

## Medicare Minute Teaching Materials — January 2026

### What’s New in 2026?

#### 1. Have costs for Medicare Part A (hospital insurance) changed in 2026?

Yes, the costs associated with Part A are different this year. Remember, Medicare Part A covers inpatient hospital services, skilled nursing facility services, home health care, and hospice. Look through your 2026 *Medicare & You* handbook (see question 9) to understand Part A-covered services. The following chart shows costs last year compared to this year.

Original Medicare Part A Costs: 2025 vs. 2026		
	2025	2026
<b>Part A premium</b>	<b>\$0/month</b> if you’ve worked and paid Medicare tax more than 10 years	<b>\$0/month</b> if you’ve worked and paid Medicare tax more than 10 years
	<b>\$285/month</b> if you’ve worked and paid Medicare tax between 7.5 and 10 years	<b>\$311/month</b> if you’ve worked and paid Medicare tax between 7.5 and 10 years
	<b>\$518/month</b> if you’ve worked and paid Medicare tax fewer than 30 quarters (7.5 years)	<b>\$565/month</b> if you’ve worked and paid Medicare tax fewer than 30 quarters (7.5 years)
<b>Hospital deductible</b>	<b>\$1,676</b> each benefit period	<b>\$1,736</b> each benefit period
<b>Hospital coinsurance</b>	<b>\$0/day</b> for days 1 – 60 once you’ve met your deductible	<b>\$0/day</b> for days 1 – 60 once you’ve met your deductible
	<b>\$419/day</b> for days 61 – 90 of each benefit period	<b>\$434/day</b> for days 61 – 90 of each benefit period
	<b>\$838/day</b> for days 91 – 150 (non-renewable lifetime reserve days)	<b>\$868/day</b> for days 91 – 150 (non-renewable lifetime reserve days)
<b>Skilled nursing facility coinsurance</b>	<b>\$0/day</b> for days 1 – 20 each benefit period (after a minimum 3-day inpatient hospital stay)	<b>\$0/day</b> for days 1 – 20 each benefit period (after a minimum 3-day inpatient hospital stay)
	<b>\$209.50/day</b> for days 21 – 100 each benefit period	<b>\$217/day</b> for days 21 – 100 each benefit period

If you have a Medicare Advantage plan, your plan provides your Part A coverage. If you have the same Medicare Advantage plan in 2026 as you did in 2025, your plan should have sent you an Annual Notice of Change (ANOC) or Evidence of Coverage (EOC) notice explaining any changes for the coming year. Review this notice to understand your plan’s costs, covered services, and rules. Contact your plan if you did not receive these documents in the fall or if you want another copy. If you chose a new Medicare Advantage plan, review the costs associated with the plan for 2026.

**2. Have costs for Medicare Part B (medical insurance) changed in 2026?**

Yes, the costs associated with Part B are different this year. Remember that Medicare Part B covers outpatient medical services, such as services from a licensed health professional, preventive services, outpatient therapy, and home health services.

Original Medicare Part B Costs: 2025 vs. 2026		
	2025	2026
<b>Part B premium*</b>	\$185/month	\$202.90/month
<b>Part B deductible</b>	\$257/year	\$283/year
<b>Part B coinsurance</b>	20% for most services	20% for most services
* If your annual income is higher than \$109,000 for an individual (\$218,000 for a couple), you will pay a higher Part B premium. Visit <a href="http://www.medicare.gov">www.medicare.gov</a> for Part B costs by annual income.		

Medicare Advantage costs: If you have a Medicare Advantage plan, your plan administers your Part A and Part B coverage. Remember that most people with Medicare, whether they have Original Medicare or a Medicare Advantage plan, pay the Part B monthly premium. Some people with a Medicare Advantage plan may also pay an additional monthly premium for that plan. The amount you pay for Medicare Advantage plan deductibles, copayments, and/or coinsurances varies by plan.

If you have the same Medicare Advantage plan in 2026 as you did in 2025, your plan should have sent you an Annual Notice of Change (ANOC) or Evidence of Coverage (EOC) notice explaining any changes for the coming year. Review this notice to understand your plan’s costs, covered services, and rules. Contact your plan if you did not receive these documents in the fall or want another copy. If you chose a new Medicare Advantage plan, you should get an EOC for the new plan. Review that document to understand the costs associated with the plan for 2026.

