

Tufts Medicare Preferred HMO Value Rx (HMO) offered by Tufts Associated Health Maintenance Organization (Tufts Health Plan)

Annual Notice of Change for 2026

You're enrolled as a member of Tufts Medicare Preferred HMO Value Rx (HMO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Tufts Medicare Preferred HMO Value Rx (HMO).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.thpmp.org or call Member Services at 1-800-701-9000 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Member Services at 1-800-701-9000 (TTY users call 711) for more information. Hours are 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday-Friday from April 1 to September 30. This call is free.
- This information is available in different formats, including large print.

About Tufts Medicare Preferred HMO Value Rx (HMO)

- Tufts Health Plan is an HMO/PPO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal.
- When this material says "we," "us," or "our," it means Tufts Associated Health Maintenance Organization. When it says "plan" or "our plan," it means Tufts Medicare Preferred HMO Value Rx (HMO).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Tufts Medicare Preferred HMO Value Rx (HMO).** Starting January 1, 2026, you'll get your medical and drug coverage through Tufts Medicare Preferred HMO Value Rx (HMO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	\$83	\$93
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered services. (Go to Section 1.2 for details.)	\$3,650	\$3,850
Primary care office visits	\$10 copayment per visit	\$10 copayment per visit
Specialist office visits	\$25 copayment per visit	\$25 copayment 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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	You pay \$200 copayment per day for days 1-5 and \$0 copayment after day 5.	You pay \$200 copayment per day for days 1-5 and \$0 copayment after day 5.
Inpatient psychiatric stays	You pay \$200 copayment per day for days 1-5 and \$0 copayment after day 5.	You pay \$200 copayment per day for days 1-5 and \$0 copayment after day 5.
Part D drug coverage deductible (Go to Section 1.7 for details.)	Deductible: \$0	Deductible: \$0

	2025 (this year)	2026 (next year)
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: \$0 - \$14 copayment • Drug Tier 2: \$4 - \$19 copayment • Drug Tier 3: 23% coinsurance You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 50% coinsurance You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance • Drug Tier 6: \$0 copayment	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: \$0 - \$14 copayment • Drug Tier 2: \$4 - \$19 copayment • Drug Tier 3: 20% coinsurance You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 40% coinsurance You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance • Drug Tier 6: \$0 copayment

	2025 (this year)	2026 (next year)
	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$83	\$93
Additional premium for optional supplemental benefits Tufts Medicare Preferred Dental Option If you’ve enrolled in an optional supplemental benefit package, you’ll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)	\$37	\$38

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you’re required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that’s at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

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

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you’ve paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don’t count toward your maximum out-of-pocket amount.	\$3,650	\$3,850 Once you’ve paid \$3,850 out-of-pocket for covered services, you’ll pay nothing for your covered services for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* www.thpmp.org to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here’s how to get an updated *Provider Directory*:

- Visit our website at www.thpmp.org.
- Call Member Services at 1-800-701-9000 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-800-701-9000 (TTY users call 711) for help.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* www.thpmp.org to see which pharmacies are in our network. Here’s how to get an updated *Pharmacy Directory*:

- Visit our website at www.thpmp.org.
- Call Member Services at 1-800-701-9000 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-701-9000 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Prior Authorizations	The following in-network benefits have a change in prior authorization requirements. • Outpatient hospital observation does <u>not</u> require prior authorization.	• Outpatient hospital observation may require prior authorization. Please refer to your Evidence of Coverage for more information.
Referrals	The following in-network benefits have a change in referral requirements. • Diabetes self-management training requires a referral.	• Diabetes self-management training does <u>not</u> require a referral.

	2025 (this year)	2026 (next year)
		Please refer to your <i>Evidence of Coverage</i> for more information.
Chronic pain management	Not covered.	Cost sharing will vary depending on individual services provided under the course of treatment. Please refer to your <i>Evidence of Coverage</i> for more information.
Meals Post-Hospitalization/Rehabilitation	You pay \$0 copayment for up to 28 home-delivered meals (2 meals per day for 14 days) supplied by plan-approved vendor after a qualifying discharge from hospital or extended care facility. There is no annual limit to the number of discharges after which meals may be provided.	<u>Not covered</u>
Medicare Part B drugs- Part B drugs	Part B drugs may be subject to Step Therapy requirements that include Part B to Part B drugs.	Part B drugs may be subject to Step Therapy requirements that include Part B to Part B drugs, Part B to Part D drugs, and Part D to Part B drugs. Please refer to your <i>Evidence of Coverage</i> for more information.

