MMM Elite Ultra (HMO POS) *offered by* MMM Healthcare, LLC

Annual Notice of Changes for 2017

You are currently enrolled as a member of MMM Único Extra. 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.**

Additional Resources

- This information is available for free in other languages.
- Please contact our Member Services number at 787-620-2397 (Metro Area), 1-866-333-5470 (toll free) for additional information. (TTY users should call 1-866-333-5469). Hours are Monday through Sunday, from 8:00 a.m. to 8:00 p.m.
- Member Services also has free language interpreter services available for non-English speakers.
- *Servicios al Afiliado también tiene servicios de interpretación del lenguaje de manera gratuita para personas que no hablan inglés.*
- Upon request, this information may be available in different formats, like Braille, Spanish language, large print and other formats. Please contact our Member Services number if you need plan information in another format or language.
- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual requirement for MEC.

About MMM Elite Ultra

- MMM Healthcare, LLC is an HMO plan with a Medicare contract. Enrollment in MMM depends on contract renewal.
- When this booklet says "we," "us," or "our," it means MMM Healthcare, LLC. When it says "plan" or "our plan," it means MMM Elite Ultra.

MMM-MKD-MIS-4826-090116-E

H4003 – MMM Healthcare, LLC Y0049_2017 1127 0007 1 File & Use 09092016 CMS Accepted

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 2.1 and 2.5 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 2.6 for information about changes to our drug coverage.
- ☐ **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 2.3 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? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to stay with MMM Elite Ultra:

If you want to stay with us next year, it's easy - you don't need to do anything.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for MMM Elite Ultra 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 attached *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2016 (this year)	2017 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0
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 2.2 for details.)	$3,250	$3,250
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $14 copay per visit	Primary care visits: $0 copay per visit Specialist visits: Your costs for services may vary depending on the tier of your provider. Tier 1- Preferred Network $7 copay per visit. Tier 2- General Network $13 copay per visit.

Cost	2016 (this year)	2017 (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.	Your costs for services may vary depending on the tier of your provider. Tier 1- Preferred Network $50 copay per stay. Tier 2- General Network $100 copay per stay	Your costs for services may vary depending on the tier of your provider. Tier 1- Preferred Network $75 copay per stay. Tier 2- General Network $125 copay per stay
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $90 Copayment during the Initial Coverage Stage: • Drug Tier 1: (Preferred Generics): $4 copay • Drug Tier 2 (Generics): $14 copay • Drug Tier 3 (Preferred Brand): $25 copay • Drug Tier 4 (Non Preferred Brand): $60 copay • Drug Tier 5 (Specialty Drugs): 31% coinsurance	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: (Preferred Generics): $2 copay • Drug Tier 2 (Generics): $7 copay • Drug Tier 3 (Preferred Brand): $35 copay • Drug Tier 4 (Non Preferred Drugs): $65 copay • Drug Tier 5 (Specialty Drugs): 33% coinsurance

Annual Notice of Changes for 2017
Table of Contents

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in MMM Elite Ultra in 2017

On January 1, 2017, MMM Healthcare, LLC will be combining MMM Único Extra with one of our plans, MMM Elite Ultra.

If you do nothing to change your Medicare coverage by December 7, 2016, we will automatically enroll you in our MMM Elite Ultra. This means starting January 1, 2017, you will be getting your medical and prescription drug coverage through MMM Elite Ultra. 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 must do so between October 15 and December 7.

The information in this document tells you about the differences between your current benefits in MMM Único Extra and the benefits you will have on January 1, 2017 as a member of MMM Elite Ultra.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- 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 2.2 – 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 services for the rest of the year.

Cost	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,250	$3,250 Once you have paid $3,250 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – 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.mmm-pr.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **Please review the 2017 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.
- When possible we will 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 2.4 – 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 Provider and Pharmacy Directory is located on our website at www.mmm-pr.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **Please review the 2017 Provider and Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – 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 *2017 Evidence of Coverage.*

Cost	2016 (this year)	2017 (next year)
Chiropractic services	You pay a $7 copay for Medicare covered visits. You pay a $15 copay for routine visits to the chiropractor. Maximum coverage of $1,000 with up to 8 visits per year. Referral from your PCP required for certain services.	You pay a $10 copay for Medicare covered chiropractic visits. Routine visits to the chiropractor are not covered. No Referral required

Cost	2016 (this year)	2017 (next year)
Dental services	Comprehensive dental services are not covered.	You pay 0% of the total cost for diagnostic dental services. You pay 33% of the total cost for comprehensive services with a maximum of up to $500 for prosthodontics.
Durable medical equipment and related supplies	You pay 20% of the total cost for durable medical equipment and related supplies	You pay 5% -20% of the total cost for durable medical equipment and related supplies. • 5% of the total cost for supplies • 10% of the total for wheelchairs • 10% of the total for hospital beds • 20% of the total for power wheelchairs • 10% of the total for all other durable medical equipment
Emergency services	You pay a $65 copay for emergency room visits.	You pay a $75 copay for emergency room visits.
Outpatient mental health care	You pay a $14 copay for outpatient mental health care visits.	You pay a $12 copay for outpatient mental health care visits.
Outpatient substance abuse services	You pay a $14 copay for outpatient substance abuse visits.	You pay a $12 for outpatient substance abuse visits.

