HMO Basic Rx *(*Medicare Advantage HMO*) offered by* Tufts Health Plan Medicare Preferred

Annual Notice of Changes for 2018

You are currently enrolled as a member of Tufts Medicare Preferred HMO Basic Rx. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1 and 2 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2018 Drug List and look in Section 1.6 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 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

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

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

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

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

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

- If you want to **keep** Tufts Medicare Preferred HMO Basic Rx, you don't need to do anything. You will stay in Tufts Medicare Preferred HMO Basic Rx.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in Tufts Medicare Preferred HMO Basic Rx.
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Relations number at 1-800-701-9000 for additional information. (TTY users should call 1-800-208-9562.) Hours are Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from Oct. 1 – Feb. 14.)
- This information is available in different formats, including large print.
- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Tufts Medicare Preferred HMO Basic Rx

- Tufts Health Plan is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Tufts Health Plan Medicare Preferred. When it says "plan" or "our plan," it means Tufts Medicare Preferred HMO Basic Rx.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Tufts Medicare Preferred HMO Basic Rx in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$39.00	$46.00
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,400	$3,400
Doctor office visits	Primary care visits: $10 per visit Specialist visits: $30 per visit	Primary care visits: $10 per visit Specialist visits: $40 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay $275 per day for days 1-5 and $0 after day 5 for Medicare covered services received in a general acute care, psychiatric, rehabilitation, or long-term acute care hospital.	You pay $275 per day for days 1-5 and $0 after day 5 for Medicare covered services received in a general acute care, psychiatric, rehabilitation, or long-term acute care hospital.

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: You pay the first $300 of the total cost for prescription drugs in Tier 3, Tier 4, and/or Tier 5. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 per prescription at a retail pharmacy for a 30-day supply. $8 per prescription at a retail pharmacy for up to a 60-day supply. $12 per prescription at a retail pharmacy for up to a 90-day supply. $4 per prescription at a mail order pharmacy for a 30-day supply. $8 per prescription at a mail order pharmacy for up to a 60-day supply. $8 per prescription at a mail order pharmacy for up to a 90-day supply. • Drug Tier 2: $8 per prescription at a retail pharmacy for a 30-day supply. $16 per prescription at a retail pharmacy for up to a 60-day supply. $24 per prescription at a retail pharmacy for up to a 90-day supply. $8 per prescription at a mail order pharmacy for a 30-day supply. $16 per prescription at a mail order pharmacy for up to a 60-day supply.	Deductible: You pay the first $350 of the total cost for prescription drugs in Tier 3, Tier 4, and/or Tier 5. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 per prescription at a retail pharmacy for a 30-day supply. $8 per prescription at a retail pharmacy for up to a 60-day supply. $12 per prescription at a retail pharmacy for up to a 90-day supply. $4 per prescription at a mail order pharmacy for a 30-day supply. $8 per prescription at a mail order pharmacy for up to a 60-day supply. $8 per prescription at a mail order pharmacy for up to a 90-day supply. • Drug Tier 2: $8 per prescription at a retail pharmacy for a 30-day supply. $16 per prescription at a retail pharmacy for up to a 60-day supply. $24 per prescription at a retail pharmacy for up to a 90-day supply. $8 per prescription at a mail order pharmacy for a 30-day supply. $16 per prescription at a mail order pharmacy for up to a 60-day supply.

