Valor Health Plan

Insurance focused on you.

ANNUAL NOTICE OF CHANGE (ANOC)

2026

Valor Health Plan (*HMO-SNP*) offered by *TSG Guard, Inc.*

Annual Notice of Change for 2026

You're enrolled as a member of *Valor Health 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, 2025, you'll stay enrolled in *Valor Health Plan*.
- To change to a **different plan**, you can switch plans or switch to Original Medicare (either with or without a separate Medicare drug plan) at any time.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

More Resources

- *Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the relevant state or states in our plan's service area and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication.*
- Call Member Services at 1-800-485-3793 (TTY users call 711) for more information. Hours are October 1 – March 31, 8:00 a.m. to 8:00 p.m. with interactive voice response system for Thanksgiving and Christmas Day. April 1 – September 30, 8:00 a.m. to 8:00 p.m. with interactive voice response system for Saturdays, Sundays and Federal Holidays. This call is free.
- This document may be available in an alternate format (braille, large format, etc.) Please contact Member Services for more information.

OMB Approval 0938-1051 (Expires: August 31, 2026)

About *Valor Health Plan*

- Valor Health Plan (HMO-SNP) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means *TSG Guard, Inc. (Valor Health Plan).* When it says “plan” or “our plan,” it means *Valor Health Plan.*
- **If you do nothing by December 7, 2025, you’ll automatically be enrolled in *Valor Health Plan*.** Starting January 1, 2026, you’ll get your medical and drug coverage through *Valor Health Plan*. Go to Section 2 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.	*$39.30*	***$31.38***
Deductible	*$257* except for insulin furnished through an item of durable medical equipment	***$283*** **except for insulin furnished through an item of durable medical equipment**
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 for details.)	*$9,350*	***$9,250***
Primary care office visits	*20%* per visit	***20%*** **per visit**
Specialist office visits	*20%* per visit	***20%*** **per visit**
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term	You pay a $1,676 deductible for days 1-60	**You pay a $1,736 deductible for days 1-60**

	2025 (this year)	**2026 (next year)**
care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	You pay a $419 copay per day for days 61-90 You pay a $838 per lifetime reserve day. Cost shares are applied starting on the first day of admission and do not include the date of discharge.	**You pay a $434 copay per day for days 61-90** **You pay a $868 per lifetime reserve day. Cost shares are applied starting on the first day of admission and do not include the date of discharge.**
Part D drug coverage deductible (Go to Section 1 for details.)	*$590* (except for covered insulin products and most adult Part D vaccines)	***$615*** **(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.)	*25% Coinsurance* **during the Initial Coverage Stage:** You pay up to *$35* per month supply of each covered insulin product on this tier. **Catastrophic Coverage Stage:** During this payment stage, you pay nothing for your covered Part D drugs	***25% Coinsurance*** **during the Initial Coverage Stage:** ***You pay up to $35 per month supply of each*** **covered insulin product on this tier.** **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.)	*$39.30*	***$31.38***

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 3 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 and deductibles) **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.	*$9,350*	***$9,250*** **Once you've paid *2026 MOOP amount* 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 (www.valorhealthplan.com) 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 (www.valorhealthplan.com).
- Call Member Services at 1-800-485-3793 (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 Services at **1-800-485-3793 (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 (www.valorhealthplan.com) to see which pharmacies are in our network. Here's how to get an updated Pharmacy Directory:

- Visit our website at www.valorhealthplan.com.

- Call Member Services at 1-800-485-3793 (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 Services at 1-800-485-3793 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	**2026 (next year)**
Colorectal Cancer Screening	Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema.	**Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy.**
Emergency Services	20% of the total cost for Medicare covered services (up to $110)	**20% of the total cost for Medicare covered services** **(up to $115)**

	2025 (this year)	**2026 (next year)**
Inpatient Hospital Care	You pay a $1,676 deductible for days 1-60 You pay a $419 copay per day for days 61-90 You pay a $838 per lifetime reserve day. Cost shares are applied starting on the first day of admission and do not include the date of discharge.	**You pay a $1,736 deductible for days 1-60** **You pay a $434 copay per day for days 61-90** **You pay a $868 per lifetime reserve day. Cost shares are applied starting on the first day of admission and do not include the date of discharge.**