Cost	2016 (this year)	2017 (next year)
Doctor office visits	You pay a $14 copay per specialist visit. You pay a $14 copay for other healthcare professional visits. Referral from your PCP required for certain services.	Your costs may vary depending on the tier of your provider. Tier 1- Preferred Network You pay a $7 copay per specialist visit. Tier 2- General Network You pay a $13 copay per specialist visit. You pay a $10 copay for other healthcare professional visits. No referrals required.
Podiatry services	You pay a $7 copay for Medicare covered visits and for routine visits. Up to one (1) routine visit per year. Referral from your PCP required for certain services.	You pay a $10 copay for Medicare covered visits and for routine visits. Up to one (1) routine visit per year. No referrals required.
Prosthetic devices and related supplies	You pay 15% of the total cost for prosthetic devices and related supplies.	You pay 20% of the total cost for prosthetic devices. You pay 10% of the total cost for related supplies.

Cost	2016 (this year)	2017 (next year)
Inpatient hospital care	Your costs may vary depending on the tier of your provider. Tier 1: Preferred Network: You pay a $50 copay per stay Tier 2: General Network: You pay a $100 copay per stay	Your costs may vary depending on the tier of your provider. Tier 1: Preferred Network: You pay a $75 copay per stay Tier 2: General Network: You pay a $125 copay per stay
Inpatient mental health care	You pay a $50 copay per stay for inpatient mental health care	You pay a $75 copay per stay for inpatient mental health care

Cost	2016 (this year)	2017 (next year)
Services to treat kidney disease and conditions	Your costs for dialysis services may vary depending on the tier of your provider. Tier 1: Preferred Network You pay 0% of the total cost for peritoneal dialysis services. You pay 10% of the total cost for other services to treat kidney disease and conditions. Tier 2: General Network You pay 0% of the total cost for peritoneal dialysis services. You pay 20% of the total cost for other services to treat kidney disease and conditions.	You pay 0% of the total cost for peritoneal dialysis services. You pay 20% of the total cost for other services to treat kidney disease and conditions.
Vision care	One pair of eyeglasses (frames and lenses). The plan covers up to $100 every year.	One pair of eyeglasses (frames and lenses) or contact lenses. The plan covers up to $100 every year.
Point of service	Point of service is not covered.	You pay 20% of the total cost for out of network covered services. This plan has a maximum annual limit of $5,000 for out of network services.

Section 2.6 – 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 in this envelope.

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 other 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.

The plan gives affected enrollees guidance regarding how to proceed after a temporary fill is provided, so that an appropriate and meaningful transition can be effectuated by the end of the transition period. Until that transition is actually made, however, either through a switch to an appropriate formulary drug, or decision of an exception request, continuation of drug coverage will be provided, other than for drugs not covered under Medicare Part D.

The plan continues to provide necessary drugs to an enrollee via an extension of the transition period, on a case-by-case basis, to the extent that his or her exception request or appeal has not been processed by the end of the minimum transition period and until such time as a transition has been made.

Exceptions will continue to be covered during the period (generally a calendar year) it was approved for, regardless of when the drug was approved. No new drug exception request needs to be submitted by the start of the year unless the prior authorization expires.

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.**

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 attached *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	The deductible is $90	Because we have no deductible, this payment stage does not apply to you.

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	2016 (this year)	2017 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy 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*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic :** You pay $4 per prescription. **Generic :** You pay $14 per prescription. **Preferred Brand:** You pay $25 per prescription.**Non Preferred Drugs:** You pay $60 per prescription. **Specialty:** You pay 31% of the total cost. _____ Once your total drug costs have reached $3,310, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic :** You pay $2 per prescription. **Generic :** You pay $7 per prescription. **Preferred Brand:** You pay $35 per prescription. **Non Preferred Drugs:** You pay $65 per prescription. **Specialty:** You pay 33% of the total cost. _____ Once your total drug costs have reached $3,700, 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 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in MMM Elite Ultra

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 2017.

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 2017 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2017*, 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 http://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, MMM Healthcare, LLC offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from MMM Elite Ultra.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from MMM Elite Ultra.
- 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 *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, 2017.

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 are 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.*

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, 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 Puerto Rico, the SHIP is called Office of the Ombudsman for the Elderly.

The Office of the Ombudsman for the Elderly 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. The Office of the Ombudsman for the Elderly 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 the Office of the Ombudsman for the Elderly at 787-721-6121 or 1-877-725-4300 (Metro Area), 1-800-981-0056 (Mayagüez Region) and 1-800-981-7735 (Ponce Region). TTY users should call 787-919-7291. You can learn more about Office of the Ombudsman for the Elderly by visiting their website (www.oppea.pr.gov).

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);

- **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 Puerto Rico Department of Health Ryan White Part B Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 787-765-2929 extensions 5106, 5107, 5114, 5115, 5116, 5119, 5132, 5135, 5136, 5137 and 5138.

SECTION 7 Questions?

Section 7.1 – Getting Help from MMM Elite Ultra

Questions? We're here to help. Please call Member Services at 787-620-2397 (Metro Area), 1-866-333-5470 (toll free) for additional information. (TTY users should call 1-866-333-5469). We are available for phone calls Monday through Sunday, from 8:00 a.m. to 8:00 p.m. Calls to these numbers are free.

Read your 2017 *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 2017. For details, look in the 2017 *Evidence of Coverage* for MMM Elite Ultra. 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.mmm-pr.com. As a reminder, our website has the most up-to-date information about our provider network (Provider and Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (http://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 http://www.medicare.gov and click on "Find health & drug plans").

Read *Medicare & You 2017*

You can read the *Medicare & You 2017* 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 (http://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.