Cost	2017 (this year)	2018 (next year)
	$16 per prescription at a mail order pharmacy for up to a 90-day supply.	$16 per prescription at a mail order pharmacy for up to a 90-day supply.
	• Drug Tier 3: $47 per prescription at a retail pharmacy for a 30-day supply. $94 per prescription at a retail pharmacy for up to a 60-day supply. $141 per prescription at a retail pharmacy for up to a 90-day supply. $47 per prescription at a mail order pharmacy for a 30-day supply. $94 per prescription at a mail order pharmacy for up to a 60-day supply. $94 per prescription at a mail order pharmacy for up to a 90-day supply.	• Drug Tier 3: $47 per prescription at a retail pharmacy for a 30-day supply. $94 per prescription at a retail pharmacy for up to a 60-day supply. $141 per prescription at a retail pharmacy for up to a 90-day supply. $47 per prescription at a mail order pharmacy for a 30-day supply. $94 per prescription at a mail order pharmacy for up to a 60-day supply. $94 per prescription at a mail order pharmacy for up to a 90-day supply.
	• Drug Tier 4: $100 per prescription at a retail or mail order pharmacy for a 30-day supply. $200 per prescription at a retail or mail order pharmacy for up to a 60-day supply. $300 per prescription at a retail or mail order pharmacy for up to a 90-day supply.	• Drug Tier 4: $100 per prescription at a retail or mail order pharmacy for a 30-day supply. $200 per prescription at a retail or mail order pharmacy for up to a 60-day supply. $300 per prescription at a retail or mail order pharmacy for up to a 90-day supply.
	• Drug Tier 5: 27% per prescription at a retail or mail order pharmacy for a 30-day supply. 60-day and 90-day supplies are not covered for drugs on Tier 5.	• Drug Tier 5: 26% per prescription at a retail or mail order pharmacy for a 30-day supply. 60-day and 90-day supplies are not covered for drugs on Tier 5.

Annual Notice of Changes for 2018
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$39.00	$46.00
Optional Supplemental Benefit: Delta Dental Option	$54	$54

- 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 enroll in Medicare prescription drug coverage in the future.
- 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 1.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2017 (this year)	2018 (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 plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at tuftsmedicarepreferred.org. You may also call Customer Relations for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

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

Section 1.4 – 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 Directory is located on our website at tuftsmedicarepreferred.org. You may also call Customer Relations for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider Directory to see which pharmacies are in our network**.

Section 1.5 – 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 *2018 Evidence of Coverage.*

Cost	2017 (this year)	2018 (next year)
Dental services (Medicare-covered)	You pay $30 for each	You pay $40 for each

Cost	2017 (this year)	2018 (next year)
Please refer to your 2018 Evidence of Coverage (EOC) for Delta Dental Option rider benefit information.	Medicare-covered office visit.	Medicare-covered office visit.
Emergency care	You pay $75 for each Medicare-covered emergency room visit.	You pay $100 for each Medicare-covered emergency room visit.
Hearing services	You pay $30 for a Medicare-covered hearing exam. You pay $30 for an annual routine hearing exam.	You pay $40 for a Medicare-covered hearing exam. You pay $40 for an annual routine hearing exam.
Outpatient mental health care	You pay $30 for each individual or group therapy visit for Medicare-covered outpatient mental health services.	You pay $40 for each individual or group therapy visit for Medicare-covered outpatient mental health services.
Outpatient substance abuse services	You pay $30 for each individual or group therapy visit for Medicare-covered outpatient substance abuse services.	You pay $40 for each individual or group therapy visit for Medicare-covered outpatient substance abuse services.
Physician/Practitioner services, including doctor's office visits	You pay $10 for each covered visit or consultation in an outpatient location with your PCP or other primary care physician. You pay $30 for each covered visit or consultation in an outpatient location with a specialist.	You pay $10 for each covered visit or consultation in an outpatient location with your PCP or other primary care physician. You pay $40 for each covered visit or consultation in an outpatient location with a specialist.
Podiatry services	You pay $30 for each Medicare-covered visit.	You pay $40 for each Medicare-covered visit.
Therapeutic radiology	You pay $0 for Medicare-covered radiation therapy and Chemotherapy visits.	You pay $60 for Medicare-covered radiation therapy and Chemotherapy visits.

