BlueCare Plus
Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402

How to get important plan materials online

We've made it easier to find important info about your plan.

Go to **bluecareplus.bcbst.com/yourmaterials**.
Then log in to or create your online member account.

Once you're signed in, you can:

- Find a doctor, hospital or pharmacy in our network — available **Oct. 15, 2025**.
- See if your prescriptions are on our covered drug list (formulary) — available **Oct. 15, 2025**.
- View a copy of our Evidence of Coverage (EOC) — available **Oct. 15, 2025**.

Why is it better to go online?

Your online member account gives you the most up-to-date info and materials you may need. That makes it a good place to go for important details about your coverage.

We're here for you

If you need help finding a network pharmacy or provider, or want information about your EOC or the drugs we cover just give us a call at **1-800-332-5762**, TTY **711**. You can also opt out of phone calls about your plan and request plan materials in print.

Best of Health,
Your Member Care Team

H3259_26ORN_C (05/25)

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-332-5762 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-332-5762 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-332-5762 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-332-5762 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

注意 : 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-800-332-5762 (文本电话 : 711) 或咨询您的服务提供商。

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-332-5762 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-332-5762 (TTY : 711) ou parlez à votre fournisseur.

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-332-5762 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-332-5762 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-332-5762 (TTY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-332-5762 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس،به‌طور رایگان موجود می‌باشند. با شماره 1-800-332-5762 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-332-5762 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

注 : 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル (誰もが利用できるよう配慮された) な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-332-5762 (TTY : 711) までお電話ください。または、ご利用の事業者にご相談ください。

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-332-5762 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-332-5762 (TTY: 711) o makipag-usap sa iyong provider.

BlueCare Plus Tennessee

BlueCare Plus Tennessee, an Independent Licensee of the Blue Cross Blue Shield Association

BlueCare Plus (HMO D-SNP)SM offered by Volunteer State Health Plan, Inc. (BlueCare Plus Tennessee)

Annual Notice of Change for 2026

Introduction

You're currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, rules, and costs. This *Annual Notice of Change* tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at bluecareplus.bcbst.com. Call Member Service at the number at the bottom of the page to get a copy by mail. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Additional resources

- This document is available for free in Spanish and Arabic.
- You can get this Annual Notice of Change for free in other formats, such as large print, accessible electronic document, or audio. Call Member Service at **1-800-332-5762** for additional information. (TTY users should call **711**.) Hours are from **October 1 to March 31,** you may call us seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to September 30**, you may call us Monday through Friday from 8 a.m. to 9 p.m. ET. The call is free.
- Members can call Member Service at the toll-free number at the bottom of this page to request needed materials in their preferred language or an alternate format, at no additional cost. If you would like to receive these materials annually, please let us know when you make your request. We will document your preferences and send you these materials annually. If you would like to stop receiving these materials annually, please call us at the tollfree number at the bottom of this page.

Table of Contents

A. Disclaimers

BlueCare Plus Tennessee is an HMO Dual Eligible Special Needs Plan (D-SNP) with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in BlueCare Plus Tennessee depends on contract renewal.

TennCare(Medicaid) is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare(Medicaid) is not responsible for guaranteeing the availability or quality of these benefits.

References to more, extra, additional or otherwise enhanced benefits BlueCare Plus Tennessee offers are applicable only to Medicare benefits, not Medicaid benefits.

The BlueCare Plus plan has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan won't pay for these services, unless authorized in advance or in emergency situations. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call us at the toll-free number at the bottom of this page or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services. This plan doesn't require referrals to see specialists in the BlueCare Plus Tennessee network.

The healthy food benefit listed is a special supplemental benefit for members with certain chronic conditions. Qualifying chronic conditions include, but aren't limited to, cardiovascular disorders, diabetes mellitus, obesity, chronic lung disorders and chronic gastrointestinal disorders. Additional qualifying conditions exist. See plan materials for a complete list. Not all members (even those with a qualifying condition) qualify. Eligibility is based on meeting the CMS definition of "chronically ill enrollee" and all applicable plan coverage criteria.

B. Reviewing your Medicare and TennCare (Medicaid) coverage for next year

It's important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section D** for more information on changes to your benefits for next year.

If you choose to leave our plan, your Medicare membership will end on the last day of the month in which your request was made. The specific date your TennCare will end depends on when we take action on your case. Your notice will tell you when your TennCare ends, it may not be the last day of the month. You'll still be in the Medicare and TennCare programs as long as you're eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section F2.** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- TennCare options and services in **Section F2.** For questions about how to get your TennCare services after you leave our plan, contact the TN SHIP at 1-877-801-0044 TTY 1-800-848-0299, www.tnmedicarehelp.com. Ask how joining another plan or returning to Original Medicare affects how you get your TennCare coverage.