	2025 (this year)	2026 (next year)
Medicare preventive services	The plan covers Medicare preventive services covered by Medicare.	The plan covers Medicare preventive services covered by Medicare, including the following new services: • Pre-exposure prophylaxis (PrEP) for HIV prevention • Screening for Hepatitis C Virus infection Please refer to your <i>Evidence of Coverage</i> for more information.
Physician/Practitioner services, including doctor's office visits - Additional Telehealth Services	Please refer to your <i>Evidence of Coverage</i> for list of covered services.	In addition to current services, the following services will also be covered: • Pulmonary Rehabilitation Services • Partial Hospitalization Services • Intensive Outpatient Services • Cardiac Rehabilitation Services • Intensive Cardiac Rehabilitation Services Please refer to your <i>Evidence of Coverage</i> for more information.

	2025 (this year)	2026 (next year)
Special Supplemental Benefit for the Chronically Ill (SSBCI)	Covered for members diagnosed with heart failure, COPD, diabetes, dementia, ESRD, and stroke. Participation in Care Management is required and Care Managers will refer eligible members for eligible services. Covered services include: • \$0 copayment for non-emergency medical transportation by plan-approved vendor to doctor appointments and other approved locations. • 10% coinsurance for Pulse Oximeter supplied by a plan-approved DME vendor. Trip limits and quantity limits apply to non-emergency transportation and Pulse Oximeter, respectively.	Not covered.

	2025 (this year)	2026 (next year)
Tufts Medicare Preferred Dental Option	\$37 monthly premium \$1,000 annual benefit limit. Class 1 services: \$0 copay. Class 2 services: 20% coinsurance. Class 3 services: 50% coinsurance. No waiting period. Services are covered with providers in the Dominion PPO Network only.	\$38 monthly premium \$1,000 annual benefit limit. Class 1 services: \$0 copay. Class 2 services: 20% coinsurance. Class 3 services: 50% coinsurance. No waiting period. Services are covered with providers in the Dominion PPO Network only. Please refer to your Evidence of Coverage for more information.

	2025 (this year)	2026 (next year)
Vision care - eyewear	The plan covers up to \$150 per calendar year toward the full retail price (not sale price) for eyeglasses (lenses, frames, or a combination) and/or contact lenses from an EyeMed Vision Care participating provider, or up to \$90 per calendar year from a non-participating provider. Multiple purchases are allowed during the year up to the full annual benefit amount.	The plan covers up to \$150 per calendar year toward the full retail price (not sale price) for eyeglasses (lenses, frames, or a combination) and/or contact lenses from an EyeMed Vision Care participating provider, or up to \$90 per calendar year from a non-participating provider. Only one purchase is allowed per calendar year up to the benefit amount; any unused amount after the single purchase will expire and cannot be applied toward another purchase during the calendar year. Please refer to your <i>Evidence of Coverage</i> for more information.

Section 1.6 Changes to Part D 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.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier.

Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-701-9000 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We have included a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and didn't get this material with this packet, call Member Services at 1-800-701-9000 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

We have no deductible, so this payment stage doesn't apply to you.

- **Stage 2: Initial Coverage**

In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach \$2,100.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan’s full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don’t count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	Because we have no deductible, this payment stage doesn’t apply to you.

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply, at a network pharmacy that offers preferred cost sharing, or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you’ve paid \$2,100 out of pocket for covered Part D drugs, you’ll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Tier 1: Preferred Generic 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.	<i>Standard cost sharing:</i> You pay \$14. Your cost for a one-month mail-order prescription is \$0. <i>Preferred cost sharing:</i> You pay \$0.	<i>Standard cost sharing:</i> You pay \$14. You pay the lesser of \$14 or 25% of the total cost per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is \$0. <i>Preferred cost sharing:</i> You pay \$0.
Tier 2: Generic 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.	<i>Standard cost sharing:</i> You pay \$19. Your cost for a one-month mail-order prescription is \$4. <i>Preferred cost sharing:</i> You pay \$4.	<i>Standard cost sharing:</i> You pay \$19. You pay the lesser of \$19 or 25% of the total cost per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is \$4. <i>Preferred cost sharing:</i> You pay \$4. You pay the lesser of \$4 or 25% of the total cost per month supply of each covered insulin product on this tier.

	2025 (this year)	2026 (next year)
Tier 3: Preferred Brand 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.	<i>Standard cost sharing:</i> You pay 23% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 23% of the total cost. <i>Preferred cost sharing:</i> You pay 23% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier.	<i>Standard cost sharing:</i> You pay 20% of the total cost. You pay the lesser of \$35 or 20% of the total cost per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 20% of the total cost. <i>Preferred cost sharing:</i> You pay 20% of the total cost. You pay the lesser of \$35 or 20% of the total cost per month supply of each covered insulin product on this tier.