**3. Have costs for Medicare Part D (prescription drug coverage) changed in 2026?**

Yes. Each year, Part D plans can make changes to their premiums, deductibles, and copays. And throughout the year, you move through coverage phases. In each coverage phase, your costs will be different. You might also experience drug cost changes if you take a medication with negotiated prices (see question 4). Remember that there are two ways to get Part D coverage—through a stand-alone Part D plan, or as part of a Medicare Advantage plan. The information here on Part D costs applies to both kinds of Part D coverage.

If you have Medicare prescription drug coverage, your plan should have notified you about any changes in costs for that plan in 2026. Part D plans can change the drugs they cover, their pharmacy networks, and their costs (such as premiums, copayments, and deductibles) from year to year. Your Part D plan should have sent you an ANOC or EOC notice informing you of your plan’s benefits, costs, and covered drugs for 2026. If you have a

Medicare Advantage plan with prescription drug coverage, you should have received one EOC that describes both your health and prescription drug coverage for 2026.

The following chart shows costs last year compared to this year. Be sure to review your plan materials for specific changes for your plan.

<b>Medicare Part D Costs: 2025 vs. 2026</b>		
	<b>2025</b>	<b>2026</b>
<b>Part D base premium</b>	<b>\$36.78</b>	<b>\$38.99</b>
<b>Part D maximum deductible</b>	<b>Up to \$590/year</b>	<b>Up to \$615/year</b>
<b>Part D catastrophic coverage limit</b> You pay \$0 for covered drugs after your cost-sharing for covered drugs reaches this amount.	<b>\$2,000</b>	<b>\$2,100</b>

#### **4. What are the drugs with negotiated prices this year?**

The Inflation Reduction Act (IRA) of 2022 created a new ability for Medicare to negotiate prices for the most expensive drugs the program covers. The first set of negotiated drug prices will go into effect in 2026 and are estimated to save \$1.5 billion in annual out-of-pocket costs for Medicare beneficiaries while saving the Medicare program \$6 billion per year. The negotiated prices are a minimum of 38% off the 2023 list price.

Drugs selected for negotiation must be brand-name drugs that don't have competition and must be among those that drive the most Medicare spending. These are the ten drugs for 2026:

- Eliquis
- Jardiance
- Xarelto
- Januvia
- Farxiga
- Entresto
- Enbrel
- Imbruvica
- Stelara
- NovoLog

These medications treat serious chronic illnesses like cancer, diabetes, blood clots, heart failure, autoimmune conditions, and chronic kidney disease.

All eligible Medicare beneficiaries will have access to these prices and new drugs will be added to the negotiated list each year. The next set of negotiated prices, for 15 additional drugs including popular diabetes drugs like Ozempic, will go into effect in 2027.

Note that Medicare is negotiating the total price for the drug, not the amount beneficiaries pay as a copay or coinsurance. It's likely, but not guaranteed, that beneficiaries will see savings – the amount will depend on the structure of their specific Part D plan.

## **5. What is telehealth coverage like in 2026?**

Before the COVID-19 Public Health Emergency (PHE), Medicare telehealth coverage was very limited. For example, before the PHE, telehealth services were:

- Generally only covered in rural areas, and you would still have to go to a specific “originating site” (often a different medical office or clinic) to receive the telehealth.
- Generally only covered if provided via interactive, two-way audio and video technology
- Limited to certain providers, such as physicians and nurse practitioners

During the PHE, telehealth coverage was temporarily expanded to include more flexibilities and allow more people to receive care from their homes. These flexibilities have been extended through December 31, 2027.

Through December 31, 2027, telehealth services are:

- Covered for all beneficiaries in any geographic area, at home in addition to health care settings.
- Sometimes delivered using audio only
- Provided by any health care professional that was eligible to bill Medicare

After December 31, 2027, most telehealth services will again be more limited unless Congress acts. For now, only some of the broader telehealth coverage has been made permanent.

After December 31, 2027, telehealth services will likely be:

- Still available regardless of geographic area for certain types of care
  - For example: Behavioral/mental health care, monthly End-Stage Renal Disease (ESRD) visits for home dialysis, diabetes self-management training, and Medicare nutrition therapy
- Still able to be delivered using audio-only communication platforms for behavioral/mental health care
- Subject to pre-PHE restrictions for other types of care

## **6. Are any new Special Enrollment Periods (SEPs) in 2026?**

Yes. There is a new, temporary SEP for Incorrect Medicare Plan Finder MA Provider Directory Information. In fall 2025, Medicare Plan Finder incorporated provider directory information to help beneficiaries when comparing Medicare Advantage (or MA) plans. This new, temporary SEP is for any beneficiary who relied on provider directory information during the first year of the Medicare Plan Finder provider directory, and, within three months of the effective date of that coverage, discovered that the directory information was inaccurate and their preferred provider is not in the plan's network.

