

Fallon Medicare Plus Blue HMO (a Medicare HMO) offered by Fallon Community Health Plan (Fallon Health)

Annual Notice of Change for 2026

You're enrolled as a member of Fallon Medicare Plus Blue HMO.

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

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Fallon Medicare Plus Blue HMO.
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at fallonhealth.org/medicare or call Customer Service at 1-800-325-5669 (TTY users call TRS 711) to get a copy by mail.

More Resources

- Call Customer Service at 1-800-325-5669 (TTY users call TRS 711) for more information. Hours are 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31). This call is free.
- This information is available in alternate formats, such as braille, large print or audio.

About Fallon Medicare Plus Blue HMO

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

H9001_260023_M
25-670-026 Rev. 00 08/25

Table of Contents

Summary of Important Costs for 2026	3
SECTION 1 Changes to Benefits & Costs for Next Year	6
Section 1.1 Changes to the Monthly Plan Premium	6
Section 1.2 Changes to Your Maximum Out-of-Pocket Amount	6
Section 1.3 Changes to the Provider Network	7
Section 1.4 Changes to the Pharmacy Network	7
Section 1.5 Changes to Benefits & Costs for Medical Services	8
Section 1.6 Changes to Part D Drug Coverage	12
Section 1.7 Changes to Prescription Drug Benefits & Costs	13
SECTION 2 Administrative Changes	16
SECTION 3 How to Change Plans.....	17
Section 3.1 Deadlines for Changing Plans	17
Section 3.2 Are there other times of the year to make a change?	17
SECTION 4 Get Help Paying for Prescription Drugs	18
SECTION 5 Questions?	19
Get Help from Fallon Medicare Plus Blue HMO	19
Get Free Counseling about Medicare	20
Get Help from Medicare	20

Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	\$164	\$174
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered services. (Go to Section 1.2 for details.)	\$3,400	\$3,400
Primary care office visits	\$10 per in-office visit or \$0 per telehealth visit	\$10 per in-office visit or \$0 per telehealth visit
Specialist office visits	\$20 per in-office or telehealth visit	\$20 per in-office or telehealth visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	You pay a \$200 copayment for each inpatient hospital admission per benefit period. There is a \$400 maximum out-of-pocket limit every year for inpatient acute hospital care. There is a \$400 maximum out-of-pocket limit every year for inpatient rehabilitation hospital care.	You pay a \$200 copayment for each inpatient hospital admission per benefit period; this includes medical, surgical, detoxification and rehabilitation services. There is a \$400 maximum out-of-pocket limit every year for inpatient acute hospital care. There is a \$400 maximum out-of-

	2025 (this year)	2026 (next year)
<i>Inpatient hospital stays, continued</i>	There is no copayment for substance use disorder inpatient admissions when the primary reason is substance detoxification and/or rehabilitation.	pocket limit every year for inpatient rehabilitation hospital care. There is a \$400 maximum out-of-pocket limit every year for substance use disorder inpatient admissions when the primary reason is substance detoxification and/or rehabilitation.
Part D drug coverage deductible (Go to Section 1.7 for details.)	\$0	\$0
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: • \$0 copay for a 30-day supply • \$0 copay for a 60-day supply • \$0 copay for a 100-day supply Drug Tier 2 • \$7 copay for a 30-day supply • \$14 copay for a 60-day supply • \$21 copay for a 90-day supply	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: • \$0 copay for a 30-day supply • \$0 copay for a 60-day supply • \$0 copay for a 100-day supply Drug Tier 2 • \$7 copay for a 30-day supply • \$14 copay for a 60-day supply • \$21 copay for a 90-day supply

	2025 (this year)	2026 (next year)
<i>Part D drug coverage, continued</i>	Drug Tier 3 • \$42 copay for a 30-day supply • \$84 copay for a 60-day supply • \$126 copay for a 90-day supply • You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 4 • \$95 copay for a 30-day supply • \$190 copay for a 60-day supply • \$285 copay for a 90-day supply • You pay \$35 per month supply of each covered insulin product on this tier. Drug Tier 5 • 33% of the total cost for a 30-day supply Drug Tier 6 • \$0 copay for a 30-day supply Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	Drug Tier 3 • \$47 copay for a 30-day supply • \$94 copay for a 60-day supply • \$141 copay for a 90-day supply • You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 4 • 35% of the total cost for a 30-day supply • 35% of the total cost for a 60-day supply • 35% of the total cost for a 90-day supply • You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 5 • 33% of the total cost for a 30-day supply Drug Tier 6 • \$0 copay for a 30-day supply Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$164	\$174