B1. Information about BlueCare Plus

- BlueCare Plus is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members.
- When this *Annual Notice of Change* says “we,” “us,” “our,” or “our plan,” it means BlueCare Plus.

B2. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit and cost changes to make sure they'll work for you next year.
  - Refer to **Section D1** for information about benefit and cost changes for our plan.
- **Check if there are any changes to our drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different cost-sharing tier? Can you use the same pharmacies? Will there be any changes such as prior authorization, step therapy or quantity limits?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section D2** for information about changes to our drug coverage.
  - Your drug costs may have risen since last year.
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.
- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section C** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - How much will you spend out-of-pocket for the services and drugs you use regularly?
  - How do the total costs compare to other coverage options?
- **Think about whether you're happy with our plan.**

If you decide to stay with BlueCare Plus:	If you decide to change plans:
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in BlueCare Plus.	If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section F2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our network providers and pharmacies

Amounts you pay for your drugs depends on which pharmacy you use. Our plan has a network of pharmacies. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

Our provider and pharmacy networks have changed for 2026.

Please review the 2026 Provider and Pharmacy Directory to find out if your providers (primary care provider, specialists, hospitals, etc.) or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at bluecareplus.bcbst.com. You may also call Member Service at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Evidence of Coverage* or call Member Service at the number at the bottom of the page for help.

D. Changes to benefits and costs for next year

D1. Changes to benefits and costs for medical services

We're changing our coverage for certain medical services and what you pay for these covered medical services next year. The table below describes these changes.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from TennCare (Medicaid), very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward your maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$9,350** Once you have paid $9,350 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year	**$9,250** Once you have paid $9,250 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year
Monthly Premium You must also continue to pay your Medicare Part B premium unless it is paid for you by TennCare (Medicaid)	**$40.00** **Note**: Because you receive "Extra Help" your premium is $0	**$27.70** **Note**: Because you receive "Extra Help" your premium is $0
Dental Services	**In Network:** There is no coinsurance, copayment or deductible for covered Preventative and Comprehensive dental services.	**In Network:** There is no coinsurance, copayment or deductible for covered Preventative and Comprehensive dental services.

If you have questions, please call BlueCare Plus Tennessee at 1-800-332-5762, TTY 711, From Oct. 1 to Mar. 31, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From Apr. 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. The call is free. **For more information**, visit bluecareplus.bcbst.com.

	2025 (this year)	2026 (next year)
Dental Services (continued)	**$3000** maximum annual allowance for Comprehensive Dental Services; ex: Fillings, Dentures, Extractions. There is a $1000 limit for certain major restorative procedures. Advance determinations are recommended.	**$3000** maximum annual allowance for covered Comprehensive Dental Services; ex: Fillings, Dentures, Extractions. Advance determinations are recommended.
Flex Card Allowance *** The Healthy Food benefit is a special supplemental benefit for people living with chronic health conditions (SSBCI) and is available only to members who qualify.** **Not all members are eligible. Refer to Section A and your EOC, Chapter 4 for more information.**	**In-Network:** OTC, Healthy Food and Housing Utilities **$200** monthly benefit allowance. The maximum combined allowance for covered OTC, Healthy Food and Housing Utilities is **$200** every month There is no coinsurance, copayment or deductible for covered OTC, Healthy Food and Housing Utilities. This allowance doesn't roll over. Any remaining balance will expire at the end of each month.	**In-Network:** OTC Items, Transportation and Healthy Food*. **Housing Utilities are not covered.** **$318** monthly benefit allowance The maximum combined allowance for covered OTC Items, Transportation and Healthy Food* is **$318** every month. There is no coinsurance, copayment or deductible for covered OTC Items, Transportation and Healthy Food* This allowance doesn't roll over. Any unused amount will expire at the end of each month.
Personal Emergency Response System (PERS)	**In-Network:** **Plan-covered** There is no coinsurance, copayment or deductible for the	PERS is not covered by our plan. **TennCare (Medicaid) Covered** **Personal Emergency Response System (PERS)**

