

## 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](https://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, 2026**.
- › See if your prescriptions are on our covered drug list (formulary) — available **Oct. 15, 2026**.
- › View a copy of our Evidence of Coverage (EOC) — available **Oct. 15, 2026**.



### 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've updated our Notice of Privacy Practices

We now give you more info about where we get your personal data and how we use and share it. You can find it online at [bluecareplus.bcbst.com/documents](https://bluecareplus.bcbst.com/documents).

## 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 **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

Member Service: 8 a.m. to 9 p.m. ET, 7 days a week (**Oct. 1–March 31**); 8 a.m. to 9 p.m. ET, M–F (**April 1–Sept. 30**). BlueCare Plus Tennessee complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex<sup>1</sup>. 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 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 800-332-5762 (TTY: 711) o hable con su proveedor.

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 800-332-5762 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

<sup>1</sup>Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)  
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# 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。

**ध्यान आपो:** જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-332-5762 (TTY: 711) પર કોલ 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 ይቀርባል፡፡ መረጃን በተደራሽ ቅርጽ ለማቅረብ ተገቢ የሆኑ ተጨማሪ አገዛዎች 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، فستوفر 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 می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-800-332-5762 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste 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 serbisyonang 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, an Independent Licensee of the Blue Cross Blue Shield Association

## BlueCare Plus Select (HMO D-SNP)<sup>SM</sup> offered by Volunteer State Health Plan, Inc. (BlueCare Plus Tennessee)

# Annual Notice of Change for 2027

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, 2026, you'll stay in BlueCare Plus Select.
- To change to a **different plan**, visit [Medicare.gov](https://www.Medicare.gov) or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [bluecareplus.bcbst.com](https://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. 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 (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 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, 2026, you’ll automatically be enrolled in** BlueCare Plus Select. Starting January 1, 2027, you’ll get your medical and drug coverage through BlueCare Plus Select. 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 2027

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2026<br>(this year)                                                                                                                                          | 2027<br>(next year)                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>* Your premium can be higher or lower than this amount. Go to Section 1.1 for details.                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$27.70</b> (Note: Because you receive "Extra Help", your premium is <b>\$0</b> .)                                                                        | <b>\$13.70</b> (Note: Because you receive "Extra Help", your premium is <b>\$0</b> .)                                                                               |
| <b>Maximum out-of-pocket amount</b><br>This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to section 1.2 for details.)<br><b>Because our members also get assistance from TennCare (Medicaid), very few members ever reach this out-of-pocket maximum.</b><br>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. | <b>\$9,250</b><br>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. | <b>\$9,850</b><br><b>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.</b> |
| <b>Primary care office visits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Primary care visits:<br><b>\$0</b> copay per visit                                                                                                           | <b>Primary care visits:</b><br><b>\$0</b> copay per visit                                                                                                           |
| <b>Specialist office visits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Specialist visits:<br><b>\$0</b> copay per visit                                                                                                             | <b>Specialist visits:</b><br><b>\$0</b> copay per visit                                                                                                             |

|                                                                                                                                                                                                                                                                         | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient hospital stays</b><br>Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged. | \$0 copay per stay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$0 copay per stay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Part D drug coverage</b><br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)                                                                                                                        | Part D drug coverage deductible<br><br>Deductible: \$0<br><br>Copayment during the Initial Coverage Stage:<br><br><u>Drug Tier 1:</u><br><b>Preferred Generic Drugs</b><br><b>\$0 copay</b> per prescription<br><br><u>Drug Tier 2:</u><br><b>Preferred Brand Drugs</b><br><b>25% coinsurance</b> of the total cost per prescription<br><br>For each covered insulin product on Tier 2 you pay <b>25% coinsurance</b> of the total cost, for a one month 30-day supply, but no more than <b>\$35</b> monthly. | <b>Part D drug coverage deductible</b><br><br><b>Deductible: \$0</b><br><br><b>Copayment during the Initial Coverage Stage:</b><br><br><u><b>Drug Tier 1:</b></u><br><b>Preferred Generic Drugs</b><br><b>25% coinsurance</b> of the total cost per prescription<br><br><u><b>Drug Tier 2:</b></u><br><b>Generic Drugs</b><br><b>25% coinsurance</b> of the total cost per prescription<br><br><u><b>Drug Tier 3:</b></u><br><b>Preferred Brand Drugs</b><br><b>25% coinsurance</b> of the total cost per prescription<br><br><b>For each covered insulin product on Tier 3 you pay 25% coinsurance of the</b> |