Medicare will grant an SEP to beneficiaries who:

- Used Medicare Plan Finder provider directory information to select a Medicare Advantage plan

- Enrolled in that plan through Medicare Plan Finder
- And, within three months of the effective date of the plan, realize that their preferred provider is not in the plan's network.

To use this SEP, a beneficiary will need to call 1-800-MEDICARE (633-4227) so that a Medicare representative can confirm that the enrollment happened directly through Medicare Plan Finder and then make the requested enrollment change. Beneficiaries can choose to enroll in a different Medicare Advantage plan or switch to Original Medicare with or without a Part D plan. The requested change will be effective the first day of the following month, not retroactively.

Remember that this SEP is temporary and only for beneficiaries with Medicare Advantage plan effective dates of 1/1/2026 through 12/1/26.

### **7. How has Medicare eligibility for non-citizens changed?**

Due to the One Big Beautiful Bill Act (OBBBA), there are new eligibility restrictions for lawfully present immigrants. Before the OBBBA, non-citizens with legal immigration statuses were eligible for Medicare if they:

- Qualified to receive Social Security retirement benefits, Social Security Disability Insurance, or Railroad Retirement Benefits
- OR, were lawful residents age 65 and older and lived continuously in the U.S. for five years.

OBBBA made Medicare eligibility changes for some immigrants. Eligibility for Social Security retirement benefits, Social Security Disability Insurance, or Railroad Retirement Benefits is no longer sufficient for Medicare eligibility without consideration of immigration status.

There is no change for (meaning these groups will maintain their Medicare eligibility):

- Lawful permanent residents (green card holders)
- Certain immigrants from Cuba or Haiti
- Certain immigrants from the Compact of Free Association (COFA) states

All other immigrants with qualifying Social Security quarters, including refugees, asylees, and victims of abuse or trafficking, will lose Medicare coverage. The Congressional Budget Office estimates that this is 100,000 individuals nationally.

This change is effective immediately for people not yet enrolled. Those who are already enrolled will be disenrolled within 18 months of passage (by January 4, 2027). The Social Security Administration is required to identify current beneficiaries who will be disenrolled.

### **8. Will Original Medicare have prior authorization in 2026?**

First, know that there is no change to Medicare coverage or payment policy this year. For the most part, Original Medicare services will not be subject to new prior authorization in 2026. However, there is a CMS demonstration program that will test prior authorization for certain services only and in certain states only.

The Wasteful and Inappropriate Service Reduction (WISeR) Model plans to introduce new prior authorization for some Medicare services. It aims to use technologies like Artificial Intelligence and Machine Learning, along with clinician review, to review the medical necessity of Medicare services identified by the administration as being frequently inappropriately provided, dangerous, or both. The WISeR Model begins on January 1, 2026, and runs for six years, through December 31, 2031. The model runs in the following states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington. The model only applies to select items and services for the initial year of implementation (subject to change):

- Stimulator services
  - Electrical nerve stimulators
  - Sacral nerve stimulation for urinary incontinence
  - Phrenic nerve stimulator
  - Deep brain stimulation for essential tremor and Parkinson’s disease
  - Vagus nerve stimulation
- Induced lesions of nerve tracts
- Epidural steroid injections for pain management
- Percutaneous vertebral augmentation (PVA) for vertebral compression fracture (VCF)
- Cervical fusion
- Arthroscopic lavage and arthroscopic debridement for the osteoarthritic knee
- Hypoglossal nerve stimulation for obstructive sleep apnea
- Incontinence control devices
- Diagnosis and treatment of impotence
- Percutaneous image-guided lumbar decompression for lumbar spinal stenosis
- Skin and tissue substitutes
  - Application of bioengineered skin substitutes to lower extremity chronic non-healing wounds
  - Wound application of cellular and/or tissue-based products (CTPs), lower extremities

### **9. What is the *Medicare & You* handbook? How can I get one?**

*Medicare & You* is a handbook published by Medicare each year. It explains Medicare-covered services and the costs associated with Original Medicare for the coming year. Each Medicare beneficiary is mailed a copy of *Medicare & You* in the early fall, regardless of whether they have Original Medicare or a Medicare Advantage plan. If you did not receive one last year, call 1-800-MEDICARE (633-4227) to request a copy. You can also download a general version of the handbook at [www.medicare.gov](http://www.medicare.gov).

