2019

Annual Notice of Change

American Health Advantage of Oklahoma (HMO-SNP) H3708 001
January 1, 2019 – December 31, 2019

Toll-free: 1-866-583-4649 (TTY/TDD users call 711)
Hours: 8:00 a.m. to 8:00 p.m., 7 days a week
www.ok.amhealthplans.com

MedicareRx
Prescription Drug Coverage

AMERICAN HEALTH ADVANTAGE OF OKLAHOMA

H3708_ANOC19_M

American Health Advantage of Oklahoma (HMO SNP) offered by Oklahoma Superior Select, Inc.

Annual Notice of Changes for 2019

You are currently enrolled as a member of American Health Advantage of Oklahoma (HMO SNP). 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 3.1 and 3.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 3.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price

information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ 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 3.3 for information about our Provider 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 5.2 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.

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

- If you want to **keep** American Health Advantage of Oklahoma (HMO SNP), you don't need to do anything. You will stay in American Health Advantage of Oklahoma (HMO SNP).
- To change to a **different plan** that may better meet your needs, you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Services number at 1-866-583-4649 for additional information. (TTY/TDD users should call 711.) Hours are seven (7) days a week from 8:00 a.m. to 8:00 p.m.

- This document may be available in an alternate format (braille, large print, etc.). Please contact Member Services for more information. (Phone numbers are printed on the back cover of this booklet).
- **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 American Health Advantage of Oklahoma (HMO SNP)

- American Health Advantage of Oklahoma (HMO SNP) is a health plan with a Medicare contract. Enrollment in American Health Advantage of Oklahoma (HMO SNP) depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Oklahoma Superior Select, Inc. When it says "plan" or "our plan," it means American Health Advantage of Oklahoma (HMO SNP).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for American Health Advantage of Oklahoma (HMO SNP) 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* * Your premium may be higher or lower than this amount. See Section 3.1 for details.	$27.60	$30.80
Deductible	$183	$183 These are 2018 cost sharing amounts and may change for 2019. American Health Advantage of Oklahoma (HMO SNP) will provide updated rates as soon as they are released.
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 3.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: 20% per visit Specialist visits: 20% per visit	Primary care visits: 20% per visit Specialist visits: 20% per visit

Cost	2018 (this year)	2019 (next year)
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.	For each Medicare covered stay: Deductible for each benefit period: $1,340 Days 1-60: $0 Days 61-90: $335 coinsurance per day Days 91 & beyond: $670	For each Medicare covered stay: Deductible for each benefit period: $1,340 Days 1-60: $0 Days 61-90: $335 coinsurance per day Days 91 & beyond: $670 These are 2018 cost sharing amounts and may change for 2019. American Health Advantage of Oklahoma (HMO SNP) will provide updated rates as soon as they are released.
Part D prescription drug coverage (See Section 3.6 for details.)	Deductible: $405 Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25%	Deductible: $415 Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25%

Annual Notice of Changes for 2019
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SECTION 1 We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from Tribute Health Plan of Oklahoma (HMO SNP) to American Health Advantage of Oklahoma (HMO SNP).

You will receive a new ID card by mail. Member materials will reflect this new name change.

SECTION 2 Unless You Choose Another Plan, You Will Be Automatically Enrolled in American Health Advantage of Oklahoma (HMO SNP) in 2019

If you do nothing to change your Medicare coverage by December 7, 2018, we will automatically enroll you in our American Health Advantage of Oklahoma (HMO SNP). This means starting January 1, 2019, you will be getting your medical and prescription drug coverage through American Health Advantage of Oklahoma (HMO SNP). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you can do so between January 1 and March 31. You can also change plans between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in Tribute Health Plan of Oklahoma (HMO SNP) and the benefits you will have on January 1, 2019 as a member of American Health Advantage of Oklahoma (HMO SNP).

SECTION 3 Changes to Benefits and Costs for Next Year

Section 3.1 – 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.)	$27.60	$30.80

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.

- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 3.2 – 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. 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	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) 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.	$6,700	$6,700 Once you have paid $6,700 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 3.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.ok.amhealthplans.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider 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 3.4 – Changes to the Pharmacy Network

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.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.ok.amhealthplans.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**.