	2025 (this year)	2026 (next year)
Personal Emergency Response System (PERS) (Continued)	personal emergency response system	TennCare (Medicaid) will consider benefits for any service not covered by Medicare.
Transportation Services	**In-Network:** **Plan Covered** There is no coinsurance, copayment, or deductible for plan-approved transportation. Our plan provides transportation for one-way plan-approved medical, vision, dental, hearing appointments, pharmacy and fitness center visits and non-emergency ambulance rides that are not covered by the member's Medicaid plan every year. Plan covers **150** one-way trips to plan-approved locations every year. **TennCare (Medicaid)-covered** Provides transportation for unlimited plan-approved non-emergent medical appointments within 90 miles from pick-up location.	**In Network:** **Plan Covered** Our plan provides transportation for plan-approved medical, vision, hearing appointments, pharmacy and fitness center visits and non-emergency ambulance rides that are not covered by the member's Medicaid plan. This Transportation benefit uses a shared monthly benefit allowance loaded onto the member's Flex Card. **Note:** Must use an approved FlexCard transportation provider **TennCare (Medicaid) Covered** Provides transportation for covered TennCare services.
Vision Care	**In-Network:** **Medicare-Covered** There is no coinsurance, copayment or deductible for Medicare-Covered exams to diagnose and treat diseases/conditions of the eye, glaucoma screening,	**In-Network:** **Medicare-Covered** There is no coinsurance, copayment or deductible for Medicare-Covered exams to diagnose and treat diseases/conditions of the eye, glaucoma screening,

	2025 (this year)	2026 (next year)
Vision Care (continued)	eyeglasses/contact lenses after cataract surgery. **Plan-Covered** There is no coinsurance, copayment or deductible for supplemental vision exams or eyewear. **$500** annual allowance for supplemental vision care; one routine eye exam and limit of one pair of eyeglasses (lens and/or frames) or contact lenses each year.	eyeglasses/contact lenses after cataract surgery. **Plan-Covered** There is no coinsurance, copayment or deductible for supplemental vision exams or eyewear. **$400** annual allowance for supplemental vision care; one routine eye exam each year and limit of one pair of eyeglasses (lens and/or frames) or contact lenses each year.

D2. Changes to drug coverage

Changes to our *Drug List*

An updated *List of Covered Drugs* is located on our website at bluecareplus.bcbst.com. You may also call Member Service at the numbers at the bottom of the page for updated drug information or to ask us to mail you a *List of Covered Drugs*. The *List of Covered Drugs* is also called the *Drug List*.

We made changes to our *Drug List,* which could include removing or adding drugs, changing drugs we cover and changes to 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 find out if there are 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 and/or the state 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 a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
    - You can call Member Service at the numbers at the bottom of the page to ask for a *List of Covered Drugs* that treat the same condition.

- This list can help your provider find a covered drug that might work for you.

- Ask us to cover a temporary supply of the drug.
  - In some situations, we'll cover a **temporary** supply of the drug during the first 90 days of the calendar year.
  - This temporary supply is for up to 30 days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Evidence of Coverage*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.

If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition. You will need to call Member Service at the toll-free number at the bottom of this page to request an exception for the upcoming plan year.

Starting in 2026, we may immediately remove brand name drugs or original biological products on our Drug List, if we replace them with new generics or certain biosimilars versions of the brand name drug or original biological product on the same or lower cost-sharing tier with the same or fewer rules. 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 rules 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, please 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 Service at the number at the bottom of the page or ask your health care provider, prescriber, or pharmacist for more information.

Changes to drug costs

There are two payment stages for your Medicare Part D drug coverage under BlueCare Plus. How much you pay depends on which stage you’re in when you get a prescription filled or refilled. These are the two stages:

Stage 1 Initial Coverage Stage	Stage 2 Catastrophic Coverage Stage
During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through December 31, 2026. You begin this stage after you pay a certain amount of out-of-pocket costs.

The Initial Coverage Stage ends when your total out-of-pocket costs for drugs reaches **$2,100**. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Evidence of Coverage* for more information on how much you'll pay for drugs.

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.

D3. Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, our plan pays a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

We moved some of the drugs on our Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our Drug List.

The following table shows your costs for a one-month supply filled at a network pharmacy with standard copays in each of our 4 drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

Most adult Part D vaccines are covered at no cost to you.

For 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, Section D** of your *Evidence of Coverage*.

