

Mass General Brigham Advantage Secure (HMO-POS) offered by Mass General Brigham Health Plan

Annual Notice of Change for 2027

You're enrolled as a member of Mass General Brigham Advantage Secure (HMO-POS).

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

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in Mass General Brigham Advantage Secure (HMO-POS).
- To change to a **different plan**, visit [Medicare.gov](https://www.Medicare.gov) or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [MGBAdvantage.org](https://www.MGBAdvantage.org) or call Customer Service at 1-855-833-3668 (TTY users call 711) to get a copy by mail.

More Resources

- Call Customer Service at 1-855-833-3668. (TTY users call 711) for more information. Hours are October 1 through March 31, seven days a week from 8:00 am – 8:00 pm EST and April 1 through September 30, Monday through Friday 8:00 am – 8:00 pm EST. This call is free.
- This document is also available in braille and large print. Please contact Customer Service at the number above for more information.

About Mass General Brigham Advantage Secure (HMO-POS)

- Mass General Brigham Health Plan is an HMO-POS organization with a Medicare contract. Enrollment in Mass General Brigham Health Plan depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means Mass General Brigham Health Plan. When it says “plan” or “our plan,” it means Mass General Brigham Advantage Secure (HMO-POS).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in** Mass General Brigham Advantage Secure (HMO-POS). Starting January 1, 2027, you'll get

your medical and drug coverage through Mass General Brigham Advantage Secure (HMO-POS). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Table of Contents

Summary of Important Costs for 2027	4
SECTION 1 Changes to Benefits & Costs for Next Year	7
Section 1.1 Changes to the Monthly Plan Premium	7
Section 1.2 Changes to Your Maximum Out-of-Pocket Amount	7
Section 1.3 Changes to the Provider Network	8
Section 1.4 Changes to the Pharmacy Network.....	8
Section 1.5 Changes to Benefits & Costs for Medical Services	9
Section 1.6 Changes to Part D Drug Coverage	38
Section 1.7 Changes to Prescription Drug Benefits & Costs	39
SECTION 2 Administrative Changes	41
SECTION 3 How to Change Plans.....	42
Section 3.1 Deadlines for Changing Plans.....	42
Section 3.2 Are there other times of the year to make a change?	43
SECTION 4 Get Help Paying for Prescription Drugs	43
SECTION 5 Questions?	44
Get Help from Mass General Brigham Advantage Secure (HMO-POS)	44
Get Free Counseling about Medicare	45
Get Help from Medicare	45

Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	\$62	\$60
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: \$3,350 From network and out-of-network providers combined: \$7,000	From network providers: \$5,000 From network and out-of-network providers combined: \$5,000
Primary care office visits	In-Network \$0 Copayment per visit Out-of-Network \$20 Copayment per visit	In-Network \$0 Copayment per visit Out-of-Network \$30 Copayment per visit
Specialist office visits	In-Network \$45 Copayment per visit Out-of-Network \$50 Copayment per visit	In-Network \$45 Copayment per visit Out-of-Network \$60 Copayment per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient	In-Network For each admission, you pay \$250 Copayment per day for days 1-5.	In-Network For each admission, you pay \$275 Copayment per day for days 1-5.

	2026 (this year)	2027 (next year)
hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	\$0 Copayment per day for days 6 and beyond. Out-of-Network For each admission, you pay 30% Coinsurance per stay	\$0 Copayment per day for days 6 and beyond. Out-of-Network Not Covered.
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible \$350 tiers 3, 4 and 5 except for covered insulin products and most adult Part D vaccines. Deductible is not applicable on tiers 1 and 2. Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: \$0 Drug Tier 2: \$5 Drug Tier 3: \$47 You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 4: 25% You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 5: 29% You pay no more than \$35 per month supply of each covered insulin product on this tier.	Part D drug coverage deductible \$700 tiers 3, 4 and 5 except for covered insulin products and most adult Part D vaccines. Deductible is not applicable on tiers 1 and 2. Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: \$0 Drug Tier 2: \$5 Drug Tier 3: 17% You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 4: 22% You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 5: 25% You pay no more than \$35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs. You can have cost sharing for drugs that are covered under our enhanced benefit.	insulin product on this tier. Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs. You can have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2026 (this year)	2027 (next year)
Monthly plan premium	\$62	\$60
(You must also continue to pay your Medicare Part B premium.)		