### **10. What is a transition refill?**

A transition refill, also known as a transition fill, is typically a one-time, 30-day supply of a drug that you were taking:

- Before switching to a different Part D plan (either stand-alone or through a Medicare Advantage plan)
- Or, before your current plan changed its coverage rules at the start of a new calendar year

Transition refills let you get temporary coverage for drugs that are not on your plan’s formulary or that have certain coverage restrictions (such as prior authorization or step therapy).

Transition refills are not for new prescriptions. You can only get transition fills for drugs you were already taking before switching plans or before your existing plan changed its coverage rules.

The following situations describe when you can get a transition refill if you do not live in a nursing home (there are different rules for transition refills for those living in nursing homes):

1. Your current plan is changing how it covers a Medicare-covered drug you have been taking.
  - If your plan is taking your drug off its formulary or adding a coverage restriction for the next calendar year for reasons other than safety, the plan must either:
    - Help you switch to a similar drug that is on your plan's formulary before January 1
    - Or, help you file an exception request before January 1
    - Or, give you a 30-day transition fill within the first 90 days of the new calendar year along with a notice about the new coverage policy.
2. Your new plan does not cover a Medicare-covered drug you have been taking.
  - If a drug you have been taking is not on your new plan's formulary, this plan must give you a 30-day transition refill within the first 90 days of your enrollment. It must also give you a notice explaining that your transition refill is temporary and informing you of your [appeal rights](#).
  - If a drug you have been taking is on your new plan's formulary but with a coverage restriction, this plan must give you a 30-day transition refill free from any restriction within the first 90 days of your enrollment. It must also give you a notice explaining that your transition refill is temporary and informing you of your appeal rights.
  - In both of the above cases, if a drug you have been taking is not on your new plan's formulary, be sure to see whether there is a similar drug that is covered by your plan (check with your doctor about possible alternatives) and, if not, file an exception request. (If your request is denied, you have the right to appeal.)

Note: If you file an exception request and your plan does not process it by the end of your 90-day transition refill period, your plan must provide additional temporary refills until the exception is completed.

Remember: All stand-alone Part D plans and Medicare Advantage plans that offer drug coverage must provide transition refills in the above cases. When you use your transition refill, your plan must send you a written notice within three business days. The notice will tell you that the supply was temporary and that you should either change to a covered drug or file an exception request with the plan.

### **11. What is the Medicare Advantage Open Enrollment Period?**

During the Medicare Advantage Open Enrollment Period (MA OEP), you can switch from your Medicare Advantage plan (excluding Medical Savings Accounts, cost plans, and PACE) to another Medicare Advantage plan or to Original Medicare with or without a stand-alone prescription drug plan. The MA OEP occurs each year from January 1 through March 31. Remember, you can only use this enrollment period if you have a Medicare Advantage plan. Changes made during this period take effect on the first of the following month. For example, if you switch to a new Medicare Advantage plan in February, your new coverage begins March 1. Unlike Fall Open Enrollment, you can only make a single change during the MA OEP.

## **12. Will I have other opportunities to change my coverage in 2026?**

Many people have to wait until Fall Open Enrollment to change their coverage if they aren't happy with it. You may have the opportunity to change your coverage earlier in 2026, though, depending on your circumstances.

If you have Medicaid, an Medicare Savings Program (MSP), or Extra Help: If you have Medicaid, an MSP, or Extra Help, you have a Special Enrollment Period (SEP) to enroll in a stand-alone Part D plan or switch between stand-alone Part D plans. This SEP is available once per month, and cannot be used to enroll in a Medicare Advantage plan.

If your Medicare Advantage or Part D plan ended at the close of the year: If your plan ended, it should have sent you a letter in early October explaining that it will no longer be available next year. Because your plan is ending, you have an SEP from December 8, 2025 through February 28, 2026 to change your Medicare health and drug coverage.

- Changes you make from December 8 through December 31 take effect January 1.
- Changes you make during January take effect February 1. Since your plan ended as of December 31, you will be automatically enrolled in Original Medicare as of January 1 so that you still have coverage until you have made a formal decision.
- Changes you make in February take effect March 1. Since your plan ended as of December 31, you will be automatically enrolled in Original Medicare as of January 1 so that you still have coverage until you have made a formal decision.

