VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP) offered by VillageCareMAX

Annual Notice of Change for 2027

You're enrolled as a member of VillageCareMAX Medicare Health Advantage Plan.

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 VillageCareMAX Medicare Health Advantage Plan.
- To change to a **different plan**, visit 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 www.villagecaremax.org or call Member Services at 1-855-296-8800 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Member Services at 1-855-296-8800 (TTY users call 711) for more information. Hours are 7 days a week, 8 am to 8 pm. This call is free.
- This information is available in large print, braille, or audio.

About VillageCareMAX Medicare Health Advantage Plan

- VillageCareMAX is an HMO plan with Medicare and New York State Medicaid contracts. Enrollment in VillageCareMAX depends on contract renewal. The plan also has a written agreement with the New York Medicaid program to coordinate your Medicaid benefits. Our plan also has a written agreement with the New York Medicaid program to coordinate your Medicaid benefits.
- When this material says "we," "us," or "our," it means VillageCareMAX. When it says "plan" or "our plan," it means VillageCareMAX Medicare Health Advantage Plan.
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in VillageCareMAX Medicare Health Advantage Plan.** Starting January 1, 2027, you'll get your medical and drug coverage through VillageCareMAX Medicare Health Advantage Plan. Go to Section 4 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	$0 or $58.80 Part D prescription drug premium depending on if you receive Extra Help or Low Income Subsidy (LIS)	**$0 or $40.50** **Part D prescription drug premium depending on if you receive Extra Help or Low Income Subsidy (LIS)**
Deductible	The Part B Deductible is $0. If you are eligible for Medicare cost-sharing help under Medicaid, you pay $0.	**The Part B Deductible is $0.** **If you are eligible for Medicare cost-sharing help under Medicaid, you pay $0.**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	$9,250 If you are eligible for Medicare cost-sharing help under Medicaid, you most likely are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	**$9,850** **If you are eligible for Medicare cost-sharing help under Medicaid, you most likely are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.**

	2026 (this year)	2027 (next year)
Primary care office visits	$0 per visit If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay $0 per visit.	**$0 per visit** **If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay $0 per visit.**
Specialist office visits	$0 per visit If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay $0 per visit.	**$0 per visit** **If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay $0 per visit.**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	$0 If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay $0.	**$0** **If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay $0.**
Part D drug coverage (Go to Section 1 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible $615 except for covered insulin products and most adult Part D vaccines Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: $4 copay	**Part D drug coverage deductible** **$700** **except for covered insulin products and most adult Part D vaccines** **Copayment/Coinsurance as applicable during the Initial Coverage Stage:**

	2026 (this year)	2027 (next year)
Part D drug coverage (continued)	Drug Tier 2: $8 copay Drug Tier 3: 21% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 4: 25% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 5: 25% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 6: $0 copay 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.	**Drug Tier 1: $5 copay** **Drug Tier 2: $12 copay** **Drug Tier 3: 25% coinsurance** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 4: 32% coinsurance** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 5: 25% coinsurance** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 6: $0 copay** **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

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium unless it's paid for you by Medicaid.)	$0 or $58.80 Part D prescription drug premium depending on if you receive Extra Help or Low Income Subsidy (LIS)	**$0 or $40.50** **Part D prescription drug premium depending on if you receive Extra Help or Low Income Subsidy (LIS)**

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 Cost-sharing paid by the beneficiary, Medicaid, and other secondary insurance contributes towards this out-of-pocket maximum. Because our members get most cost sharing paid by Medicaid, very few members ever reach this out-of-pocket maximum. If you are eligible for Medicaid help with Part A and Part B	$9,250	**$9,850** **Once you've paid $9,850 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.**

	2026 (this year)	2027 (next year)
Maximum out-of-pocket amount (continued) copayments, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. 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.		

Section 1.3 Changes to the Provider Network

There are no changes to our network of providers for next year.

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 Services at 1-855-296-8800 (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.

There are no changes to our network of pharmacies for next year.