Factors that could change your Part D Premium Amount

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

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

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

	2026 (this year)	2027 (next year)
Maximum out-of-pocket amount	\$3,350	\$5,000
Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket		Once you've paid \$5,000 out-of-pocket for covered Part A and Part B services you'll pay nothing for your covered Part A and B

	2026 (this year)	2027 (next year)
amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.		services for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider Directory* MGBAdvantage.org to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at MGBAdvantage.org.
- Call Customer Service at 1-855-833-3668 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at 1-855-833-3668 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network.

For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2027 *Pharmacy Directory* MGBAdvantage.org to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at MGBAdvantage.org.
- Call Customer Service at 1-855-833-3668 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-855-833-3668 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2026 (this year)	2027 (next year)
Abdominal Aortic Aneurysm Screening	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Abdominal Aortic Aneurysm Screening.
Acupuncture for chronic low back pain	In-Network: You pay a \$45 copayment for each visit for Medicare-covered services. Out-of-Network: You pay a \$50 copayment for each visit for Medicare-covered services.	In-Network: You pay a \$45 copayment for each visit for Medicare-covered services. Out-of-Network: You pay a \$60 copayment for each visit for Medicare-covered services.

	2026 (this year)	2027 (next year)
Ambulance Services - Air and Ground Ambulance	In-Network: You pay \$300 copayment for each one-way trip for Medicare-covered air and ground ambulance. Out-of-Network: You pay \$300 copayment for each one-way trip for Medicare-covered air and ground ambulance.	In-Network: You pay \$300 copayment for each one-way trip for Medicare-covered air and ground ambulance. Out-of-Network: Non-emergency ambulance services not covered.
Annual Physical Exam	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$20 copayment for Annual Physical Exam.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Annual Physical Exam.
Annual Wellness Visit	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Annual Wellness Visit.
Bone Mass Measurement	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Bone Mass Measurement.

	2026 (this year)	2027 (next year)
Breast Cancer Screening (mammograms)	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Breast Cancer Screening (mammograms).
Cardiac Rehabilitation Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay \$10 copayment for Cardiac Rehabilitation Services. Out-of-Network: Not covered.
Cardiovascular Disease Risk Reduction Visit (Therapy For Cardiovascular Disease)	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Cardiovascular Disease Risk Reduction Visit (Therapy For Cardiovascular Disease).
Cardiovascular Disease Screening Tests	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Cardiovascular Disease Screening Tests.

	2026 (this year)	2027 (next year)
Cervical And Vaginal Cancer Screening	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Cervical And Vaginal Cancer Screening.
Chiropractic Services	In-Network: You pay \$15 copayment for Medicare-covered Chiropractic Services. Out-of-Network: You pay \$50 copayment for Medicare-covered Chiropractic Services.	In-Network: You pay \$15 copayment for Medicare-covered Chiropractic Services. Out-of-Network: Not covered.
Colorectal Cancer Screening	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Colorectal Cancer Screening.

Dental Services**In-Network:**

Medicare-Covered Exam:
You pay \$45 copayment

Diagnostic and Preventive Services: You pay nothing for covered services when using a DentaQuest provider.

Comprehensive Dental Services: You pay nothing for covered services when using a DentaQuest provider.

Out-of-Network:

Medicare-Covered Exam:
You pay \$50 copayment

Diagnostic and Preventive Services: You pay \$0 copayment and the difference between billed and allowed amount for covered services when using a non-DentaQuest provider.

Comprehensive Dental Services: You pay 20% of the total cost and the difference between the billed amount and allowed amount for covered services when using a non-DentaQuest provider.

In-Network and Out-of-Network:

Annual maximum of \$2000 for comprehensive in network and out of network combined dental services.