If possible, you should make Medicare health and drug coverage changes by December 31 to make sure you have coverage that suits your needs when the year begins.

If you enrolled in a plan by mistake or because of misleading information: If you enrolled in a Medicare Advantage plan or Part D plan by mistake or after receiving misleading information, you may be able to disenroll and change plans. Typically, you have the right to change plans if you:

- Joined unintentionally: You may have enrolled believing you were joining a Medigap plan to supplement Original Medicare, or you meant to sign up for a stand-alone Part D plan and accidentally joined a Medicare Advantage plan.
- Joined based on incorrect or misleading information: You may have been misled for example if a plan representative told you that your doctors are in the plan's network but they are not, or you were promised benefits that the plan does not really cover.
- Through no fault of your own, ended up or were kept in a plan you do not want: You can make a change if you tried to switch plans during an enrollment period but were kept in your old plan or if you were enrolled in a plan because of an administrative or computer error.

The steps you should take to disenroll depend on whether you have used services and whether the plan paid for those services.

- If you used any service since joining the plan (for example, saw a doctor or filled a prescription) and received a denial of coverage, you should request retroactive disenrollment, meaning disenrollment back to the date you enrolled in the plan. Depending on your situation, you may then wish to select Original Medicare (with or without a Part D plan) or a different Medicare Advantage plan. If you are granted retroactive disenrollment, be sure to ask your providers to re-file claims with your new plan.

- If you have not used any services since joining the plan, you may want to request a Special Enrollment Period (SEP) to disenroll from your plan. This option may be processed faster than retroactive disenrollment. If your request is granted, you will be disenrolled from your plan at the end of the month in which you made the request. To prevent gaps in coverage, sign up for new coverage immediately after you are disenrolled from the plan you did not want.

To request retroactive disenrollment or an SEP, call 1-800-MEDICARE (633-4227) and explain to the customer service representative exactly how you joined the plan by mistake.

If you qualify for another Special Enrollment Period (SEP): There are several circumstances in which you may be able to make changes to your Medicare health/drug coverage. For example, you have a SEP if you move outside of your plan's service area, if your Medicare Advantage plan terminated a significant amount of its network providers, or if you enroll in certain State Pharmaceutical Assistance Programs (SPAPs).

If you need to make changes to your coverage but you are not sure whether you qualify for an SEP, call your State Health Insurance Assistance Program (SHIP) to learn more. Contact information for your local SHIP is on the last page of this document.

### **13. Will I be getting a new Medicare card for 2026?**

No, you will not be getting a new Medicare card. Starting in April 2018, CMS sent new Medicare cards to all Medicare beneficiaries. By the end of January 2019, all beneficiaries had their new Medicare cards, which were designed to better protect against identity theft by removing their Social Security number. Although the rollout of these updated cards is complete, scams around these new cards continue.

For example, scammers may falsely tell you that Medicare is issuing an updated or new card—perhaps a plastic one, metal one, or one with a chip. The scammers may tell you that you need to verify your identity for them to send your new Medicare card. This is the scammer's attempt to gain your personal or financial information.

Here are some red flags to be aware of:

- Unsolicited calls from someone claiming to be from Medicare
- Anyone saying that they need your information to send you an updated Medicare card
- Anyone claiming that your card is expiring and that you will be charged a fine if you do not get a new one
- Anyone stating that Medicare is issuing new cards, and you need to verify your Medicare number

If you believe you have experienced potential fraud, contact your Senior Medicare Patrol (SMP). Contact information for your local SMP is on the final page of this document.

### **14. Who should I contact if I have questions about my 2026 Medicare coverage?**

**1-800-MEDICARE (800-633-4227):** Call 1-800-MEDICARE (633-4227) to request another copy of your *Medicare & You* handbook or to learn more information about your 2026 coverage.

**State Health Insurance Assistance Program (SHIP):** Contact your SHIP if you have questions about changes in costs and coverage of your Medicare in 2026, for help understanding SEPs, or to learn about programs that can help you with Medicare costs. SHIP team members provide unbiased Medicare counseling and assistance. Contact information for your SHIP is on the last page of this document.

**Senior Medicare Patrol (SMP):** Contact your SMP if you believe you have experienced potential fraud, errors, or abuse. Contact information for your local SMP is on the final page of this document.