	2025 (this year)	2026 (next year)
Drugs in Tier 1 **Preferred Generic Drugs** Cost for a one-month 30-day supply of a drug in Tier 1 that is filled at a network pharmacy or through mail-order	**Generic Drugs**: Your copay for a one-month 30-day supply is **$0 to $4.90 per prescription**. **Brand Drugs**: Your copay for a one-month 30-day supply is **$0 to $12.15 per prescription**. Your copay for a one-month 30-day mail-order prescription is **$0 to $4.90 per prescription for Generic Drugs**. Your copay for a one-month 30-day mail-order prescription is **$0 to $12.15 per prescription for Brand Drugs**.	**Preferred Generic Drugs**: Your copay for a one-month 30-day supply is ***$0*** **for Preferred Generic Drugs.** Your copay for a one-month 30-day mail-order prescription is ***$0*** **for Preferred Generic Drugs**.
Drugs in Tier 2 **Preferred Brand Drugs** Cost for a one-month 30-day supply of a drug in Tier 2 that is filled at a network pharmacy or through mail order	**Non-Applicable**	**Preferred Brand Drugs**: Your copay for a one-month 30-day supply is **25% coinsurance** of the total cost for **Preferred Brand Drugs.** Your copay for a one-month 30-day supply of each covered insulin product is **25% coinsurance of total cost, but no more than $35 monthly.** Your copay for a one-month 30-day mail-order prescription is **25% coinsurance** of the total cost for **Preferred Brand Drugs.**

	2025 (this year)	2026 (next year)
Drugs in Tier 3 **Non-Preferred Drugs** Cost for a one-month 30-day supply of a drug in Tier 3 that's filled at a network pharmacy or through mail-order.	**Non-Applicable**	**Non-Preferred Drugs**: Your copay for a one-month 30-day supply is **25% coinsurance** of the total cost for **Non-Preferred Drugs** Your copay for a one-month 30-day mail-order prescription is **25% coinsurance** of the total cost for **Non-Preferred Drugs**
Drugs in Tier 4 **Specialty Drugs** Cost for a one-month 30-day supply of a drug in Tier 4 that's filled at a network pharmacy or through mail-order	**Non-Applicable**	**Specialty Drugs**: Your copay for a one-month 30-day supply is **25% coinsurance** of the total cost for **Specialty Drugs** Your copay for a one-month 30-day mail-order prescription is **25% coinsurance** of the total cost for **Specialty Drugs**.

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$2,100**. At that point the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Evidence of Coverage* for more information about how much you pay for drugs.

D4. Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit of **$2,100** for your drugs, the Catastrophic Coverage Stage begins, and you pay nothing for your covered drugs. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

For more information about your costs in the Catastrophic Coverage stage, refer to **Chapter 6, Section E** of your *Evidence of Coverage.*

E. 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 Medicare Part D drug costs by spreading them across **monthly payments that vary throughout the 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 for drugs covered by Part D.

	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).	If you're participating in the Medicare Prescription Payment Plan and remain in the same plan, you don't need to do anything to stay in the Medicare Prescription Payment Plan.

F. Choosing a plan

F1. Staying in our plan

We hope to keep you as a plan member. You don't have to do anything to stay in our plan. Unless you sign up for a different Medicare plan or change to Original Medicare, you'll automatically stay enrolled as a member of our plan for 2026.

F2. Changing plans

For your TennCare plan, TennCare members may change their Managed Care Organization (MCO) one (1) time within the initial ninety (90) calendar days from the date of the letter informing them of their MCO assignment. You'll remain a member of the designated MCO until you're given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for members in West Tennessee, in May for members in Middle Tennessee, and in July for members in East Tennessee. Most people with Medicare can end their membership during certain times of the year. Because you have TennCare you can end your membership in our plan any month of the year

In addition, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you moved out of our service area,
- your eligibility for TennCare or Extra Help changed, **or**
- you recently moved into or are currently getting care in, an institution (like a skilled nursing facility or a long-term care hospital). If you recently moved out of an institution, you can change plans or change to Original Medicare for two full months after the month you move out.

F2. Changing plans (continued)

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section F2**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-Inclusive Care for the Elderly (PACE) plan, if you qualify.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-inclusive Care for the Elderly (PACE) inquiries, call 423-698-0802. If you need help or more information: • Call TN SHIP at the Tennessee Commission on Aging and Disability 1-877-801-0044 TTY 1-800-848-0299, For more information or to find a local TN SHIP office in your area, please visit www.tnmedicarehelp.com **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins. Your TennCare enrollment won't be affected by this change.

2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call TN SHIP at the Tennessee Commission on Aging and Disability 1-877-801-0044 TTY 1-800-848-0299, For more information or to find a local TN SHIP office in your area, please visit www.tnmedicarehelp.com. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your TennCare enrollment won't be affected by this change.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare drug plan **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call TN SHIP at the Tennessee Commission on Aging and Disability 1-877-801-0044 TTY 1-800-848-0299 www.tnmedicarehelp.com	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call TN SHIP at the Tennessee Commission on Aging and Disability 1-877-801-0044 TTY 1-800-848-0299, www.tnmedicarehelp.com. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your TennCare enrollment won't be affected by this change.

