

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

Annual Notice of Changes for 2017

You are currently enrolled as a member of Tufts Medicare Preferred HMO Value 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.**

Additional Resources

- This information is available for free in other languages.
- 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.)
- Customer Relations also has free language interpreter services available for non-English speakers.
- Esta información está disponible de forma gratuita en otros idiomas. Comuníquese con nuestro departamento de atención al cliente al número 1-800-701-9000 para obtener información adicional. (Los usuarios de TTY deben llamar al 1-800-208-9562). El horario es de lunes a viernes, de 8:00 am a 8:00 pm (del 1 de octubre al 14 de febrero, los representantes están disponibles los 7 días a la semana, de 8:00 am a 8:00 pm). Atención al cliente también ofrece servicios gratuitos de interpretación disponibles para las personas que no hablan inglés.
- This information is available in different formats, including large print.
- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information on the individual requirement for MEC.

About Tufts Medicare Preferred HMO Value 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 Value Rx.

Think about Your Medicare Coverage for Next Year

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

Important things to do:

- Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1 and 2 for information about benefit and cost changes for our plan.
- Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 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? How do the total costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.**

If you decide to stay with Tufts Medicare Preferred HMO Value Rx:

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

If you decide to change plans:

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

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Tufts Medicare Preferred HMO Value 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	2016 (this year)	2017 (next year)
<p>Monthly plan premium*</p> <p>* Your premium may be higher or lower than this amount. See Section 1.1 for details.</p>	\$120.30	\$125.00
<p>Maximum out-of-pocket amount</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	\$3,400	\$3,400
<p>Doctor office visits</p>	<p>Primary care visits: \$10 per visit</p> <p>Specialist visits: \$20 per visit</p>	<p>Primary care visits: \$10 per visit</p> <p>Specialist visits: \$20 per visit</p>

Cost	2016 (this year)	2017 (next year)
<p>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.</p>	<p>You pay \$165 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.</p>	<p>You pay \$200 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.</p>
<p>Part D prescription drug coverage (See Section 1.6 for details.)</p>	<p>Deductible: You pay the first \$200 of the total cost for prescription drugs in Tier 3, Tier 4, and/or Tier 5.</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • 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. 	<p>Deductible: You pay the first \$250 of the total cost for prescription drugs in Tier 3, Tier 4, and/or Tier 5.</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • 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.

Cost	2016 (this year)	2017 (next year)
	\$12 per prescription at a retail pharmacy for up to a 90-day supply.	\$12 per prescription at a retail pharmacy for up to a 90-day supply.
	\$3 per prescription at a mail order pharmacy for a 30-day supply.	\$4 per prescription at a mail order pharmacy for a 30-day supply.
	\$7 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 60-day supply.
	\$10 per prescription at a mail order pharmacy for up to a 90-day supply.	\$8 per prescription at a mail order pharmacy for up to a 90-day supply.
	<ul style="list-style-type: none"> • Drug Tier 2: \$8 per prescription at a retail pharmacy for a 30-day supply. 	<ul style="list-style-type: none"> • 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.	\$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.	\$24 per prescription at a retail pharmacy for up to a 90-day supply.
	\$7 per prescription at a mail order pharmacy for a 30-day supply.	\$8 per prescription at a mail order pharmacy for a 30-day supply.
	\$14 per prescription at a mail order pharmacy for up to a 60-day supply.	\$16 per prescription at a mail order pharmacy for up to a 60-day supply.