In-Network:

Medicare-Covered Exam:
You pay \$45 copayment

Diagnostic and Preventive Services: You pay nothing for covered services when using a DentaQuest provider.

Comprehensive Dental Services: You pay nothing for covered services when using a DentaQuest provider.

Out-of-Network:

Medicare-Covered Exam:
Not Covered

Diagnostic and Preventive Services: You pay 50% of the total cost and the difference between billed and allowed amount for covered services when using a non-DentaQuest provider.

Comprehensive Dental Services: You pay 50% of the total cost and the difference between the billed amount and allowed amount for covered services when using a non-DentaQuest provider.

In-Network and Out-of-Network:

Annual maximum of \$800 for comprehensive in network and out of

	2026 (this year)	2027 (next year)
		network combined dental services.
Depression Screening	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Depression Screening
Diabetes Screening	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Diabetes Screening.

	2026 (this year)	2027 (next year)
Diabetes self-management training, diabetic services, and supplies	In-Network: Diabetic Supplies & Service including Monitors: You pay nothing for this benefit. Diabetes Self-Management Training: You pay nothing for this benefit. Diabetic Therapeutic Shoes or Inserts: You pay a 20% of the total cost for Medicare-covered Diabetic Therapeutic Shoes or Inserts. Out-of-Network: Diabetic Supplies & Service including Monitors: You pay a 20% of the total cost for diabetic supplies and services including Medicare-covered monitors. Diabetes Self-Management Training: You pay nothing for this benefit. Diabetic Therapeutic Shoes or Inserts: You pay a 20% of the total cost for Medicare-covered Diabetic Therapeutic Shoes or Inserts.	In-Network: Diabetic Supplies & Service including Monitors: You pay nothing for this benefit. Diabetes Self-Management Training: You pay nothing for this benefit. Diabetic Therapeutic Shoes or Inserts: You pay a 20% of the total cost for Medicare-covered Diabetic Therapeutic Shoes or Inserts. Out-of-Network: Diabetic Supplies & Service including Monitors: Not Covered. Diabetes Self-Management Training: You pay \$30 copayment. Diabetic Therapeutic Shoes or Inserts: Not Covered

	2026 (this year)	2027 (next year)
Diagnostic Procedures Tests	In-Network: You pay \$20 copayment for Medicare-covered Diagnostic Procedures Tests, including technician materials and supplies. Out-of-Network: You pay 20% of the total cost for Medicare-covered Diagnostic Procedures Tests, including technician materials and supplies.	In-Network: You pay \$20 copayment for Medicare-covered Diagnostic Procedures Tests, including technician materials and supplies. Out-of-Network: You pay \$25 copayment for Medicare-covered Diagnostic Procedures Tests, including technician materials and supplies.
Diagnostic Radiological Services	In-Network: You pay a \$75 - \$160 copayment for Medicare-covered Diagnostic Radiological Services, including technician materials and supplies. Out-of-Network: You pay 20% of the total cost of the total cost for Medicare-covered Diagnostic Radiological Services, including technician materials and supplies.	In-Network: You pay a \$75 - \$200 copayment for Medicare-covered Diagnostic Radiological Services, including technician materials and supplies. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Durable Medical Equipment (DME) and related supplies	In-Network: You pay a 20% of the total cost for Durable Medical Equipment (DME) and related supplies. You pay 20% of the total cost for Medicare oxygen equipment coverage every month. Out-of-Network: You pay a 20% of the total cost for Durable Medical Equipment (DME) and related supplies. You pay 20% of the total cost for Medicare oxygen equipment coverage every month.	In-Network: You pay a 20% of the total cost for Durable Medical Equipment (DME) and related supplies. You pay 20% of the total cost for Medicare oxygen equipment coverage every month. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Health and wellness education programs	In-Network and Out-of-Network: This plan covers \$450 in a calendar year for a combined Wellness Benefit which includes eligible fitness programs, home fitness equipment, weight loss programs or costs towards your prescription hearing aids. Activity and fitness trackers, such as Fitbit® and other wearable fitness tracking devices, are covered under this benefit. Weight loss and weight management programs, including but not limited to commercial, online, app-based, virtual, and in-person programs, are covered under this benefit.	In-Network and Out-of-Network: This plan covers \$160 in a calendar year for a combined Wellness Benefit which includes eligible fitness programs, home fitness equipment or costs towards your prescription hearing aids. Activity and fitness trackers, such as Fitbit® and other wearable fitness tracking devices, are not covered under this benefit. Weight loss and weight management programs, including but not limited to commercial, online, app-based, virtual, and in-person programs, are not covered under this benefit.
Hearing Services	In-Network: You pay \$45 copayment for Medicare-covered Hearing Exams. Out-of-Network: You pay \$50 copayment for Medicare-covered Hearing Exams.	In-Network: You pay \$45 copayment for Medicare-covered Hearing Exams. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
HIV Screening	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for HIV Screening.
Home Health Agency Care	In-Network: You pay nothing for this benefit. Out-of-Network: You pay a 30% of the total cost for Medicare-covered Home Health Services.	In-Network: You pay nothing for this benefit. Out-of-Network: Not covered.
Home Infusion Therapy	In-Network: You pay 0 - 20% coinsurance for home infusion therapy. You pay \$0 copayment for Part B Prescription Drug Administration in the home setting. Out-of-Network: You pay 20% coinsurance for home infusion therapy. You pay \$0 copayment for Part B Prescription Drug Administration in the home setting.	In-Network: You pay 0 - 20% coinsurance for home infusion therapy. You pay \$0 copayment for Part B Prescription Drug Administration in the home setting. Out-of-Network: Not Covered.