4. You can change to:	**Here is what to do:**
Any Medicare health plan during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section A.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 423-698-0802. If you need help or more information: • Call TN SHIP at the Tennessee Commission on Aging and Disability 1-877-801-0044 TTY 1-800-848-0299, www.tnmedicarehelp.com **OR** Enroll in a new Medicare plan. You're automatically disenrolled from our Medicare plan when your new plan's coverage begins. Your TennCare enrollment won't be affected by this change.

Your TennCare services

For questions about how to get your TennCare services after you leave our plan, contact the TN SHIP at 1-877-801-0044 TTY 1-800-848-0299, www.tnmedicarehelp.com. Ask how joining another plan or returning to Original Medicare affects how you get your TennCare coverage.

G. Getting help

G1. Our plan

We're here to help if you have any questions. Call Member Service at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your *Evidence of Coverage*

Your *Evidence of Coverage* is a legal, detailed description of our plan's benefits. It has details about benefits and costs for 2026. It explains your rights and the rules to follow to get services and drugs we cover.

The *Evidence of Coverage* for 2026 will be available by October 15. An up-to-date copy of the *Evidence of Coverage* is available on our website at bluecareplus.bcbst.com. You may also call Member Service at the numbers at the bottom of the page to ask us to mail you an *Evidence of Coverage* for 2026.

Our website

You can visit our website at bluecareplus.bcbst.com. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List (List of Covered Drugs).*

G2. TN SHIP (TN State Health Insurance Assistance Program)

You can also call the state health insurance program (SHIP). In Tennessee the SHIP is called the TN SHIP. TN SHIP can help you understand your plan choices and answer questions about switching plans. TN SHIP isn't connected with us or with any insurance company or health plan. TN SHIP has trained counselors statewide and services are free. TN SHIP phone number is 1-877-801-0044. For more information or to find a local TN SHIP office in your area, please visit www.tnmedicarehelp.com

G. Getting help (continued)

G3. Long-Term Care Ombudsman

The Ombudsman works with many agencies and may be able to help resolve questions or concerns that involve state and federal agencies administering services to the elderly. Concerns can include quality of care, financial information, resident rights, admissions, transfer, and discharge. Also included are questions regarding nursing homes, homes for the aged, assisted care living facilities, Medicaid, and Medicare.

The Ombudsperson Program can help you if you have a problem with our plan. The ombudsperson's services are free and available in all languages. The Ombudsperson Program:

- works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.
- makes sure you have information related to your rights and protections and how you can get your concerns resolved.
- isn't connected with us or with any insurance company or health plan. The phone number for the Ombudsperson Program is 1-877-236-0013.

G4. Medicare

To get information directly from Medicare:

- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- chat live at www.Medicare.gov/talk-to-someone
- write to Medicare at PO Box 1270, Lawrence, KS 66044.

Medicare's Website

You can visit the Medicare website (www.medicare.gov). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to www.medicare.gov and click on "Find plans.")

G. Getting help (continued)

Medicare & You 2026

You can read the *Medicare & You 2026* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G5. TennCare

TennCare is the state of Tennessee's Medicaid program. It provides healthcare to mostly low-income pregnant women, parents or caretakers of a minor child, children, and individuals who are elderly or have a disability. Have questions about your TennCare coverage? Call your health plan or call TennCare Connect at 1-855-259-0701 or 1-800-848-0298 TTY. Or use the free TennCare Connect member portal at: www.tenncareconnect.tn.gov

G6. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that may help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December) as monthly payments. This program doesn't save you money or lower your drug costs.

"Extra Help" from Medicare and help from your state's pharmaceutical assistance program (SPAP) and the AIDS Drug Assistance Program (ADAP), for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone. All enrollees are eligible to participate in this program, regardless of income level. To learn more about this program please contact us at the phone number at the bottom of this page or visit www.medicare.gov.

G. Getting help (continued)

G7. Programs that help pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have TennCare (Medicaid), you are already enrolled in "Extra Help", also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State TennCare (Medicaid) Office (applications)
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Ryan White Program (Tennessee's AIDS Drug Assistance program). For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call the Ryan White Program (Tennessee's AIDS Drug Assistance program) at 1-615-741-7500. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.