Cost	2016 (this year)	2017 (next year)
	<p>\$21 per prescription at a mail order pharmacy for up to a 90-day supply.</p>	<p>\$16 per prescription at a mail order pharmacy for up to a 90-day supply.</p>
	<ul style="list-style-type: none"> • Drug Tier 3: 	<ul style="list-style-type: none"> • Drug Tier 3:
	<p>\$47 per prescription at a retail pharmacy for a 30-day supply.</p>	<p>\$47 per prescription at a retail pharmacy for a 30-day supply.</p>
	<p>\$94 per prescription at a retail pharmacy for up to a 60-day supply.</p>	<p>\$94 per prescription at a retail pharmacy for up to a 60-day supply.</p>
	<p>\$141 per prescription at a retail pharmacy for up to a 90-day supply.</p>	<p>\$141 per prescription at a retail pharmacy for up to a 90-day supply.</p>
	<p>\$47 per prescription at a mail order pharmacy for a 30-day supply.</p>	<p>\$47 per prescription at a mail order pharmacy for a 30-day supply.</p>
	<p>\$94 per prescription at a mail order pharmacy for up to a 60-day supply.</p>	<p>\$94 per prescription at a mail order pharmacy for up to a 60-day supply.</p>
	<p>\$141 per prescription at a mail order pharmacy for up to a 90-day supply.</p>	<p>\$94 per prescription at a mail order pharmacy for up to a 90-day supply.</p>
	<ul style="list-style-type: none"> • Drug Tier 4: 	<ul style="list-style-type: none"> • Drug Tier 4:
	<p>\$100 per prescription at a retail or mail order pharmacy for a 30-day supply.</p>	<p>\$100 per prescription at a retail or mail order pharmacy for a 30-day supply.</p>

Cost	2016 (this year)	2017 (next year)
	<p>\$200 per prescription at a retail or mail order pharmacy for up to a 60-day supply.</p>	<p>\$200 per prescription at a retail or mail order pharmacy for up to a 60-day supply.</p>
	<p>\$300 per prescription at a retail or mail order pharmacy for up to a 90-day supply.</p>	<p>\$300 per prescription at a retail or mail order pharmacy for up to a 90-day supply.</p>
<ul style="list-style-type: none"> • Drug Tier 5: 	<p>28% per prescription at a retail or mail order pharmacy for a 30-day supply.</p>	<ul style="list-style-type: none"> • Drug Tier 5: <p>28% per prescription at a retail or mail order pharmacy for a 30-day supply.</p>
	<p>28% per prescription at a retail or mail order pharmacy for up to a 60-day supply.</p>	<p>60-day and 90-day supplies are not covered for drugs on Tier 5.</p>
	<p>28% per prescription at a retail or mail order pharmacy for up to a 90-day supply.</p>	

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$120.30	\$125.00
Optional Supplemental Benefit: Delta Dental Option	\$53	\$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 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	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your 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 2017 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.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 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 2017 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 *2017 Evidence of Coverage*.

Cost	2016 (this year)	2017 (next year)
Ambulance services	You pay \$150 for Medicare-covered ambulance services per day.	You pay \$225 for Medicare-covered ambulance services per day.
Bathroom Safety Equipment	<p>You pay 10% coinsurance for the following bathroom safety equipment:</p> <ul style="list-style-type: none"> • Standard Raised Toilet Seat: 1 per member per lifetime • Standard Bathroom Grab Bars: Up to 2 per member per lifetime • Standard Tub Seat: 1 per member per lifetime 	<p>You pay 10% coinsurance for the following bathroom safety equipment:</p> <ul style="list-style-type: none"> • Standard Raised Toilet Seat: 1 per member every 5 years • Standard Bathroom Grab Bars: Up to 2 per member every 5 years • Standard Tub Seat: 1 per member every 5 years
Chiropractic services	<p>You pay \$15 for each Medicare-covered visit.</p> <p>We cover only manual manipulation of the spine to correct subluxation.</p> <p>Initial evaluation is not covered.</p>	<p>You pay \$15 for each Medicare-covered visit.</p> <p>We cover manual manipulation of the spine to correct subluxation.</p> <p>In addition, an initial evaluation is covered by Tufts Health Plan Medicare Preferred once every calendar year. You pay \$15 for the visit.</p>