	2026 (this year)	2027 (next year)
Immunizations	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Immunizations.
Inpatient Hospital Care	In-Network: You pay a \$250 copayment each day for days 1-5. You pay a \$0 copayment each day for days 6-90. Out-of-Network: Out-of-Network: For each admission you pay 30% of the total cost per stay.	In-Network: You pay a \$275 copayment each day for days 1-5. You pay a \$0 copayment each day for days 6-90. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Inpatient Services in a Psychiatric Hospital	In-Network: In a psychiatric unit at a general hospital, you pay a \$250 copayment each day for days 1-5. You pay \$0 copayment for days 6 and beyond. In a free-standing psychiatric hospital, you pay a \$250 copayment each day for days 1 - 5. You pay \$0 copayment each day for days 6 and beyond. Out-of-Network: For each admission you pay 30% of the total cost per stay.	In-Network: In a psychiatric unit at a general hospital, you pay a \$275 copayment each day for days 1-5. You pay \$0 copayment for days 6 and beyond. In a free-standing psychiatric hospital, you pay a \$275 copayment each day for days 1 - 5. You pay \$0 copayment each day for days 6 and beyond. Out-of-Network: Not covered.
Intensive Outpatient Program (IOP)	In-Network: You pay \$40 copayment for Intensive Outpatient Program (IOP). Out-of-Network: You pay a 30% of the total cost for Intensive Outpatient Program (IOP).	In-Network: You pay \$55 copayment for Intensive Outpatient Program (IOP). Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Laboratory Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay a 20% of the total cost for Medicare-covered Laboratory Services.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$25 copayment for Medicare-covered Laboratory Services.
Meals Program - Post Hospitalization	You pay nothing for this benefit.	Not covered.
Medical Nutrition Therapy	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Medical Nutrition Therapy.
Medical Supplies	In-Network: You pay a 20% of the total cost for Medical Supplies. Out-of-Network: You pay a 20% of the total cost for Medical Supplies.	In-Network: You pay a 20% of the total cost for Medical supplies. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Medicare Diabetes Prevention Program (MDPP)	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Medicare Diabetes Prevention Program (MDPP).
Medicare Part B Prescription Drugs	In-Network: You pay 20% of the total cost unless the Part B drug is listed as rebate-eligible, resulting in a lower coinsurance. You pay up to \$35 copayment for one-month supply for Medicare Part B Insulin Drugs. Out-of-Network: You pay a 20% of the total cost for Medicare Part B Prescription Drugs. You pay \$35 copayment for Medicare Part B Prescription Drugs.	In-Network: You pay 20% of the total cost unless the Part B drug is listed as rebate-eligible, resulting in a lower coinsurance. You pay up to \$35 copayment for one-month supply for Medicare Part B Insulin Drugs. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Medicare-covered Digital Rectal Exams	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Medicare-covered Digital Rectal Exams.
Medicare-covered EKG following Welcome Visit	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Medicare-covered EKG following Welcome Visit.
Obesity Screening And Therapy To Promote Sustained Weight Loss	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Obesity Screening And Therapy To Promote Sustained Weight Loss.