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 1.7 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.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$3,400	\$3,400 Once you've paid \$3,400 out of pocket for covered services, you'll pay nothing for your covered services for the rest of the calendar year. There is no change to your maximum out-of-pocket amount for the upcoming benefit year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* fallonhealth.org/medicare 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 fallonhealth.org/medicare.
- Call Customer Service at 1-800-325-5669 (TTY users call TRS 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 Customer Service at 1-800-325-5669 (TTY users call TRS 711) for help. 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 of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* fallonhealth.org/medicare to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at fallonhealth.org/medicare.
- Call Customer Service at 1-800-325-5669 (TTY users call TRS 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 Customer Service at 1-800-325-5669 (TTY users call TRS 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Benefit Bank	You pay \$0 for covered Benefit Bank items and services up to the benefit maximum of \$500. You pay all costs over \$500, and once the Benefit Bank is exhausted, you will be responsible for the entire cost of items and services not otherwise covered.	You pay \$0 for covered Benefit Bank items and services up to the benefit maximum of \$250. You pay all costs over \$250, and once the Benefit Bank is exhausted, you will be responsible for the entire cost of items and services not otherwise covered.
Diabetes self-management training, diabetic services and supplies	Our preferred blood glucose monitors are OneTouch® glucose monitors and test strips (up to five test strips per day) manufactured by LifeScan.	Our preferred blood glucose monitors are Accu-Chek® glucose monitors and test strips (up to five test strips per day) manufactured by Roche. Plan members can obtain an Accu-Chek® glucose monitor at network pharmacies.

	2025 (this year)	2026 (next year)
Inpatient hospital care	You pay a \$200 a day copayment for each inpatient admission per benefit period; this includes medical, surgical, and rehabilitation services. There is a \$400 maximum out-of-pocket limit every year for inpatient acute hospital care. There is a \$400 maximum out-of-pocket limit every year for inpatient rehabilitation hospital care. There is no copayment for substance use disorder inpatient admissions when the primary reason is substance detoxification and/or rehabilitation.	You pay a \$200 a day copayment for each inpatient admission per benefit period; this includes medical, surgical, detoxification, and rehabilitation services. There is a \$400 maximum out-of-pocket limit every year for inpatient acute hospital care. There is a \$400 maximum out-of-pocket limit every year for inpatient rehabilitation hospital care. There is a \$400 maximum out-of-pocket limit every year for substance use disorder inpatient admissions when the primary reason is substance detoxification and/or rehabilitation.
Medicare Part B prescription drugs	Step Therapy is required for the following Part B prescription drugs: • Abraxane - Aloxi/Palonestrom (avyxa) • Asceniv/Alyglo/ Yimmugo • Avastin/Alymsys/ Vegzelma/Avzivi/ Bendamustine • Beovu	Step Therapy is required for the following Part B prescription drugs: • Abraxane • Actemra IV/Tofidence/tocilizuma b-anoh/ Avtozma Aloxi/Palonestrom (avyxa) • Asceniv/Alyglo/ Yimmugo

	2025 (this year)	2026 (next year)
Medicare Part B prescription drugs, continued	• Bortezomib • Cimerli • Durolane/Gel-One/ GelSyn3/GenVisc 850/Hyalgan/ Hymovis/ Monovisc/Orthovisc/ sodium hyaluronate/ Supartz/Supartz FX/Synojoynt/Trivisc/ VISCO-3/Triluron • Eylea/Eylea HD • Fusilev/Khapzory • Herceptin Hylecta • Herceptin/Ontruzant/ Herzuma/Ogivri/ Hercessi • HP Acthar • Lucentis/Byooviz • Macugen • Neupogen • Pemfexy • Procrit/Epogen (non- ESRD) • Prolia/Xgeva/Wgost/ Jubbonti • Remicade/Avsola/ Renflexis/infliximab • Releuko/Granix/ Nivestym • Rituxan Hyleca • Rituxan/Riabni/ Ruxience • Rolvedon • Ryzneuta • Soliris/Bkemv • Sustol • Susvimo • Treanda/Vivimusta	• Avastin/Alymsys/ Vegzelma/Avzivi/ Jobevne • Bendeka • Beovu • Bortezomib • Cimerli • Cinqair • Durolane/Gel-One/ GelSyn3/GenVisc 850/Hyalgan/Hymovis/ Monovisc/Orthovisc/ sodium hyaluronate/ Supartz/Supartz FX/Synojoynt/Trivisc/ VISCO-3/Triluron • Eylea/Eylea HD • Fusilev/Khapzory • Herceptin Hylecta • Herceptin/Ontruzant/ Herzuma/Ogivri/ Hercessi • HP Acthar • Lucentis/Byooviz • Macugen • Neupogen • Nypozi • Pavblu/Ahzantive/ Enzeevu • Pemfexy/Pemetrexed dipotassium/Pemrydi Piasky • Procrit/Epogen (non- ESRD) • Prolia/Xgeva/Wgost/ Jubbonti/Xbryk/ Ospomyv/ Osenvelt/Stobpclo/ Bomyntra/Conexxence