|  | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                  | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p><u>Drug Tier 3:</u><br/><b>Non-Preferred Drugs</b><br/>25% coinsurance of the total cost per prescription</p> <p><u>Drug Tier 4:</u><br/><b>Specialty Drugs</b><br/>25% coinsurance of the total cost per prescription</p> <p>Catastrophic Coverage Stage:<br/><b>\$0 copay</b><br/>During this payment stage, you pay nothing for your covered Part D drugs.</p> | <p>total cost, for a one month 30-day supply, but no more than \$35 monthly.</p> <p><u>Drug Tier 4:</u><br/><b>Non-Preferred Drugs</b><br/>25% coinsurance of the total cost per prescription</p> <p><u>Drug Tier 5:</u><br/><b>Specialty Drugs</b><br/>25% coinsurance of the total cost per prescription</p> <p><u>Drug Tier 6:</u><br/><b>Select Care Drugs</b><br/><b>\$0 copay per prescription</b></p> <p>Catastrophic Coverage Stage:<br/><b>\$0 copay</b><br/>During this payment stage, you pay nothing for your covered Part D drugs.</p> |

## SECTION 1 Changes to Benefits & Costs for Next Year

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### Section 1.1 Changes to the Monthly Plan Premium

|                                                                                                                                              | 2026(this year)                                                                       | 2027 (next year)                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <b>Monthly plan premium</b><br>(You must also continue to pay your Medicare Part B premium unless it's paid for you by TennCare (Medicaid).) | <b>\$27.70</b> (Note: Because you receive "Extra Help", your premium is <b>\$0.</b> ) | <b>\$13.70</b> (Note: Because you receive "Extra Help", your premium is <b>\$0.</b> ) |

### Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2026<br>(this year) | 2027<br>(next year)                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Maximum out-of-pocket amount</b></p> <p>Cost-sharing paid by the beneficiary, Medicaid, and other secondary insurance contributes towards this out-of-pocket maximum. Because our members get most cost sharing paid by Medicaid, very few members ever reach this out-of-pocket maximum.</p> <p>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.</p> <p>Your costs for covered medical services (such as copayments) <b>count</b> toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount.</p> | \$9,250             | <p><b>\$9,850</b></p> <p><b>Once you've paid \$9,850 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.</b></p> |

### Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider Directory* [bluecareplus.bcbst.com](http://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](http://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. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

## Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2027 *Pharmacy Directory* [bluecareplus.bcbst.com/pharmacy](https://bluecareplus.bcbst.com/pharmacy) to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at [bluecareplus.bcbst.com/pharmacy](https://bluecareplus.bcbst.com/pharmacy).
- 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.

|                                                                                                                                                                                                                                                                       | 2026<br>(this year)                                                                                                                                                                                        | 2027<br>(next year)                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Flex Card Allowance</b><br><b>*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. See more info on pg. 2 or refer</b> | OTC items, Healthy Food* and Transportation<br><br><b>\$283</b> monthly benefit allowance.<br><br>The maximum combined allowance for covered OTC items, Healthy Food* and Transportation is <b>\$283</b> . | <b>OTC Items and Healthy Food*</b><br><br><b>Transportation is not included in the Flex Card allowance.</b><br><br><b>\$192</b> monthly benefit allowance.<br><br><b>The maximum combined</b> |

|                                                       | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>to Chapter 4 of your EOC for more information.</b> | <p>There is no coinsurance, copayment or deductible for covered OTC Items, Healthy Food* and Transportation.</p> <p>This allowance doesn't roll over. Any unused amount will expire at the end of each month.</p>                                                                                                                                                                                                                                                                                       | <p><b>allowance for covered OTC Items and Healthy Food* is \$192 every month.</b></p> <p><b>There is no coinsurance, copayment or deductible for covered OTC Items and Healthy Food*.</b></p> <p><b>This allowance doesn't roll over. Any unused amount will expire at the end of each month.</b></p>                                                                                                                                                                                                                                               |
| <b>Transportation Services</b>                        | <p><b>In-Network:</b></p> <p><b>Plan Covered</b><br/>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.</p> <p><b>Note:</b> Must use an approved FlexCard transportation provider</p> <p><b>TennCare (Medicaid) Covered</b></p> | <p><b>In-Network:</b></p> <p><b>Plan Covered</b><br/><b>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 100 one-way trips to plan-approved locations every year.</b></p> <p><b>TennCare (Medicaid) covered</b><br/><b>Provides transportation</b></p> |

|  | 2026<br>(this year)                                    | 2027<br>(next year)                   |
|--|--------------------------------------------------------|---------------------------------------|
|  | Provides transportation for covered TennCare services. | <b>for covered TennCare services.</b> |

## 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 AND posted online at [bluecareplus.bcbst.com/pharmacy](https://bluecareplus.bcbst.com/pharmacy).