	2026 (this year)	2027 (next year)
Occupational Therapy Services	In-Network: You pay \$15 copayment for Occupational Therapy Services. Out-of-Network: You pay \$50 copayment for Occupational Therapy Services.	In-Network: You pay \$25 copayment for Occupational Therapy Services. Out-of-Network: Not covered.
Opioid Treatment Program Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$50 copayment for Opioid Treatment Services.	In-Network: You pay nothing for this benefit. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Other Health Care Professional Services	In-Network: You pay \$0 copayment for other health providers, such as physician assistants, nurse practitioners, or social workers in a primary care setting. You pay \$45 copayment for health providers, such as physician assistants, nurse practitioners, or social workers in a specialist setting. Out-of-Network: You pay \$20 copayment for other health providers, such as physician assistants, nurse practitioners, or social workers in an office setting. You pay \$50 copayment for other health providers, such as physician assistants, nurse practitioners, or social workers in a specialist setting.	In-Network: You pay \$0 copayment for other health providers, such as physician assistants, nurse practitioners, or social workers in a primary care setting. You pay \$45 copayment for other health providers, such as physician assistants, nurse practitioners, or social workers in a specialist setting. Out-of-Network: You pay \$30 copayment for other health providers, such as physician assistants, nurse practitioners, or social workers in a primary care setting. You pay \$60 copayment for other health providers, such as physician assistants, nurse practitioners, or social workers in a specialist setting.
Outpatient Blood Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Outpatient hospital observation	In-Network: You pay nothing for this benefit. Out-of-Network: You pay a 30% of the total cost for Outpatient hospital observation.	In-Network: You pay \$300 copayment per stay for Outpatient hospital observation. Out-of-Network: Not covered.
Outpatient Mental Health Care - Psychiatric Services	In-Network: You pay \$20 copayment for each individual or group therapy visit (including telehealth) for psychiatrist. Out-of-Network: You pay \$50 copayment for each individual or group therapy visit (including telehealth) for psychiatrist.	In-Network: You pay \$20 copayment for each individual or group therapy visit (including telehealth) for psychiatrist. Out-of-Network: You pay \$60 copayment for each individual or group therapy visit (including telehealth) for psychiatrist.
Outpatient Mental Health Services	In-Network: You pay \$20 copayment for each individual or group therapy visit for Outpatient Mental Health Services. Out-of-Network: You pay \$50 copayment for each individual or group therapy visit for Outpatient Mental Health Services.	In-Network: You pay \$20 copayment for each individual or group therapy visit for Outpatient Mental Health Services. Out-of-Network: You pay \$60 copayment for each individual or group therapy visit for Outpatient Mental Health Services.

