 21-100: $167 per day For each Medicare-covered SNF stay. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered SNF stay.	In-Network You pay a copayment of: – Days 1-20: $20 per day – Days 21-100: $172 per day For each Medicare-covered SNF stay. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered SNF stay.

Cost	2018 (this year)	2019 (next year)
Supervised exercise therapy (SET)	Not covered.	**Authorization rules may apply.** **Referral from your Primary Care Physician (PCP) is required.** In-Network You pay a copayment of $10 for each Medicare-covered supervised exercise therapy visit. Out-of-Network You pay a coinsurance of 50% for each Medicare-covered supervised exercise therapy visit.
Urgently needed services	In-Network and Out-of-Network You pay a copayment of $25 for Medicare-covered urgently needed services.	In-Network and Out-of-Network You pay a copayment of $30 for Medicare-covered urgently needed services.
Vision services	In-Network You pay a copayment of $0 or $35 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening. $0 for glaucoma screenings and diabetic retinal exams. $35 for all other Medicare-covered vision services. You pay a copayment of $0 for: – Medicare-covered eyewear (one pair of eyeglasses with standard frames/ lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens) Supplemental routine eye exam not covered. Routine eyewear not covered. Out-of-Network You pay a coinsurance of 50% for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. You pay a coinsurance of 50% for Medicare-covered eyewear (one pair of eyeglasses with standard frames/lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens). Supplemental routine eye exam not covered. Routine eyewear not covered.	In-Network You pay a copayment of $0 or $35 for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening. $0 for glaucoma screenings and diabetic retinal exams. $35 for all other Medicare-covered vision services. You pay a copayment of $0 for: – Medicare-covered eyewear (one pair of eyeglasses with standard frames/ lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens) – up to one supplemental routine eye exam every year Out-of-Network You pay a coinsurance of 50% for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. You pay a copayment of $0 for up to one supplemental routine eye exam every year. You pay a coinsurance of 50% for Medicare-covered eyewear (one pair of eyeglasses with standard frames/lenses or one set of standard contact lenses after cataract surgery that implants an intraocular lens).

Cost	2018 (this year)	2019 (next year)
Vision services (continued)		In-Network and Out-of-Network You pay a copayment of $0 up to the plan coverage limit for: – up to one pair of eyeglasses (lenses and frames) every year – unlimited contact lenses up to plan coverage limit – up to one pair of eyeglass lenses every year – up to one pair eyeglass frames every year – upgrades $250 plan coverage limit for supplemental eyewear every year. Supplemental annual eyewear allowance applies to the retail value only. Applicable taxes are not covered.

SECTION 2 Administrative Changes

Please see the table below for other important changes to your plan.

Process	2018 (this year)	2019 (next year)
Customer Service Hours	Customer Service is available **October 1 – February 14,** 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From **February 15 – September 30,** Monday – Friday 8:00 a.m. – 8:00 p.m. local time; **Saturday 8:00 a.m. – 6:00 p.m.** local time. Messaging service used weekends, after hours, and on federal holidays.	Customer Service is available **October 1 – March 31,** 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From **April 1 – September 30,** Monday – Friday 8:00 a.m. – 8:00 p.m. local time; **Saturday 8:00 a.m. – 5:00 p.m.** local time. Messaging service used weekends, after hours, and on federal holidays.
Mailing Address Change: Customer Service	Cigna-HealthSpring Attn: Member Services P.O. Box 2888 Houston, TX 77252	Cigna-HealthSpring Attn: Member Services 2800 North Loop West Houston, TX 77092
Mailing Address Change: Payment Requests for Part C (Medical Services)	Cigna-HealthSpring Attn: Medical Claims P.O. Box 981706 El Paso, TX 79998	Cigna-HealthSpring Attn: Direct Member Reimbursement, Medical Claims P.O. Box 20002 Nashville, TN 37202

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in our plan

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 stay enrolled as a member of our plan for 2019.

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 2019 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, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Cigna-HealthSpring offers other Medicare health plans and Medicare prescription drug 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 Cigna-HealthSpring Advantage (PPO).
  - To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Cigna-HealthSpring Advantage (PPO).
- 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 this (phone numbers are in Section 7.1 of this booklet).
  - — *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 4 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, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2019, 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, 2019. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Texas, the SHIP is called Texas Health Information Counseling & Advocacy Program (HICAP).

Texas Health Information Counseling & Advocacy Program (HICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Texas Health Information Counseling & Advocacy Program (HICAP) 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 Texas Health Information Counseling & Advocacy Program (HICAP) at 1-800-252-9240.

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.** 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. Many people are eligible and don't even know it. 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 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Texas has a program called Kidney Health Care Program 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 (the name and phone numbers for this organization are in Section 5 of this booklet).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. In Texas, the ADAP is the Texas HIV Medication Program. Note: 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.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. To contact the Texas HIV Medication Program, please call 1-800-255-1090.

  For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Texas HIV Medication Program at 1-800-255-1090.

SECTION 7 Questions?

Section 7.1 Getting Help from our plan

Questions? We're here to help. Please call Customer Service at 1-800-668-3813 (TTY only, call 711). We are available for phone calls October 1 – March 31, 8:00 a.m. – 8:00 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8:00 a.m. – 8:00 p.m. local time, Saturday 8:00 a.m. – 5:00 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Calls to these numbers are free.

Read your 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Cigna-HealthSpring Advantage (PPO). 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 included in this envelope.

Visit our Website

You can also visit our website at www.cignahealthspring.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*).

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

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2019*

You can read *Medicare & You 2019* Handbook. Every year in the fall, this booklet 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 booklet, you can get it at the Medicare website (https://www.medicare.gov) 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.