

WellSense Choice (HMO) offered by Boston Medical Center Health Plan, Inc., d/b/a WellSense Health Plan

Annual Notice of Change for 2026

You're enrolled as a member of WellSense Choice (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 WellSense Choice (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 wellsense.org/yourmedicare or call Member Service at 855-833-8128 (TTY users call 711) to get a copy by mail. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.

More Resources

- We can provide this information to you in braille, large print, other alternative formats, including audio, at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you.
- Call Member Service at 855-833-8128 (TTY users call 711) for more information. Hours are Monday – Friday, 8 a.m. – 8 p.m. (Representatives are available 7 days a week, 8 a.m. – 8 p.m. from October 1 – March 31). This call is free.
- Member Service also has free language interpreter services available.

About WellSense Choice (HMO)

- WellSense Health Plan is an HMO plan with a Medicare contract. Enrollment in WellSense Medicare Advantage HMO plans depends on contract renewal.
- When this material says "we," "us," or "our," it means WellSense Health Plan. When it says "plan" or "our plan," it means WellSense Choice (HMO).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in WellSense Choice (HMO).** Starting January 1, 2026, you'll get your medical and

drug coverage through WellSense Choice (HMO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1 for details.	\$29	\$13.90
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 for details.)	\$3,900	\$4,200
Primary care office visits	\$0 copayment per visit	\$0 copayment per visit
Specialist office visits	\$20 copayment per visit	\$35 copayment per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a	\$395 copayment per day for days 1-6 \$0 copayment per day for days 7-90	\$450 copayment per day for days 1-7 \$0 copayment per day for days 8-90

	2025 (this year)	2026 (next year)
doctor's order. The day before you're discharged is your last inpatient day.		
Part D drug coverage deductible (Go to Section 1 for details.)	\$0	\$495, except for covered insulin products and most adult Part D vaccines
Part D drug coverage (Go to Section 1 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	<p>Copayment/ Coinsurance during the Initial Coverage Stage:</p> <p>Drug Tier 1: \$0</p> <p>Drug Tier 2: \$5</p> <p>Drug Tier 3: \$47</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4: \$100</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 5: 33%</p> <p>Catastrophic Coverage Stage:</p>	<p>Copayment/ Coinsurance during the Initial Coverage Stage:</p> <p>Drug Tier 1: \$0</p> <p>Drug Tier 2: \$10</p> <p>Drug Tier 3: \$47</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4: \$100</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 5: 27%</p>

	2025 (this year)	2026 (next year)
	During this payment stage, you pay nothing for your covered Part D drugs.	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.)	\$29	\$13.90

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 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.

	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.	\$3,900	\$4,200 Once you've paid \$4,200 out of pocket for covered Part A and Part B services, you'll 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

Our network of providers has changed for next year. Review the 2026 *Provider Directory* at wellsense.org/find-a-provider 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 wellsense.org/yourmedicare.
- Call Member Service at 855-833-8128 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Service at 855-833-8128 (TTY users call 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* at wellsense.org/find-a-provider to see which pharmacies are in our network. Here’s how to get an updated *Pharmacy Directory*:

- Visit our website at wellsense.org/yourmedicare.
- Call Member Service at 855-833-8128 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Service at 855-833-8128 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Inpatient hospital care	\$395 copayment for days 1-6 \$0 copayment for days 7-90	\$450 copayment for days 1-7 \$0 copayment for days 8-90

	2025 (this year)	2026 (next year)
Inpatient services in a psychiatric hospital	<p>\$395 copayment for days 1-6</p> <p>\$0 copayment for days 7-90</p> <p><i>Prior authorization is required.</i></p>	<p>\$430 copayment for days 1-6</p> <p>\$0 copayment for days 7-90</p> <p><i>No prior authorization required.</i></p>
Skilled nursing facility (SNF) care	<p>\$0 copayment per day for days 1-20</p> <p>\$214 copayment per day for days 21-100 in a benefit period</p>	<p>\$0 copayment per day for days 1-20</p> <p>\$218 copayment per day for days 21-100 in a benefit period</p>
Pulmonary rehabilitation services	<p>\$35 copayment per visit</p>	<p>\$40 copayment per visit</p>
Emergency care	<p>\$140 copayment per visit. Copayment is waived if admitted to the hospital within 24 hours of a visit to the Emergency Department of a hospital.</p>	<p>\$150 copayment per visit. Copayment is waived if admitted to the hospital within 24 hours of a visit to the Emergency Department of a hospital.</p>

	2025 (this year)	2026 (next year)
Urgently needed services	\$40 copayment per visit. Copayment is waived if admitted to the hospital within 24 hours of a visit to an Urgent Care Center.	\$65 copayment per visit. Copayment is waived if admitted to the hospital within 24 hours of a visit to an Urgent Care Center.
Partial hospitalization	\$130 copayment per visit <i>Prior authorization is required.</i>	\$175 copayment per visit <i>No prior authorization required.</i>
Intensive outpatient program services	\$130 copayment per visit <i>Prior authorization is required</i>	\$180 copayment per visit <i>No prior authorization required</i>
Specialist office visits	\$20 copayment per visit	\$35 copayment per visit
Podiatry services	\$20 copayment per visit	\$35 copayment per visit