	2026 (this year)	2027 (next year)
Outpatient substance use disorder services	In-Network: You pay \$20 copayment for each individual or group therapy visit for outpatient substance use disorder services. Out-of-Network: You pay \$50 copayment for each individual or group therapy visit for outpatient substance use disorder services.	In-Network: You pay \$20 copayment for each individual or group therapy visit for outpatient substance use disorder services. Out-of-Network: You pay \$60 copayment for each individual or group therapy visit for outpatient substance use disorder services.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	In-Network: You pay \$0 - \$200 copayment for Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers. Out-of-Network: You pay a 30% of the total cost for Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.	In-Network: You pay \$0 - \$300 copayment for Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Over-the-counter (OTC) drugs and supplies	Our plan covers up to \$95 per calendar quarter for OTC drugs and supplies using your Flexible Benefit Card at a participating physical retail location (brick-and-mortar) where Mastercard is accepted or ordering through Convey Health Solutions. Unused balances at the end of the quarter cannot be carried over to the next quarter. If your order total exceeds your quarterly amount, you may use a credit card to pay the remaining balance.	Our plan covers up to \$30 per calendar quarter for OTC drugs and supplies using your Flexible Benefit Card at a participating physical retail location (brick-and-mortar) where Mastercard is accepted or ordering through Convey Health Solutions. Unused balances at the end of the quarter cannot be carried over to the next quarter. If your order total exceeds your quarterly amount, you may use a credit card to pay the remaining balance.
Partial Hospitalization Services	In-Network: You pay \$40 copayment for Partial Hospitalization Services. Out-of-Network: You pay a 30% of the total cost for Partial Hospitalization Services.	In-Network: You pay \$55 copayment for Partial Hospitalization Services. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Physical Therapy and Speech Therapy Services	In-Network: You pay \$15 copayment for Physical Therapy and Speech Therapy Services. Out-of-Network: You pay \$50 copayment for Physical Therapy and Speech Therapy Services.	In-Network: You pay \$25 copayment for Physical Therapy and Speech Therapy Services. Out-of-Network: Not covered.
Physician Specialist Services	In-Network: You pay \$45 copayment for Physician Specialist Services. Out-of-Network: You pay \$50 copayment for Physician Specialist Services.	In-Network: You pay \$45 copayment for Physician Specialist Services. Out-of-Network: You pay \$60 copayment for Physician Specialist Services.
Physician Specialist Services - Referrals	You do not need a referral from your Primary Care Physician (PCP) to see a specialist.	A referral from your Primary Care Physician (PCP) will be required for visits to certain specialists. For more information, view Chapter 3 Section 2.2 of the Evidence of Coverage.

	2026 (this year)	2027 (next year)
Podiatry Services	In-Network: You pay \$30 copayment for Podiatry Services. Out-of-Network: You pay \$50 copayment for Podiatry Services.	In-Network: You pay \$30 copayment for Podiatry Services. Out-of-Network: Not covered.
Pre-Exposure Prophylaxis (PrER) For HIV Prevention	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Pre-Exposure Prophylaxis (PrER) For HIV Prevention.
Primary Care Physician (PCP) Selections	You are not required to select a Primary Care Physician (PCP).	You must select a Primary Care Physician (PCP). Your PCP will help coordinate your care.
Primary Care Physician (PCP) Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$20 copayment for Primary Care Physician (PCP) Services.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Primary Care Physician (PCP) Services.

	2026 (this year)	2027 (next year)
Prostate Cancer Screening Exams	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Prostate Cancer Screening Exams.
Prosthetic and Orthotic Devices and Related Supplies	In-Network: You pay a 20% of the total cost for Prosthetic and Orthotic Devices and Related Supplies. Out-of-Network: You pay a 20% of the total cost for Prosthetic and Orthotic Devices and Related Supplies.	In-Network: You pay a 20% of the total cost for Prosthetic and Orthotic Devices and Related Supplies. Out-of-Network: Not covered.
Pulmonary Rehabilitation Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay \$10 copayment for Pulmonary Rehabilitation Services. Out-of-Network: Not covered.
Radiation Therapy	In-Network: \$60 copayment for radiation therapy. Out-of-Network: 20% coinsurance for radiation therapy.	In-Network: \$60 copayment for radiation therapy. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Screening And Counseling To Reduce Alcohol Misuse	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Screening And Counseling To Reduce Alcohol Misuse.
Screening For Hepatitis C Virus Infection	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Screening For Hepatitis C Virus Infection.
Screening For Lung Cancer With Low Dose Computed Tomography (LDCT)	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Screening For Lung Cancer With Low Dose Computed Tomography (LDCT).