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 Services at 1-855-296-8800 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

	2026 (this year)	2027 (next year)
Dental Services:	$0 for Medicare-covered dental services. Service limits apply for both preventive and comprehensive dental. Coverage subject to change per Medicaid policy. $0 copay, no allowance limit for additional dental benefits, but some service limits apply. $0 copayment for Periodic Oral evaluations, 2 every 6 months Maxillofacial Prosthetics are not covered.	**$0 for Medicare-covered dental services.** **Service limits apply for both preventive and comprehensive dental. Coverage subject to change per Medicaid policy.** **$0 copay, no allowance limit for additional dental benefits, but some service limits apply.** **$0 copayment for Periodic Oral Evaluations, 1 every 6 months.** **$0 copayment for Maxillofacial Prosthetics, 1 every 12 months.*** ***Prior Authorization is required.**

	2026 (this year)	2027 (next year)
Diabetic Supplies and Services:	Abbott is the preferred manufacturer for blood glucose, glucometers and testing supplies. Applies to medical deductible and Maximum out-of-pocket (MOOP) amount. Prior authorization is required for certain services.	**Abbott is the preferred manufacturer for blood glucose, glucometers, and testing supplies.** **Abbott and Dexcom are the preferred manufacturers for continuous glucose monitors and testing supplies.** **Applies to medical deductible and Maximum out-of-pocket (MOOP) amount.** **Prior authorization is required for certain services/items.** **If another manufacturer's product is needed, it is managed through the exception process.**
Hearing Services	$0 copay for prescription hearing aids – all types. $1,500 per year for hearing aids (maximum of $750 per ear). Prior authorization is required for all prescription hearing aids.	**$0 copay for prescription hearing aids – all types.** **$1,400 per year for hearing aids (maximum of $700 per ear).** **Prior authorization is required for certain services/items.**

	2026 (this year)	2027 (next year)
Over-the-counter (OTC) Card	$220 per month to use for OTC card approved items: • Non-prescription drugs and health-related items at participating locations or online for home delivery • OTC hearing aids Unused funds roll over month to month but expire at the end of the year.	**$200 per month to use for OTC card approved items:** • **Non-prescription drugs and health-related items at participating locations or online for home delivery** • **OTC hearing aids** • **Items from participating retailers, such as additional fitness center memberships, approved fitness equipment, and approved digital cognitive training program** **Unused funds roll over month to month but expire at the end of the year.**
Special Supplemental Benefits for the Chronically Ill (SSBCI): Food & produce (grocery items), gas-at-the-pump, utilities, rent/mortgage assistance, pest control, indoor air quality products, public transportation, transportation for non-medical needs are part of	For qualified members, SSBCI benefits are combined with the OTC benefit. The $220 per month OTC card amount can also be used for: • Food and produce (groceries) • Gas-at-the pump	**For qualified members, SSBCI benefits are combined with the OTC benefit. The $200 per month OTC card amount can also be used for:** • **Food and produce (groceries)** • **Gas-at-the pump**

	2026 (this year)	2027 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI): (continued) Special Supplemental Benefits for the Chronically Ill (SSBCI). In order to be eligible to receive SSBCI benefits, enrollees must be determined to be chronically ill, have a chronic condition (e.g., diabetes, chronic heart failure, cardiovascular disorder, chronic and disabling mental health condition, stroke, or other eligible conditions), and meet coverage criteria. Not all members may qualify.	• Indoor air quality products • Pest control products • Rental or mortgage assistance • Transportation (for non-medical needs* or bus/subway transit fare) • Utilities Unused funds roll over month to month but expire at the end of the year. *Prior Authorization is required.	• **Indoor air quality products** • **Pest control treatments or products** • **Rental or mortgage assistance** • **Transportation (for non-medical needs* or bus/subway transit fare)** • **Utilities** **Unused funds roll over month to month but expire at the end of the year.** ***Prior Authorization is not required.**
Transportation Services	Prior Authorization is required.	**Prior Authorization is not required.**

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 posted online at www.villagecaremax.org.

You can get the *complete* Drug List by calling Member Services at 1-855-296-8800 (TTY users call 711) or visiting our website at www.villagecaremax.org.