	2025 (this year)	2026 (next year)
Medicare Part B prescription drugs, continued	• Udenyca/Ziextenzo/Nyvepria/ Stimufend/ Fylnetra • Ultomiris • Vabysmo • Zilretta	• Remicade/Avsola/ Renflexis/infliximab • Releuko/Granix/ Nivestym • Rituxan Hyleca • Rituxan/Riabni/ Ruxience • Rolvedon • Ryzneuta • Soliris/Bkemv/Epysqli • Sustol • Susvimo • Treanda/Vivimusta • Udenyca/Ziextenzo/ Nyvepria/Stimufend/ Fylnetra • Ultomiris • Vabysmo • Zilretta
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a \$120 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility.	You pay a \$200 copayment for each Medicare-covered outpatient surgery in a hospital outpatient facility. You pay a \$175 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center.

	2025 (this year)	2026 (next year)
Physician/Practitioner services, including doctor's office visits	You pay a \$120 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility.	You pay a \$200 copayment for each Medicare-covered outpatient surgery in a hospital outpatient facility. You pay a \$175 copayment for each Medicare-covered outpatient surgery in an ambulatory surgical center.

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 Customer Service at 1-800-325-5669 (TTY users call TRS 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 does not apply to you.** We sent you 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 you don't get this material by September 30, 2025, call Customer Service at 1-800-325-5669 (TTY users call TRS 711) and ask for the *LIS Rider*.

Drug Payment Stages

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

- **Stage 1: Yearly Deductible**

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

- **Stage 2: Initial Coverage**

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

- **Stage 3: Catastrophic Coverage**

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

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

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

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

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 4, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026. The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy.

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 or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

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

	2025 (this year)	2026 (next year)
Tier 1 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.	\$0	\$0
Tier 2 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.	\$7	\$7

	2025 (this year)	2026 (next year)
Tier 3 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.	\$42 You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is \$42.	\$47 You pay no more than \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is \$47.
Tier 4 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.	\$95 You pay \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is \$95.	35% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 35% of the total cost.
Tier 5 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.	33% of the total cost Your cost for a one-month mail-order prescription is 33% of the total cost.	33% of the total cost Your cost for a one-month mail-order prescription is 33% of the total cost.
Tier 6	\$0	\$0

Changes to the Catastrophic Coverage Stage

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

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-844-368-8729 (TTY users call TRS 711) or visit www.Medicare.gov.
Chapter 9, Section 6.2 Asking for an exception	1. Covering a Part D drug for you that is not on our Drug List. If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 for brand name drugs or Tier 2 for generic drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.	1. Covering a Part D drug that's not on our Drug List. If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to Tier 4 for all our drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.

SECTION 3 How to Change Plans

To stay in Fallon Medicare Plus Blue HMO, you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Fallon Medicare Plus Blue HMO.

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

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Fallon Medicare Plus Blue HMO.
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Fallon Medicare Plus Blue HMO.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at 1-800-325-5669 (TTY users call TRS 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Fallon Community Health Plan (Fallon Health) offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

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

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

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

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

- Have Medicaid

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

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

SECTION 4 Get Help Paying for Prescription Drugs

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

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
 - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
 - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** Massachusetts has a program called Prescription Advantage that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit 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 Massachusetts HIV Drug Assistance Program (HDAP), which is administered by the Community Resource Initiative. HDAP helps eligible state residents living with HIV to pay for medications and health

insurance. 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 1-800-228-2714 or visit <https://crihealth.org/drug-assistance/hdap/>. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-800-325-5669 (TTY users call TRS 711 or visit www.Medicare.gov).

SECTION 5 Questions?

Get Help from Fallon Medicare Plus Blue HMO

- **Call Customer Service at 1-800-325-5669. (TTY users call TRS 711.)**

We're available for phone calls 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31). Calls to these numbers are free.

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

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Fallon Medicare Plus Blue 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 fallonhealth.org/medicare or call Customer Service at 1-800-325-5669 (TTY users call TRS 711) to ask us to mail you a copy.

- **Visit fallonhealth.org/medicare**

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 the Serving the Health Insurance Needs of Everyone (SHINE) Program.

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 (TTY users can call TRS 711, TTY/ASCI 1-800 439-2370). Learn more about SHINE by visiting www.mass.gov/info-details/serving-the-health-insurance-needs-of-everyone-shine-program.

Get Help from Medicare

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

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

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

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

- **Write to Medicare**

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

- **Visit www.Medicare.gov**

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

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

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