Cost	2016 (this year)	2017 (next year)
Hearing Aid Allowance	Hearing aids are not covered.	Hearing aids are covered up to an allowance of \$500 every 3 years.
Home Health Agency Care	You pay \$0 for Medicare-covered home health care services, including home infusion therapy services.	<p>You pay \$0 for Medicare-covered home health care services, including home infusion therapy services (see physical therapy copay below).</p> <p>You pay \$20 for each physical therapy visit provided in the home.</p>
Inpatient hospital stays	You pay \$165 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 \$200 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	2016 (this year)	2017 (next year)
<p>Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p>	<p>You pay \$0 per day for Medicare-covered X-rays.</p> <p>You pay \$0 for Medicare-covered radiation therapy and Chemo therapy visits.</p> <p>You pay \$0 for Medicare-covered surgical supplies</p> <p>You pay \$0 per day for Medicare-covered laboratory tests.</p> <p>You pay \$0 for Medicare-covered blood services.</p> <p>You pay \$75 per day for Medicare-covered diagnostic radiology services.</p> <p>You pay \$0 per day for Medicare-covered tests.</p>	<p>You pay \$5 per day for Medicare-covered X-rays.</p> <p>You pay \$0 for Medicare-covered radiation therapy and Chemo therapy visits.</p> <p>You pay \$0 for Medicare-covered surgical supplies</p> <p>You pay \$5 per day for Medicare-covered laboratory tests.</p> <p>You pay \$0 for Medicare-covered blood services.</p> <p>You pay \$100 per day for Medicare-covered diagnostic radiology services.</p> <p>You pay \$5 per day for Medicare-covered tests</p>
<p>Outpatient Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p>	<p>You pay \$125 per day for outpatient procedures and services, including but not limited to diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital or ambulatory surgical center.</p>	<p>You pay \$150 per day for outpatient procedures and services, including but not limited to diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital or ambulatory surgical center.</p>
<p>Skilled Nursing Facility (SNF) care</p>	<p>For each admission, you pay \$30 per day for days 1-20 of a benefit period, \$60 per day for days 21-44 of a benefit period, and \$0 per day for days 45-100 of a benefit period.</p>	<p>For each admission, you pay \$20 per day for days 1-20 of a benefit period, \$100 per day for days 21-44 of a benefit period, and \$0 per day for days 45-100 of a benefit period.</p>

Cost	2016 (this year)	2017 (next year)
Wigs	Wigs are covered for members who experience hair loss due to treatment for cancer. Plan covers up to \$350 in a calendar year.	Wigs are covered for members who experience hair loss due to treatment for cancer. Plan covers up to \$500 in a calendar year.

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.” A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
 - 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 coverage of the plan year or coverage. (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 get “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	2016 (this year)	2017 (next year)
<p>Stage 1: Yearly Deductible Stage</p> <p>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.</p>	<p>The deductible is \$200.</p>	<p>The deductible is \$250.</p> <p>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.</p>

Changes to Your Cost-sharing in the Initial Coverage Stage

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

Stage	2016 (this year)	2017 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>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.</p> <p>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 <i>Evidence of Coverage</i>.</p> <p>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.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Tier 1: You pay \$4 per prescription.</p> <p>Tier 2: You pay \$8 per prescription.</p> <p>Tier 3: You pay \$47 per prescription.</p> <p>Tier 4: You pay \$100 per prescription</p> <p>Tier 5: You pay 28% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$3,310, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Tier 1: You pay \$4 per prescription.</p> <p>Tier 2: You pay \$8 per prescription.</p> <p>Tier 3: You pay \$47 per prescription.</p> <p>Tier 4: You pay \$100 per prescription</p> <p>Tier 5: You pay 28% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$3,700, you will move to the next stage (the Coverage Gap Stage).</p>

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 Other Changes

Cost	2016 (this year)	2017 (next year)
<p>Covering a Part D drug for you that is not on our <i>List of Covered Drugs (Formulary)</i></p>	<p>If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay:</p> <ul style="list-style-type: none"> • The cost-sharing amount that applies to drugs in Tier 3 for generic drugs • The cost-sharing amount that applies to drugs in Tier 4 for brand name drugs 	<p>If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay:</p> <ul style="list-style-type: none"> • The cost-sharing amount that applies to drugs in Tier 4 for generic drugs • The cost-sharing amount that applies to drugs in Tier 4 for brand name drugs

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Tufts Medicare Preferred HMO Value 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 2017.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR--* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2017*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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

As a reminder, 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 Value 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 Value 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, 2017.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

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 a.m. and 7 p.m., 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 Value 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 2017 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2017. For details, look in the 2017 *Evidence of Coverage* for Tufts Medicare Preferred HMO Value 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 (<http://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on “Find health & drug plans”).

Read *Medicare & You 2017*

You can read the *Medicare & You 2017* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048