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

Annual Notice of Change for 2026

You're enrolled as a member of BlueCare Plus Select.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in BlueCare Plus Select (HMO D-SNP).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at bluecareplus.bcbst.com or call Member Service at 1-800-332-5762 (TTY users call **711**) to get a copy by mail.

More Resources

- Call Member Service at **1-800-332-5762** (TTY users call **711**) for more information. 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. This call is free.
- This material is also available in alternate formats (e.g., braille, large print, audio).

About *BlueCare Plus Select*

- 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. Our plan also has a written agreement with the (TennCare) Medicaid program to coordinate your Medicaid benefits.
- When this material says “we,” “us,” or “our,” it means Volunteer State Health Plan, Inc. (BlueCare Plus Tennessee). When it says “plan” or “our plan,” it means BlueCare Plus Select.
- TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare 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 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 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.
- **If you do nothing by December 7, 2025, you’ll automatically be enrolled in** BlueCare Plus Select (HMO DSNP). Starting January 1, 2026, you’ll get your medical and drug coverage through BlueCare Plus Select (HMO DSNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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

Table of Contents

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 1.1 for details.	**$40.00** (Note: Because you receive "Extra Help", your premium is **$0**.)	**$27.70 (Note: Because you receive "Extra Help", your premium is $0.)**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to section 1.2 for details.) **Because our members also get assistance from TennCare (Medicaid), very few members ever reach this out-of-pocket maximum.** 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** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	**$9,250** **You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.**
Primary care office visits	Primary care visits: **$0** copay per visit	**Primary care visits: $0 copay per visit**
Specialist office visits	Specialist visits: **$0** copay per visit	**Specialist visits: $0 copay per visit**

	2025 (this year)	2026 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	**$0** copay per stay	**$0 copay per stay**
Part D drug coverage deductible (Go to Section 1.7 for details.)	Deductible: $0	**Deductible: $0**

	2025 (this year)	2026 (next year)
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment during the Initial Coverage Stage: Drug Tier 1 **Generic**: **$0** copay Drug Tier 1 **Brand**: **$0** copay Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	**Copayment during the Initial Coverage Stage:** **Drug Tier 1:** **Preferred Generic Drugs** **$0 copay per prescription** **Drug Tier 2:** **Preferred Brand Drugs** **25% coinsurance of the total cost per prescription** **For each covered insulin product on Tier 2 you pay 25% coinsurance of the total cost, for a one month 30-day supply, but no more than $35 monthly.** **Drug Tier 3:** **Non-Preferred Drugs** **25% coinsurance of the total cost per prescription** **Drug Tier 4:** **Specialty Drugs** **25% coinsurance of the total cost per prescription** **Catastrophic Coverage Stage:** **$0 copay** **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 unless it's 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**.)

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 Because our members also get help 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 the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments) **count** toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$9,350	**$9,250** **Once you've paid $9,250 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* bluecareplus.bcbst.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 bluecareplus.bcbst.com.
- Call Member Service at **1-800-332-5762** (TTY users call **711**) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Service at **1-800-332-5762** (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* bluecareplus.bcbst.com to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory:*

- Visit our website at bluecareplus.bcbst.com.
- Call Member Service at **1-800-332-5762** (TTY users call **711**) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Service at **1-800-332-5762** (TTY users call **711**) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

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

	2025 (this year)	2026 (next year)
Dental Services	Not Applicable	**In-Network:** **There is no coinsurance, copayment, or deductible for covered Preventive and Comprehensive dental services.** **$3000 maximum annual allowance for covered Comprehensive Dental Services; ex: Fillings, Dentures, Extractions.** **Advance determinations are recommended**

	2025 (this year)	2026 (next year)
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 your EOC, Chapter 4, for more information.**	**In-Network:** OTC, Healthy Food, Housing Utilities and Transportation. **$275** monthly benefit allowance. The maximum combined allowance for covered OTC, Healthy Food, Housing Utilities and Transportation is **$275** every month. There is no coinsurance, copayment or deductible for covered OTC, Healthy Food, Housing Utilities and Transportation. This allowance doesn't roll over. Any unused amount will expire at the end of each month.	**In-Network:** **OTC items, Healthy Food* and Transportation** **Housing Utilities are not covered.** **$283 monthly benefit allowance.** **The maximum combined allowance for covered OTC items, Healthy Food* and Transportation is $283.** **There is no coinsurance, copayment or deductible for covered OTC Items, Healthy Food* and Transportation.** **This allowance doesn't roll over. Any unused amount will expire at the end of each month.**
Meals **Meals received following discharge from acute inpatient hospital or skilled nursing facility stay.** **Notification is required**	**In Network:** **Plan Covered** There is no coinsurance, copayment or deductible for covered meals. **56** meals following **each** qualifying inpatient stay	**In Network:** **Plan Covered** **There is no coinsurance, copayment or deductible for covered meals.** **28 meals following each qualifying inpatient stay**

	2025 (this year)	2026 (next year)
Personal Emergency Response System (PERS)	**In-Network:** **Plan-covered** There is no coinsurance, copayment or deductible for the personal emergency response system.	**PERS is not covered**
Vision	**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, 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 each year and limit of one pair of eyeglasses (lens and/or frames) or contact lenses each year.	**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, 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.**

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.