Cost	2017 (this year)	2018 (next year)
Urgently needed services Your plan includes worldwide coverage for urgently needed care.	You pay $10 for each Medicare-covered office visit with a primary care physician. You pay $30 for each Medicare covered office visit to other providers for urgently needed services.	You pay $10 for each Medicare-covered office visit with a primary care physician. You pay $40 for each Medicare covered office visit to other providers for urgently needed services.
Vision care	You pay $30 for each Medicare-covered outpatient visit for services to diagnose and/or treat a disease or condition of the eye. You pay $30 for an annual diabetic retinopathy. You pay $30 for one annual routine eye exam.	You pay $40 for each Medicare-covered outpatient visit for services to diagnose and/or treat a disease or condition of the eye. You pay $40 for an annual diabetic retinopathy. You pay $40 for one annual routine eye exam.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List."

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

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of*

Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

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 does not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Relations and ask for the "LIS Rider." Phone numbers for Customer Relations are in Section 7.1 of this booklet.

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

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

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4, and/or Tier 5 drugs until you have reached the yearly deductible.	The deductible is $300.	The deductible is $350. During this stage, you pay $4 cost-sharing for a 30-day supply of drugs on Tier 1 and $8 cost-sharing for a 30-day supply of drugs on Tier 2, and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.

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	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** 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: **Tier 1:** You pay $4 per prescription. **Tier 2:** You pay $8 per prescription. **Tier 3:** You pay $47 per prescription. **Tier 4:** You pay $100 per prescription **Tier 5:** You pay 27% of the total cost. Once your total drug costs have reached $3,700, 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: **Tier 1:** You pay $4 per prescription. **Tier 2:** You pay $8 per prescription. **Tier 3:** You pay $47 per prescription. **Tier 4:** You pay $100 per prescription **Tier 5:** You pay 26% of the total cost. Once your total drug costs have reached $3,750, 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 2 Administrative Changes

Cost	2017 (this year)	2018 (next year)
Non-emergency ambulance services	Prior authorization not required.	Prior authorization may be required.

Cost	2017 (this year)	2018 (next year)
Outpatient hospital services	Prior authorization not required. A referral is required from your PCP.	Prior authorization may be required. A referral is required from your PCP.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	Prior authorization not required. A referral is required from your PCP.	Prior authorization may be required. A referral is required from your PCP.
Outpatient diagnostic tests, x-rays, and laboratory tests	If you receive services from the same provider during an office visit, only the office visit copay will apply	If you receive services from the same provider during an office visit, a diagnostic test, x-ray, and/or laboratory test copay will apply in addition to the office visit copay. You will pay only one diagnostic test, x-ray, and/or laboratory copay per day per provider.
Tier Exception Requests	You can ask the plan to make an exception in the cost sharing tier for drugs in Tier 2, Tier 3, and Tier 4 so that you pay less for it.	You can ask the plan to make an exception in the cost sharing tier for drugs in Tier 4 so that you pay less for it. Tier exception requests can be submitted for Tier 4 only.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Tufts Medicare Preferred HMO Basic Rx

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 2018.

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 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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

As a reminder, Tufts Health Plan Medicare Preferred 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 Tufts Medicare Preferred HMO Basic Rx.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Tufts Medicare Preferred HMO Basic Rx.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Relations 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, 2018.

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, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. 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 Massachusetts, the SHIP is called SHINE (Serving Health Insurance Needs of Everyone).

SHINE 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. SHINE 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 SHINE at 1-800-243-4636 (1-800-AGE-INFO) (TTY: 1-800-872-0166). You can learn more about SHINE by visiting their website (www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html).

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 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** 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 (the name and phone numbers for this organization are in Section 5 of this booklet).
- **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 Massachusetts HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-228-2714.

SECTION 7 Questions?

Section 7.1 – Getting Help from Tufts Medicare Preferred HMO Basic Rx

Questions? We're here to help. Please call Customer Relations at 1-800-701-9000. (TTY only, call 1-800-208-9562). We are available for phone calls Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from Oct. 1 – Feb. 14). Calls to these numbers are free.

Read your 2018 *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 2018. For details, look in the 2018 *Evidence of Coverage* for Tufts Medicare Preferred HMO Basic Rx. 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 tuftsmedicarepreferred.org. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2018*

You can read the *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling
1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call
1-877-486-2048