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

Annual Notice of Change for 2027

You're enrolled as a member of Tufts Medicare Preferred HMO Basic 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, 2026, you'll stay in Tufts Medicare Preferred HMO Basic Rx (HMO).
- To change to a **different plan**, visit Medicare.gov or review the list in the back of your *Medicare & You 2027* 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 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 Basic 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 Basic Rx (HMO).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in Tufts Medicare Preferred HMO Basic Rx (HMO)**. Starting January 1, 2027, you'll get your medical and drug coverage through Tufts Medicare Preferred HMO Basic 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 2027

	2026 (this year)	2027 **(next year)**
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	$68	**$88**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered services. (Go to Section 1.2 for details.)	$3,850	**$4,500**
Primary care office visits	$10 copayment per visit	**$10 copayment per visit**
Specialist office visits	$40 copayment per visit	**$45 copayment per visit**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	You pay $275 copayment per day for days 1-5 and $0 copayment after day 5.	**You pay $350 copayment per day for days 1-5 and $0 copayment after day 5.**
Inpatient psychiatric stays	You pay $275 copayment per day for days 1-5 and $0 copayment after day 5.	**You pay $275 copayment per day for days 1-5 and $0 copayment after day 5.**

	2026 (this year)	2027 **(next year)**
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible $0	**Part D drug coverage deductible** **$200 applies to Tier 3, Tier 4, and Tier 5 drugs, except for covered insulin products and most adult Part D vaccines.**
	Copayment/Coinsurance during the Initial Coverage Stage:	**Copayment/Coinsurance during the Initial Coverage Stage:**
	Drug Tier 1: $0 - $14 copayment	**Drug Tier 1: $0 - $14 copayment**
	Drug Tier 2: $4 - $19 copayment	**Drug Tier 2: $4 - $19 copayment**
	Drug Tier 3: 20% coinsurance	**Drug Tier 3: 20% coinsurance**
	You pay no more than $35 per month supply of each covered insulin product on this tier.	**You pay no more than $35 per month supply of each covered insulin product on this tier.**
	Drug Tier 4: 40% coinsurance	**Drug Tier 4: 40% coinsurance**
	You pay no more than $35 per month supply of each covered insulin product on this tier.	**You pay no more than $35 per month supply of each covered insulin product on this tier.**
	Drug Tier 5: 33% coinsurance	**Drug Tier 5: 30% coinsurance**
	Drug Tier 6: $0 copayment	**Drug Tier 6: $0 copayment**

	2026 (this year)	2027 **(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.** **You can have cost sharing for 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

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$68	**$88**
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.)	$38	**$41.50**

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 Part D or 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 services for the rest of the calendar year.

	2026 (this year)	2027 (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.	$3,850	**$4,500** **Once you've paid $4,500 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 2027 *Provider Directory* at thpmp.org/documents 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 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. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

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 2027 *Pharmacy Directory* thpmp.org/documents to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at thpmp.org/documents.
- 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

	2026 (this year)	2027 (next year)
Emergency care	You pay $125 for each Medicare-covered visit. If you are held for observation or admitted inpatient within 1 day for the same condition following the emergency care visit, the emergency care copay will be waived and you will pay the applicable observation or inpatient hospital care copay.	**You pay $130 for each Medicare-covered visit.** **If you are held for observation or admitted inpatient within 1 day for the same condition following the emergency care visit, you will only pay the higher of the emergency care copay or the applicable observation or inpatient hospital care copay.** **Please refer to your *Evidence of Coverage* for more information.**
Emergency care - Worldwide emergency coverage	You pay $125 copayment per visit.	**You pay $130 copayment per visit.** **Please refer to your *Evidence of Coverage* for more information.**
Home and bathroom safety devices and modifications	You pay 20% coinsurance for the following covered items: • Raised Toilet Seat: 1 per member every 5 years • Bathroom Grab Bars: Up to 2 per member every 5 years • Tub Seat: 1 per member every 5 years	**Not covered.**

	2026 (this year)	2027 (next year)
Inpatient hospital care	You pay $275 copayment per day for days 1 to 5 and $0 copayment after day 5.	**You pay $350 copayment per day for days 1 to 5 and $0 copayment after day 5.** **Please refer to your *Evidence of Coverage* for more information.**
Intensive Outpatient Program Services	You pay $0 copayment per day for each Medicare-covered service.	**You pay $55 copayment per visit for each Medicare-covered service.** **Please refer to your *Evidence of Coverage* for more information.**
Medical nutrition therapy - Additional medical nutrition therapy	You pay $0 copayment for additional 3 hours of one-on-one counseling services each year if you have exhausted your Medicare-covered benefit.	**Not covered.**