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

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

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Service at **1-800-332-5762** (TTY users call **711**) for more information.

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

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

Some of these drug types may be new to you. For definitions of drug types, go to Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: www.FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients.

You can also call Member Service at **1-800-332-5762** (TTY users call **711**) or ask your health care provider, prescriber, or pharmacist for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and you don't get this material by Sept. 30, 2025 call Member Service at **1-800-332-5762** (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***

  We have no deductible, so this payment stage doesn't apply to you.

- ***Stage 2: Initial Coverage***

  In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach **$2,100**.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	**Because we have no deductible, this payment stage doesn't apply to you.**

Drug Costs in Stage 2: Initial Coverage

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

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

Once you've paid **$2,100** 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)
Drugs in Tier 1 **Preferred Generic Drugs:** Cost for a one-month 30-day supply of a drug in Tier 1 that's filled at a network pharmacy or through mail-order.	**Generic Drugs :** Your copay for a one-month 30-day supply is $0. **Brand Drugs:** Your copay for a one-month 30-day supply is $0	**<u>Preferred Generic Drugs:</u>** **Your copay for a one-month 30-day supply is** **$0 per prescription** **Your copay for a one-month 30-day supply mail-order prescription is** **$0 per prescription**

	2025 (this year)	2026 (next year)
Drugs in Tier 2 **Preferred Brand Drugs:** Cost for a one-month 30-day supply of a drug in Tier 2 that's filled at a network pharmacy or through mail-order.	Not Applicable	**Preferred Brand Drugs:** **Your copay for a one-month 30- day supply is 25% coinsurance of the total cost of the drug.** **Your copay for a one-month 30-day supply of each covered insulin product is 25% coinsurance of the total cost, but no more than $35 monthly** **Your cost for a one-month 30-day supply mail-order prescription is 25% coinsurance of the total cost for Preferred Brand Drugs.**
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.	Not Applicable	**Non-Preferred Drugs:** **Your copay for a one-month 30- day supply is 25% coinsurance of total cost of the drug.** **Your cost for a one-month 30-day supply mail-order prescription is 25% coinsurance of the total cost for Non-Preferred Drugs**

	2025 (this year)	2026 (next year)
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.	Not Applicable	**Specialty Drugs:** **Your copay for a one-month 30-day supply is 25% coinsurance of the total cost of the drug.** **Your cost for a one-month 30-day supply mail-order prescription is 25% coinsurance of the total cost for Specialty Drugs.**

Changes to the Catastrophic Coverage Stage

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

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

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 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 us 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). 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 1-800-332-5762 (TTY users call 711) or visit www.Medicare.gov.

SECTION 3 How to Change Plans

To stay in BlueCare Plus Select, 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 BlueCare Plus Select.

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 BlueCare Plus Select (HMO D-SNP).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from BlueCare Plus Select (HMO D-SNP).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Service at **1-800-332-5762** (TTY users call **711**) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 4.4 in the *Evidence of Coverage* for more information).
- **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 of this document for more information), 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

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

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

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles,

and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
- Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
- Your State Medicaid office.

- **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 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're currently enrolled, how to continue getting help, 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.
- **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 SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at **1-800-332-5762** (TTY users call **711**) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from BlueCare Plus Select

- **Call Member Service at 1-800-332-5762. (TTY users call 711.)**

  We're available for phone calls from **Oct. 1 to March 31,** seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30,** you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. 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 BlueCare Plus Select. 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 bluecareplus.bcbst.com or call Member Service at **1-800-332-5762** (TTY users call **711**) to ask us to mail you a copy.

- **Visit bluecareplus.bcbst.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 Tennessee, the SHIP is called the Tennessee State Health Insurance Assistance Program.

Call the Tennessee State Health Insurance Assistance Program. to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Call the Tennessee State Health Insurance Assistance Program at 1-877-801-0044 (Toll-Free). Learn more about the Tennessee State Health Insurance Assistance Program. by visiting (https://www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html).

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.

Get Help from Medicaid

For questions about your TennCare (Medicaid) benefits, contact TennCare (Medicaid) at 1-800-342-3145, Monday through Friday, 8 a.m. to 5 p.m. in all time zones. Offices are closed on state holidays. TTY users should call 1-877-779-3103. Ask how joining another plan or returning to Original Medicare affects how you get your TennCare (Medicaid) or ask for help with Medicaid enrollment or benefit questions.