Section 3.5 – 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)
Part B Prescription Drugs		May be subject to step therapy.
Transportation Services (Non-Emergent) – van or medical transport	Four (4) one-way trips per year to any health-related location (no cost sharing required)	Twelve (12) one-way trips per year to any health-related location (no cost sharing required)

Cost	2018 (this year)	2019 (next year)
Emergency Care	20% of the cost of Medicare covered care (Up to $80). Coinsurance is waived if admitted to the hospital within one (1) day	20% of the cost of Medicare covered care (Up to $90). Coinsurance is waived if admitted to the hospital within one (1) day
Routine Podiatry Services (Foot Care)	Not Covered	You pay nothing for up to six (6) non-covered routine podiatry services per year
Routine Eye Exam	Not Covered	One exam every year (no cost sharing required)
Eyewear (contact lenses, and eyeglasses (lenses & frames); upgrades	Not Covered	Up to $215 every year (no cost sharing required)
Enhanced Durable Medical Equipment (DME)	20% of the cost of non-Medicare covered DME	Not Covered

Section 3.6 – 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. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website www.ok.amhealthplans.com.

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.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.

  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.

- **Work with your doctor (or another prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31-days supply of medication rather than the amount provided in 2018, 9*8*-days supply of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

In order to prevent coverage gaps, the plan will provide up to a 30-day supply (or 31-day supply in the LTC setting) of the requested Part D covered non-formulary prescription drug or the formulary prescription drug that is subject to new prior authorization, step therapy requirements or more restrictive quantity limits, when you had a prescription for the medication filled within the past 120 days (this look back period may vary for some classes of medications) from the date of the attempted fill. The plan will send you a notice saying that you must either switch to a drug on the applicable plan formulary or get an exception (coverage determination) to continue taking the non-formulary medication.

If you do not switch plans for calendar year 2019 and you are on a drug as a result of a granted exception in the 2018 plan year, you may possibly be able to continue to receive that exception into the 2019 plan year. Should the plan choose not to honor the exception beyond the end of the 2018 plan year, the plan will notify you in writing at least 60 days before the end of the current plan year and will do either of the following:

- Offer to process a prospective exception request for the next plan year; or
- Provide you with a temporary supply of the requested prescription drug at the beginning of the plan year and then provide you with notice that you must either switch to a therapeutically appropriate drug on the formulary or get an exception to continue taking the requested drug.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by

the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included 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 didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 9.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your drugs until you have reached the yearly deductible.	The deductible is $405.	The deductible is $415.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: Tier 1: You pay 25% of the total cost.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: Tier 1: You pay 25% of the total cost.
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	_____ Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	_____ Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 4 Administrative Changes

We have made changes to several of our administrative requirements for Medicare services, which are identified in the below chart.

	2018 (this year)	2019 (next year)
Ambulance (Non-Emergent Medicare services)	No Prior Authorization Required	Prior Authorization Required
Kidney Disease Treatment	Prior Authorization Required	No Prior Authorization Required
Part B Prescription Drugs	No Prior Authorization Required	Prior Authorization Required for billed charges in excess of $250; May be subject to step therapy
Partial Hospitalization	No Prior Authorization Required	Prior Authorization Required
Deemed Eligibility	6 months	2 months

SECTION 5 Deciding Which Plan to Choose

Section 5.1 – If you want to stay in American Health Advantage of Oklahoma (HMO 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 stay enrolled as a member of our plan for 2019.

Section 5.2 – 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 7), or call Medicare (see Section 9.2).

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.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from American Health Advantage of Oklahoma (HMO SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from American Health Advantage of Oklahoma (HMO SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 9.1 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/TDD users should call 1-877-486-2048.

SECTION 6 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 10, Section 2.3 of the *Evidence of Coverage.*

You can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 7 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 Oklahoma, the SHIP is called Oklahoma Senior Health Counseling Program.

Oklahoma Senior Health Counseling Program 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. Oklahoma Senior Health Counseling Program 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 Oklahoma Senior Health Counseling Program at 1-800-763-2828 (TTY/TDD user's call 711). You can learn more about Oklahoma Senior Health Counseling Program by visiting their website www.ship.oid.ok.gov.

SECTION 8 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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/TDD 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 am and 7 pm, Monday through Friday. TTY/TDD users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Oklahoma HDAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Oklahoma HDAP at 405-271-4636.

SECTION 9 Questions?

Section 9.1 – Getting Help from American Health Advantage of Oklahoma (HMO SNP)

Questions? We're here to help. Please call Member Services at 1-866-583-4649. (TTY/TDD only, call 711). We are available for phone calls seven (7) days a week from 8:00 a.m. to 8:00 p.m. 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 2019 American Health Advantage of Oklahoma (HMO 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 included in this envelope.

Visit our Website

You can also visit our website at www.ok.amhealthplans.com. 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 9.2 – 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/TDD 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 the *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/TDD users should call 1-877-486-2048.

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