	2026 (this year)	2027 (next year)
Screening For Sexually Transmitted Infections (STI) And Counseling To Prevent STIs	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Screening For Sexually Transmitted Infections (STI) And Counseling To Prevent STIs.
Services to treat kidney disease - Dialysis Services	In-Network: You pay a 20% of the total cost for outpatient dialysis services. Out-of-Network: You pay a 20% of the total cost for outpatient dialysis services.	In-Network: You pay a 20% of the total cost for outpatient dialysis services. Out-of-Network: Not covered.
Services to treat kidney disease - Education Services	In-Network: You pay a \$0 copayment for kidney disease education services. Out-of-Network: You pay a \$0 copayment for kidney disease education services.	In-Network: You pay a \$0 copayment for kidney disease education services. Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Skilled Nursing Facility (SNF)	In-Network: You pay a \$0 copayment each day for days 1-20. You pay a \$160 copayment each day for days 21-44. \$0 copayment per day for days 45-100. Out-of-Network: For each admission you pay 30% of the total cost of the total cost.	In-Network: You pay a \$0 copayment each day for days 1-20. You pay a \$160 copayment each day for days 21-44. \$0 copayment per day for days 45-100. Out-of-Network: Not covered.
Smoking And Tobacco Use Cessation (Counseling To Stop Smoking Or Tobacco Use)	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Smoking And Tobacco Use Cessation (Counseling To Stop Smoking Or Tobacco Use).
Supervised Exercise Therapy (SET)	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay \$10 copayment for Supervised Exercise Therapy (SET). Out-of-Network: Not covered.

	2026 (this year)	2027 (next year)
Therapeutic Radiological Services	In-Network: You pay \$60 copayment for Therapeutic Radiological Services. Out-of-Network: You pay a 20% of the total cost for Therapeutic Radiological Services.	In-Network: You pay \$60 copayment for Therapeutic Radiological Services. Out-of-Network: Not covered.
Transportation to Medical Visits	\$120 per calendar quarter allowance to non-emergent transportation to medical appointments and to pick up prescriptions from the pharmacy. Transportation includes but not limited to taxis, public transportation, rideshare and ferry boats.	\$75 per calendar quarter allowance to non-emergent transportation to medical appointments and to pick up prescriptions from the pharmacy. Transportation includes but not limited to taxis, public transportation, rideshare and ferry boats.

	2026 (this year)	2027 (next year)
Vision Care	In-Network: You pay \$45 copayment for Medicare-covered eye exam. Medicare-covered standard eyeglasses or contact lenses after cataract surgery: You pay nothing. Routine Eye Exam through EyeMed provider: you pay \$0 copay. Prescription eyewear (contact or eyeglasses) with EyeMed: \$250 per calendar allowance. Out-of-Network: You pay \$50 copayment for Medicare-covered eye exam. Medicare-covered standard eyeglasses or contact lenses after cataract surgery: You pay \$50 copayment. Routine Eye Exam: \$40 reimbursement through EyeMed. Prescription eyewear (contact or eyeglasses) with EyeMed: \$250 per calendar allowance.	In-Network: You pay \$45 copayment for Medicare-covered eye exam. Medicare-covered standard eyeglasses or contact lenses after cataract surgery: You pay nothing. Routine Eye Exam through EyeMed provider: you pay \$0 copay. Prescription Eyewear (contact lenses or eyeglasses) with EyeMed: \$200 per calendar allowance. Out-of-Network: Medicare-covered eye exam: Not Covered. Medicare-covered standard eyeglasses or contact lenses after cataract surgery: Not Covered. Routine Eye Exam (\$40 reimbursement through EyeMed): Not Covered. Prescription Eyewear (contact lenses or eyeglasses) with EyeMed: Not Covered.

	2026 (this year)	2027 (next year)
Vision Care - Medicare-covered Glaucoma	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Medicare-covered Glaucoma screening.
Welcome To Medicare Preventive Visit	In-Network: You pay nothing for this benefit. Out-of-Network: You pay nothing for this benefit.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay \$30 copayment for Welcome To Medicare Preventive Visit.
X-Ray Services	In-Network: You pay \$10 copayment for X-Ray Services. Out-of-Network: You pay a 20% of the total cost for X-Ray Services.	In-Network: You pay \$30 copayment for X-Ray Services. Out-of-Network: Not covered.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically AND posted online at <http://mgbadvantage.org/plans/rx-information>.