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 Services at 1-855-296-8800 (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 does not apply to you.** We have included 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 didn't get this material with this packet, call Member Services at 1-855-296-8800 (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 Preferred Generic, Generic, Preferred Brand, Non-Preferred Drug, and Specialty drugs until you reach 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 $2,400.

- ***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 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	$615 During this stage, you pay $0 cost sharing for drugs on Select Care Drugs (Tier 6) and the full cost of drugs on Preferred Generic (Tier 1), Generic (Tier 2), Preferred Brand (Tier 3), Non-Preferred Drug (Tier 4), and Specialty Tier (Tier 5) until you've reached the yearly deductible.	**$700** **During this stage, you pay $0 cost sharing for drugs on Select Care Drugs (Tier 6) and the full cost of drugs on Preferred Generic (Tier 1), Generic (Tier 2), Preferred Brand (Tier 3), Non-Preferred Drug (Tier 4), and Specialty Tier (Tier 5) until you've reached the yearly deductible.**

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard cost sharing.

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)
Preferred Generic (Tier 1):	$4 You pay $4 per month supply of each covered insulin product on this tier.	**$5** **You pay $5 per month supply of each covered insulin product on this tier.**
Generic (Tier 2):	$8 You pay $8 per month supply of each covered insulin product on this tier.	**$12** **You pay $12 per month supply of each covered insulin product on this tier.**
Preferred Brand (Tier 3):	21% of the total cost You pay $35 max per month supply of each covered insulin product on this tier.	**25% of the total cost** **You pay $35 max per month supply of each covered insulin product on this tier.**
Non-Preferred Drug (Tier 4):	25% of the total cost You pay $35 max per month supply of each covered insulin product on this tier.	**32% of the total cost** **You pay $35 max per month supply of each covered insulin product on this tier.**
Specialty Tier (Tier 5):	25% of the total cost You pay $35 max per month supply of each covered insulin product on this tier.	**25% of the total cost** **You pay $35 max per month supply of each covered insulin product on this tier.**
Select Care Drugs (Tier 6):	$0	**$0**

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Vision Care: Supplemental or additional vision care benefits include routine eye exams and eyewear.	Supplemental or additional vision care benefits are managed by VersantHealth. You must use a provider in the VersantHealth network.	**Supplemental or additional vision care benefits are managed by Vision Services Plan (VSP). You must use a provider in the VSP network.**

SECTION 3 How to Change Plans

To stay in VillageCareMAX Medicare Health Advantage Plan, you don't need to do anything. Unless you sign up for a different Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our VillageCareMAX Medicare Health Advantage Plan.

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 VillageCareMAX Medicare Health Advantage Plan. 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 separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from VillageCareMAX Medicare Health Advantage Plan.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-855-296-8800 (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.
- **To learn more about Original Medicare and the different types of Medicare plans,** visit 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).

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 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

Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

  - Original Medicare *with* a separate Medicare prescription drug plan,
  - Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
  - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

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).** New York has a program called Elderly Pharmaceutical Insurance Coverage (EPIC) 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 New York State AIDS Drug Assistance 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 New York State AIDS Drug Assistance Program. 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 1-855-296-8800 (TTY users call 711) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from VillageCareMAX Medicare Health Advantage Plan

- **Call Member Services at** 1-855-296-8800 (TTY users call 711).

  We're available for phone calls 7 days a week, 8 am to 8 pm. Calls to these numbers are 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 VillageCareMAX Medicare Health Advantage Plan. 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 www.villagecaremax.org or call Member Services at 1-855-296-8800 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.villagecaremax.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 New York, the SHIP is called New York State Health Insurance Assistance Program.

Call New York State Health Insurance Assistance Program to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Call New York State Health Insurance Assistance Program at 1-800-701-0501. Learn more about New York State Health Insurance Assistance Program by visiting https://aging.ny.gov/health-insurance-information-counseling-and-assistance-programs.

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**

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

- **Write to Medicare**

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

- **Visit 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 or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Get Help from Medicaid

Call New York State Medicaid Program at 1-800-541-2831 Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM. TTY users 711 for help with Medicaid enrollment or benefit questions.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1444. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850*