	2025 (this year)	2026 (next year)
Inpatient Services in a Psychiatric Hospital	You pay a $1,676 deductible for days 1-60 You pay a $419 copay per day for days 61-90 You pay a $838 per lifetime reserve day. Cost shares are applied starting on the first day of admission and do not include the date of discharge.	**You pay a $1,736 deductible for days 1-60** **You pay a $434 copay per day for days 61-90** **You pay a $868 per lifetime reserve day. Cost shares are applied starting on the first day of admission and do not include the date of discharge.**
Over-the-counter (OTC) items	$146 per calendar quarter for OTC items	**$194 per calendar quarter for OTC items**
Urgently Needed Services	20% of the cost for Medicare covered services (up to $45) and up to 3 days	**20% of the cost for Medicare covered services (up to $40) and up to 3 days**

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 Services at *1-800-485-3793* (TTY users call *711*) or visiting our website at *www.valorhealthplan.com.*

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 *1-800-485-3793* (TTY users call *711*) for more information.

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. You can also call Member Services at *1-800-485-3793* (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 does not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by *September 30, 2025* call Member Services at *1-800-485-3793* (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 Part D 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 ***$2,100***

- ***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	$590	**$615**

Drug Costs in Stage 2: Initial Coverage

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply, or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

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

	2025 (this year)	**2026 (next year)**
Initial Coverage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. Most adult Part D vaccines are covered at no cost to you.	You pay 25% of the total cost. Once you have paid ***$2,000*** out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	You pay 25% of the total cost. Once you have paid ***$2,100*** out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

	2025 (this year)	**2026 (next year)**
Catastrophic During this stage, the plan pays its share of the cost of your drugs and you pay nothing for your covered Part D drugs. Most adult Part D vaccines are covered at no cost to you.	**The plan will pay most of the cost of your drugs** for the rest of the calendar year (through **December 31, 2025**).	**The plan will pay most of the cost of your drugs** for the rest of the calendar year (through **December 31, 2026**).

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

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.**

	2025 (this year)	**2026 (next year)**
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	**If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** **To learn more about this payment option, call us at *1-800-485-3793* (TTY users call *711*) or visit www.Medicare.gov.**

SECTION 3 How to Change Plans

To stay in Valor Health Plan, 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 Valor Health Plan.

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 Valor Health Plan.

- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Valor Health Plan.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-800-485-3793 (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.
- **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 4, 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, 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 Ohio AIDS Drug Assistance Program, Ohio Department of Health, 246 N. High Street, Columbus, Ohio 43215. For information on eligibility criteria, covered drugs, or how to enroll in the program, or if you are currently enrolled how to continue receiving assistance, call 1-800-777-4775. Be sure, when calling, to inform them of your Medicare Part D plan name of 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 1-800-485-3793 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from Valor Health Plan

- **Call Member Services at 1-800-485-3793. (TTY users call 711.)**

  We're available for phone calls October 1 – March 31, 8:00 a.m. to 8:00 p.m. with interactive voice response system for Thanksgiving and Christmas Day. April 1 – September 30, 8:00 a.m. to 8:00 p.m. with interactive voice response system for Saturdays, Sundays and Federal Holidays. 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 Valor Health 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.valorhealthplan.com or call Member Services at 1-800-485-3793 (TTY users call 711) to ask us to mail you a copy. You can also review the enclosed Evidence of Coverage to see if other benefit or cost changes affect you.

- **Visit *www.valorhealthplan.com***

  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 *Ohio*, the SHIP is called ***Ohio Senior Health Insurance Information Program (OSHIIP)***.

Call ***OSHIIP*** to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call *OSHIIP* at *1-800-686-1578*. You can learn more about ***OSHIIP*** by visiting their website (https://insurance.ohio.gov/about-us/divisions/oshiip).

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.

Valor Health Plan

Insurance focused on you.

FOR MORE INFORMATION

1-800-485-3793 TTY: 711

(8:00 a.m. to 8:00 p.m., 7 days a week)

valorhealthplan.com

Our Mission

Valor Health Plan is committed to integrity, positive outcomes, and compassionate care driven by strong partnerships in order to provide an enhanced quality of life for the members we serve.

Valor Health Plan is a HMO-SNP with a Medicare contract. Enrollment in Valor Health Plan depends on contract renewal.