**Medicare Advantage plan or Part D plan:** If you have a Medicare Advantage plan or Part D plan, contact your plan to ask about changes in your costs or coverage for 2026.

### **SHIP case study**

Leo has Original Medicare and a stand-alone Part D plan. In January 2026 he is diagnosed with a condition that requires him to take a new prescription drug. He calls his Part D plan and learns this drug is not on the plan's formulary.

### **What should Leo do?**

- Leo can call his State Health Insurance Assistance Program (SHIP) for help.
  - If he doesn't know how to reach his SHIP, he can call 877-839-2675 or visit <http://www.shiphelp.org>.
- The SHIP team member can tell Leo about formulary exceptions.
  - The SHIP team member can help Leo request a formulary exception and can instruct him on how to ask his doctor to write a letter that supports his medical need for the drug.
- The SHIP team member can also let Leo know about his opportunities to change coverage in the coming year.
  - If Leo has Medicaid, an MSP, or Extra Help, he may be eligible for an SEP to change drug plans once per month.
  - He might also qualify for a Special Enrollment Period if, for example, if he enrolls in a State Pharmaceutical Assistance Program (SPAP) or moves outside of his current plan's service area. The SHIP team member can talk to Leo about all possible special enrollment periods to check if he qualifies.
  - If there are 5-star plans where Leo lives, the SHIP team member can help him determine whether the 5-star plans would cover his medications and meet his needs.

### **SMP case study**

Roger is 71 years old and has Original Medicare. He got a call from Medicare, saying that he would be sent a new black and white Medicare card soon. In order to get his new card, though, the caller said he would need to provide his Medicare number and Social Security number. Roger felt uncomfortable, so he said he would call back later that day to provide this information. After ending the call, Roger remembered that he got a new card a few years ago, so he is unsure if Medicare issuing new cards again. He can't shake the feeling that something is wrong with the unsolicited caller's request.

### **What should Roger do?**

- Roger should call his local SMP.

- If he is unsure how to reach his local SMP, he can go to [www.smpresource.org](http://www.smpresource.org) or call 877-808-2468.
- The SMP team member can tell Roger that Medicare beneficiaries are not receiving new cards, and the call was likely a scam. Medicare will not call you unannounced and ask for your personal information over the phone. If a new Medicare card was being issued, they would notify you by mail. Roger should not call that person back.
- The SMP team member will recommend that in the future Roger immediately hang up calls on people that claim they are from Medicare unless he has recently requested a callback from Medicare’s customer service line.
- The SMP team member will collect all of the details and refer it to the proper authorities if enough information is available. They should also encourage Roger to continue to protect his personal information from callers, as he did today.

Local SHIP Contact Information	Local SMP Contact Information
<p><b>SHIP toll-free:</b> 800-247-4422  <b>SHIP email:</b> idahoshiba@doi.idaho.gov  <b>SHIP website:</b> shiba.idaho.gov</p> <p><b>To find a SHIP in another state:</b>            Call 877-839-2675 and say “Medicare” when prompted or visit <a href="http://www.shiphelp.org">www.shiphelp.org</a>.</p>	<p><b>SMP toll-free:</b> 800-247-4422  <b>SMP email:</b> idahoshiba@doi.idaho.gov  <b>SMP website:</b> <a href="http://www.medicarefraudprevention.gov">Medicare Fraud Prevention - Idaho Commission on Aging</a></p> <p><b>To find an SMP in another state:</b>            Call 877-808-2468 or visit <a href="http://www.smpresource.org">www.smpresource.org</a>.</p>
<p><i>This document is supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$3,000,000 with 100 percent funding by ACL/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS, or the U.S. government.</i></p> <p>SHIP Technical Assistance Center: 877-839-2675   <a href="http://www.shiphelp.org">www.shiphelp.org</a>   <a href="mailto:info@shiptacenter.org">info@shiptacenter.org</a>            SMP Resource Center: 877-808-2468   <a href="http://www.smpresource.org">www.smpresource.org</a>   <a href="mailto:info@smpresource.org">info@smpresource.org</a>            © 2025 Medicare Rights Center   <a href="http://www.medicareinteractive.org">www.medicareinteractive.org</a></p> <p><i>The Medicare Rights Center is the author of portions of the content in these materials but is not responsible for any content not authored by the Medicare Rights Center.</i></p>	