	2026 (this year)	2027 (next year)
Outpatient - Diagnostic radiological services	You pay $100 copayment per day for a Medicare-covered Ultrasound. You pay $250 copayment per day for other Medicare-covered diagnostic radiology services that are not Ultrasounds.	**You pay $100 copayment per day for a Medicare-covered Ultrasound.** **You pay $350 copayment per day for other Medicare-covered diagnostic radiology services that are not Ultrasounds.** **Please refer to your *Evidence of Coverage* for more information.**
Outpatient hospital observation	You pay $270 copayment per stay for each Medicare-covered service.	**You pay $300 copayment per stay for each Medicare-covered service.** **Please refer to your *Evidence of Coverage* for more information.**
Outpatient hospital services	You pay $270 copayment per day for each Medicare-covered service.	**You pay $300 copayment per day for each Medicare-covered service.** **Please refer to your *Evidence of Coverage* for more information.**

	2026 (this year)	2027 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay $0 copayment for Medicare-covered colonoscopies. You pay $170 copayment per day for other outpatient procedures and services performed in an ambulatory surgical center. You pay $270 copayment per day for other outpatient procedures and services performed in an outpatient hospital facility.	**You pay $0 copayment for Medicare-covered colonoscopies.** **You pay $170 copayment per day for other outpatient procedures and services performed in an ambulatory surgical center.** **You pay $300 copayment per day for other outpatient procedures and services performed in an outpatient hospital facility.** **Please refer to your *Evidence of Coverage* for more information.**
Partial hospitalization services	You pay $0 copayment per day for each Medicare-covered service.	**You pay $55 copayment per visit for each Medicare-covered service.** **Please refer to your *Evidence of Coverage* for more information.**
Physician/practitioner services, including doctor's office visits - Specialist	You pay $40 copayment per visit for each Medicare-covered service.	**You pay $45 copayment per visit for each Medicare-covered service.** **Please refer to your *Evidence of Coverage* for more information.**

	2026 (this year)	2027 (next year)
Physician/practitioner services, including doctor's office visits- Other healthcare professionals	You pay $10 - $40 copayment per visit depending on the Medicare-covered service.	**You pay $10 - $45 copayment per visit depending on the Medicare-covered service.** **What you pay depends on the type and setting of care received. Minimum cost share for professional services in a primary care setting. Maximum cost share for professional services in a specialty care setting.** **Please refer to your *Evidence of Coverage* for more information.**

	2026 (this year)	2027 (next year)
Physician/practitioner services, including doctor's office visits - Additional Telehealth Services	You pay $0 - $270 copayment depending on the Medicare-covered service.	**You pay $0 - $300 copayment depending on the Medicare-covered service.** **The same cost share applies to Additional Telehealth Services as corresponding in-person visits. Minimum cost share applies to e-visits, virtual check-ins, and remote patient monitoring services. Maximum cost share applies to observation services.** **Please refer to your *Evidence of Coverage* for more information.**
Skilled nursing facility (SNF) care	You pay $20 copayment per day for days 1 to 20, $160 copayment per day for days 21 to 44, and $0 copayment per day for days 45 to 100 for Medicare-covered skilled nursing facility care.	**You pay $0 copayment per day for days 1 to 20, $170 copayment per day for days 21 to 44, and $0 copayment per day for days 45 to 100 for Medicare-covered skilled nursing facility care.** **Please refer to your *Evidence of Coverage* for more information.**

	2026 (this year)	2027 (next year)
Tufts Medicare Preferred Dental Option	You pay $38 monthly premium for: $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.	**You pay $41.50 monthly premium for:** **$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.**

	2026 (this year)	2027 (next year)
Vision - Medicare-covered eye exam	You pay $15 - $40 copayment depending on the Medicare-covered service.	**You pay $0 - $15 copayment depending on the Medicare-covered service.** **Minimum cost share is for diabetic retinopathy exams. Maximum cost share is for all other medically necessary eye exams performed for a special reason.** **Please refer to your *Evidence of Coverage* for more information.**
Vision - Routine eyewear benefit	You receive $150 per calendar year toward the purchase of eyeglasses (prescription lenses, frames, or a combination of lenses and frames) and/or contact lenses from EyeMed Vision Care participating providers, or $90 per calendar year for purchases from non-EyeMed Vision Care participating providers.	**You receive $150 per calendar year toward the purchase of eyeglasses (prescription lenses, frames, or a combination of lenses and frames) and/or contact lenses from any provider.** **Please refer to your *Evidence of Coverage* for more information.**