	2025 (this year)	2026 (next year)
Outpatient hospital services	<p>\$0 copayment for hospital clinic visit</p> <p>\$380 copayment for outpatient hospital surgery services</p>	<p>\$0 copayment for hospital clinic visit</p> <p>\$425 copayment for outpatient hospital surgery services</p>
Outpatient hospital observation	\$395 copayment per day	\$450 copayment per day
Ambulatory surgical centers	\$300 copayment per visit for outpatient surgery at an Ambulatory Surgical Center	\$400 copayment per visit for outpatient surgery at an Ambulatory Surgical Center
Ambulance services	\$295 copayment per trip for ground ambulance	\$350 copayment per trip for ground ambulance
Over-the-Counter (OTC) items	Mandatory supplemental benefit of \$125 per quarter with no roll-over to the next calendar quarter of any unused amounts	Mandatory supplemental benefit of \$50 per quarter with no roll-over to the next calendar quarter of any unused amounts

	2025 (this year)	2026 (next year)
Fitness benefit - SilverSneakers	You are covered for a fitness benefit through SilverSneakers at participating locations, where you can take classes and use exercise equipment and other amenities, at no additional cost to you	Fitness Benefit is not covered
Medicare-covered dental services	\$20 copayment for this benefit	\$35 copayment for this benefit
Comprehensive dental maximum coverage	\$5,000 maximum benefit per year	\$4,000 maximum benefit per year
Comprehensive dental services	10% of the total cost for covered services	50% of the total cost for covered services
Medicare-covered eye exam	\$20 copayment for this benefit	\$35 copayment for this benefit
Medicare-covered hearing exam	\$20 copayment for this benefit	\$35 copayment for this benefit

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. **You can get the complete Drug List** by calling Member Service at 855-833-8128 (TTY users call 711) or visiting our website at wellsense.org/medicarerx.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Service at 855-833-8128 (TTY users call 711) for more information.

Starting in 2026, we can immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we can decide to keep the brand name drug or original biological product on our Drug List but immediately move it to a different cost-sharing tier or add new restrictions or both.

For example: If you take a brand name drug or biological product that's being replaced by a generic or biosimilar version, you may not get notice of the change 30 days in advance, or before you get a month's supply of the brand name drug or biological product. You might get information on the specific change after the change is already made.

Some of these drug types may be new to you. For definitions of drug types, go to Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website:

[www.FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients](https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients). You can also call Member Service at 855-833-8128 (TTY

users call 711) or ask your health care provider, prescriber, or pharmacist 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, call Member Service at 855-833-8128 (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. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Preferred Brand, Non-Preferred Brand and Specialty Tier 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 out-of-pocket 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.	\$495 During this stage, you pay \$0 cost sharing for drugs on Tier 1, \$10 cost sharing for drugs on Tier 2 and the full cost of drugs on Tiers 3, 4 and 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, 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 (Preferred Generic) Drugs: 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 (Generic) Drugs:	\$5	\$10
Tier 3 (Preferred Brand) Drugs:	\$47	\$47
Tier 4 (Non-Preferred Drug) Drugs:	\$100	\$100
Tier 5 (Specialty Tier) Drugs: 33% of the total cost Your cost for one-month mail order prescription is 33% of the total cost	33% of the total cost Your cost for one-month mail order prescription is 33% of the total cost	27% of the total cost Your cost for one-month mail order prescription is 27% of the total cost

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

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)
<p>Plan Service Area</p> <p>WellSense Signature (HMO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area.</p>	<p>Our service area includes these counties in New Hampshire:</p> <p>Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, Sullivan.</p>	<p>Our service area includes this county in New Hampshire:</p> <p>Hillsborough</p>

	2025 (this year)	2026 (next year)
Mental health and substance use disorder services	These benefits are administered by Carelon Behavioral Health at 855-834-5655.	Effective January 1, 2026, WellSense Health Plan will directly manage your behavioral health (mental health and substance use disorder) services instead of Carelon Behavioral Health. If you have any questions related to these services, please call Member Service at 855-833-8128 (TTY users call 711).
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 855-833-8128

	2025 (this year)	2026 (next year)
		(TTY users call 711) or visit www.Medicare.gov .

SECTION 3 How to Change Plans

To stay in WellSense Choice (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 WellSense Choice (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 WellSense Choice (HMO).
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from WellSense Choice (HMO).
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Service at 855-833-8128 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit 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, WellSense 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, 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.
- **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 New Hampshire Ryan White CARE Program. 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 800-852-3345, ext. 4502. 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 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 855-833-8128 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from WellSense Choice (HMO)

- Call Member Service at 855-833-8128. (TTY users call 711.)

We're available for phone calls Monday – Friday, 8 a.m. – 8 p.m. (Representatives are available 7 days a week, 8 a.m. – 8 p.m. from October 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 WellSense Choice (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 wellsense.org/yourmedicare or call Member Service at 855-833-8128 (TTY users call 711) to ask us to mail you a copy. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.

- **Visit** wellsense.org/yourmedicare

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 New Hampshire, the SHIP is called Aging and Disability Resource Centers (ADRC).

Call ADRC to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call ADRC at 866-634-9412. Learn more about ADRC by visiting

<https://www.dhhs.nh.gov/programs-services/adult-aging-care/aging-and-disability-resource-centers>.

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.