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 1-855-833-3668 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

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

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We 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, 2027, call Customer Service at 1-855-833-3668 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- **Stage 1: Yearly Deductible**

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

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach \$2,400.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit. You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2026 (this year)	2027 (next year)
Yearly Deductible	\$350	\$700
	During this stage, you pay \$0 cost-sharing for a 30-day supply of drugs on Tier 1, \$5 cost-sharing for a 30-day supply of drugs on Tier 2, and the full cost of drugs on Tiers 3-5 until you've reached the yearly deductible.	During this stage, you pay \$0 cost-sharing for a 30-day supply of drugs on Tier 1, \$5 cost-sharing for a 30-day supply of drugs on Tier 2, and the full cost of drugs on Tiers 3-5 until you've reached the yearly deductible.

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

	2026 (this year)	2027 (next year)
Tier 1 – Preferred Generic Drugs:	You pay \$0 per prescription.	You pay \$0 per prescription.
Tier 2 – Generic Drugs:	You pay \$5 per prescription.	You pay \$5 per prescription.
Tier 3 – Preferred Brand Drugs:	You pay \$47 per prescription.	You pay 17% of the total cost.
Tier 4 – Non-Preferred Drug Drugs:	You pay 25% of the total cost.	You pay 22% of the total cost.
Tier 5 – Specialty Tier Drugs:	You pay 29% of the total cost.	You pay 25% of the total cost.

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Complaints, Appeals, and Grievance on Medical Care Contact Information	Fax number: 617-526-1980 Email address: HealthPlanAppealsGrievance@mgb.org	Fax number: 617-526-1923 Email address: HealthPlanDSNPMAAppealsGrievances@mgb.org
Member Portal	Member.MassGeneralBrighamHealthPlan.org	Member.MGBHP.org

SECTION 3 How to Change Plans

To stay in Mass General Brigham Advantage Secure (HMO-POS), you don't need to do anything. Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Mass General Brigham Advantage Secure (HMO-POS).

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Mass General Brigham Advantage Secure. Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with Medicare separate drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from Mass General Brigham Advantage Secure.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll or visit our website to disenroll online at MGBAdvantage.org. Call Customer Service at 1-855-833-3668 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 3.2).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit [Medicare.gov](https://www.Medicare.gov), check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Mass General Brigham Health Plan offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

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

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without separate Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

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

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

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

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

SECTION 4 Get Help Paying for Prescription Drugs

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

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

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Massachusetts HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-800-228-2714. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-855-833-3668 (TTY users call 711) or visit [Medicare.gov](https://www.Medicare.gov).

SECTION 5 Questions?

Get Help from Mass General Brigham Advantage Secure (HMO-POS)

- **Call Customer Service at 1-855-833-3668 (TTY users call 711).**

We're available for phone calls October 1 through March 31, seven days a week from 8:00 am – 8:00 pm EST and April 1 through September 30, Monday through Friday from 8:00 am – 8:00 pm EST. This call is free.

- **Read your 2027 Evidence of Coverage**

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for Mass General Brigham Advantage Secure (HMO-POS). 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 MGBAdvantage.org or call Customer Service at 1-855-833-3668 (TTY users call 711) to ask us to mail you a copy.

- **Visit MGBAdvantage.org**

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

Get Free Counseling about Medicare

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

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

Get Help from Medicare

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

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

- **Chat live with [Medicare.gov](https://www.Medicare.gov)**

You can chat live at [Medicare.gov/talk-to-someone](https://www.Medicare.gov/talk-to-someone).

- **Write to Medicare**

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

- **Visit [Medicare.gov](https://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 2027***

The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most

frequently asked questions about Medicare. Get a copy at [Medicare.gov](https://www.Medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.