	2025 (this year)	2026 (next year)
Tier 4: Non-Preferred Drug 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.	<i>Standard cost sharing:</i> You pay 50% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 50% of the total cost. <i>Preferred cost sharing:</i> You pay 50% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier.	<i>Standard cost sharing:</i> You pay 40% of the total cost. You pay the lesser of \$35 or 25% of the total cost per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 40% of the total cost. <i>Preferred cost sharing:</i> You pay 40% of the total cost. You pay the lesser of \$35 or 25% of the total cost per month supply of each covered insulin product on this tier.
Tier 5: Specialty Tier 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.	<i>Standard cost sharing:</i> You pay 33% of the total cost. Your cost for a one-month mail-order prescription is 33% of the total cost. <i>Preferred cost sharing:</i> You pay 33% of the total cost.	<i>Standard cost sharing:</i> You pay 33% of the total cost. Your cost for a one-month mail-order prescription is 33% of the total cost. <i>Preferred cost sharing:</i> You pay 33% of the total cost.

	2025 (this year)	2026 (next year)
Tier 6: Vaccine Tier 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.	<i>Standard cost sharing:</i> You pay \$0. <i>Preferred cost sharing:</i> You pay \$0.	<i>Standard cost sharing:</i> You pay \$0. <i>Preferred cost sharing:</i> You pay \$0.

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Coverage for blood glucose monitors and blood glucose test strips	Coverage for blood glucose monitors and blood glucose test strips is limited to the OneTouch products manufactured by LifeScan, Inc. Please note, there is no preferred brand for lancets or glucose control solutions.	Coverage for blood glucose monitors and blood glucose test strips is limited to Accu-Chek products manufactured by Roche Diabetes Care, Inc. Please note, there is no preferred brand for lancets or glucose control solutions.
Hearing aids and hearing aid fitting	Services provided through Hearing Care Solutions (HCS).	Services provided through TruHearing, Inc.

	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-800-701-9000 (TTY users call 711) or visit www.Medicare.gov.

SECTION 3 How to Change Plans

To stay in Tufts Medicare Preferred HMO Value Rx (HMO), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Tufts Medicare Preferred HMO Value Rx (HMO).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Tufts Medicare Preferred HMO Value Rx (HMO).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Tufts Medicare Preferred HMO Value Rx (HMO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-800-701-9000 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder,

Tufts Associated Health Maintenance Organization offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
- Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
- Your State Medicaid Office.
- **Help from your state’s pharmaceutical assistance program (SPAP).** Massachusetts has a program called Prescription Advantage 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 (SHIP). To get the phone number for your state, visit www.shiphelp.org, or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you’re currently enrolled, how to continue getting help, call 1-617-502-1700. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn’t save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-800-701-9000 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from Tufts Medicare Preferred HMO Value Rx (HMO)

- **Call Member Services at 1-800-701-9000. (TTY users call 711.)**

We're available for phone calls 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday-Friday from April 1 to September 30.

- **Read your 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Tufts Medicare Preferred HMO Value Rx (HMO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.thpmp.org or call Member Services at 1-800-701-9000 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.thpmp.org**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Massachusetts, the SHIP is called Serving the Health Insurance Needs of Everyone (SHINE).

Call SHINE to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call SHINE at 1-800-243-4636. Learn more about SHINE by visiting www.mass.gov/health-insurance-counseling.

Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.



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Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Tufts Health Plan at
1-800-701-9000 (HMO)/1-866-623-0172 (PPO)/(TTY: 711).

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, or gender identity), you can file a grievance with:

Tufts Health Plan, Attention:

Civil Rights Legal Coordinator

1 Wellness Way, Canton, MA 02021-1166

Phone: **1-888-880-8699** ext. 48000, **(TTY: 711)**

Fax: **1-617-668-2754**

Email: OCRCoordinator@point32health.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights; electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>; or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building Washington, D.C. 20201

1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

thmpmp.org | **1-800-701-9000 (HMO)/1-866-623-0172 (PPO)/(TTY: 711)**

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) o hable con su proveedor.

Português (Portuguese) ATENÇÃO: Se fala Português, estão disponíveis para si serviços gratuitos de assistência linguística. Estão também disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ou fale com o seu prestador.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (文本电话：711) 或咨询您的服务提供商。

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nan 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) oswa pale avèk founisè w la.

Việt (Vietnamese) LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) или обратитесь к своему поставщику услуг.

(Arabic) العربية تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 711 (1-800-701-9000) (PPO) 1-866-623-0172 (HMO) أو تحدث إلى مقدم الخدمة.

ភាសាខ្មែរ (Khmer) សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Français (French) ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ou parlez à votre fournisseur.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (tty: 711) o parla con il tuo fornitore.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ή απευθυνθείτε στον πάροχό σας.

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) lub porozmawiaj ze swoim dostawcą.

हिंदी (Hindi)न दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્ઝિલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.