	2026 (this year)	2027 (next year)
Vision - Therapeutic eyewear (Medicare covered & Supplemental coverage)	You pay $0 copayment for one pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery, or for one pair of standard therapeutic eyeglasses with standard frames or contact lenses. You may use your eyewear allowance through EyeMed to purchase upgrades (i.e., non-standard frames and/or lenses) for your eyewear. Once your eyewear allowance is exhausted, however, you will be responsible for any remaining balance.	**You pay $0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery, or for one pair of therapeutic eyeglasses or contact lenses.** **Please refer to your *Evidence of Coverage* for more information.**
Wigs	Wigs are covered up to $500 per calendar year for members who experience hair loss due to treatment for cancer.	**Not covered.**

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.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3, Tier 4, and Tier 5 drugs until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. 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 $2,400.

- ***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.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2026 (this year)	2027 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	**$200** **During this stage, you pay $0 - $14 cost sharing for drugs on Tier 1: Preferred Generic, $4 - $19 cost sharing for drugs on Tier 2: Generic, and $0 cost sharing for drugs on Tier 6: Vaccine Tier, and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you have reached the yearly deductible.**

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 $2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (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.	*Standard cost sharing:* 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. *Preferred cost sharing:* You pay $0.	***Standard cost sharing:*** **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.** ***Preferred cost sharing:*** **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.	*Standard cost sharing:* 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. *Preferred cost sharing:* 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.	***Standard cost sharing:*** **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.** ***Preferred cost sharing:*** **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.**

	2026 (this year)	2027 (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.	*Standard cost sharing:* 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. *Preferred cost sharing:* 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.	***Standard cost sharing:*** **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.** ***Preferred cost sharing:*** **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.**

	2026 (this year)	2027 (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.	*Standard cost sharing:* 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. *Preferred cost sharing:* 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.	***Standard cost sharing:*** **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.** ***Preferred cost sharing:*** **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.	*Standard cost sharing:* You pay 33% of the total cost. Your cost for a one-month mail-order prescription is 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost.	***Standard cost sharing:*** **You pay 30% of the total cost.** **Your cost for a one-month mail-order prescription is 30% of the total cost.** ***Preferred cost sharing:*** **You pay 30% of the total cost.**

	2026 (this year)	2027 (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.	*Standard cost sharing:* You pay $0. *Preferred cost sharing:* You pay $0.	***Standard cost sharing:*** **You pay $0.** **Preferred cost sharing:** **You pay $0.**

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Extended day supply of Tier 1 prescription drugs	Members may receive up to a 90-day supply of Tier 1 drugs included on the formulary.	**Members may receive up to a 100-day supply of Tier 1 drugs included on the formulary.**

SECTION 3 How to Change Plans

To stay in Tufts Medicare Preferred HMO Basic Rx (HMO), you don't need to do anything. Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Tufts Medicare Preferred HMO Basic Rx (HMO).
If you want to change plans for 2027, 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 Basic Rx (HMO). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.

- **To change to Original Medicare with Medicare separate drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from Tufts Medicare Preferred HMO Basic Rx (HMO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll or visit our website to disenroll online at tuftsmedicarepreferred.org/hmo-ppo-disenrollment-form. 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 Medicare.gov, check the *Medicare & You 2027* 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, 2027, 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, 2027.

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 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. 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 2027. You do not need to submit a new election request to continue participating in 2027. **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. To learn more about this payment option, call us at 1-800-701-9000 (TTY users call 711) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from Tufts Medicare Preferred HMO Basic 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 2027 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for Tufts Medicare Preferred HMO Basic 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 thpmp.org/documents or call Member Services at 1-800-701-9000 (TTY users call 711) to ask us to mail you a copy.

- **Visit thpmp.org/documents**

  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 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 Medicare.gov**

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

- **Write to Medicare**

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

- **Visit 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 2027***

  The *Medicare & You 2027* 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 Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

TUFTS Health Plan

a Point32Health company

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**.
thpmp.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 - Dispositivo das telecomunicações para surdos: 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 fòma 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 -1-866-(HMO) 623-0172 (PPO) أو تحدث إلى مقدم الخدمة.

ភាសាខ្មែរ (**Khmer**) សូមយកចិត្តទុកដាក់៖ របសិនេបីអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតៃថ្លគឺមានសរមាប់អ្នក។ ជំនួយ និងេសវាកម្មដែលជាការជួយដ៏សមរមយ ក្នុងការផ្តល់ព័ត៌មានតាមទរមង់ដែលអាចចូលេរបីរបាស់បាន ក៏អាចរកបានដោយឥតគិតៃថ្លផងែដរ។ ហៅទូរសព្ទទៅ 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ឬនិយាយេទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

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 ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.