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.

## 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 you about your drug costs. If you get Extra Help and you don't get this material by Sept. 30, 2026 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.

- **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 **\$2,400**.

- **Stage 3: Catastrophic Coverage**

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

### Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

|                          | 2026<br>(this year)                                                     | 2027<br>(next year)                                                            |
|--------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <b>Yearly Deductible</b> | Because we have no deductible, this payment stage doesn't apply to you. | <b>Because we have no deductible, this payment stage doesn't apply to you.</b> |

### Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 1, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2026 to 2027.

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

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

Once you've paid **\$2,400** out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

|                                                                                                                                                                                                                                                                                                                               | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2027<br>(next year)                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Drugs in Tier 1<br/>Preferred Generic Drugs:</b></p> <p>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.</p>                                                                                                                                           | <p><b><u>Preferred Generic Drugs:</u></b></p> <p>Your copay for a one-month 30-day supply is <b>\$0</b> per prescription.</p> <p>Your copay for a one-month 30-day supply mail-order prescription is <b>\$0</b> per prescription.</p>                                                                                                                                                                                                                                 | <p><b><u>Preferred Generic Drugs:</u></b></p> <p><b>Your copay for a one-month 30-day supply is 25% coinsurance of the total cost of the drug.</b></p> <p><b>Your cost for a one-month 30-day supply mail-order prescription is 25% coinsurance of the total cost for Preferred Generic Drugs.</b></p> |
| <p><b>Drugs in Tier 2<br/>Generic Drugs:</b></p> <p>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.</p> <p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p> | <p><b><u>Preferred Brand Drugs:</u></b></p> <p>Your copay for a one-month 30-day supply is <b>25% coinsurance</b> of the total cost of the drug.</p> <p>Your copay for a one-month 30-day supply of each covered insulin product is <b>25% coinsurance</b> of the total cost, but no more than <b>\$35</b> monthly.</p> <p>Your cost for a one-month 30-day supply mail-order prescription is <b>25% coinsurance</b> of the total cost for Preferred Brand Drugs.</p> | <p><b><u>Generic Drugs:</u></b></p> <p><b>Your copay for a one-month 30-day supply is 25% coinsurance of the total cost of the drug.</b></p> <p><b>Your cost for a one-month 30-day supply mail-order prescription is 25% coinsurance of the total cost for Generic Drugs.</b></p>                     |

|                                                                                                                                                                                                                                                                                                                                        | 2026<br>(this year)                                                                                                                                                                                                                                                                        | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Drugs in Tier 3:<br/>Preferred Brand Drugs:</b></p> <p>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.</p> <p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p> | <p><b><u>Non-Preferred Drugs:</u></b></p> <p>Your copay for a one-month 30-day supply is <b>25% coinsurance</b> of total cost of the drug.</p> <p>Your cost for a one-month 30-day supply mail-order prescription is <b>25% coinsurance</b> of the total cost for Non-Preferred Drugs.</p> | <p><b><u>Preferred Brand Drugs:</u></b></p> <p><b>Your copay for a one-month 30-day supply is 25% coinsurance of the total cost of the drug.</b></p> <p><b>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.</b></p> <p><b>Your cost for a one-month 30-day supply mail-order prescription is 25% coinsurance of the total cost for Preferred Brand Drugs.</b></p> |
| <p><b>Drugs in Tier 4:<br/>Non-Preferred Drugs:</b></p> <p>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.</p> <p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p>   | <p><b><u>Specialty Drugs:</u></b></p> <p>Your copay for a one-month 30-day supply is <b>25% coinsurance</b> of the total cost of the drug.</p> <p>Your cost for a one-month 30-day supply mail-order prescription is <b>25% coinsurance</b> of the total cost for Specialty Drugs.</p>     | <p><b><u>Non-Preferred Drugs:</u></b></p> <p><b>Your copay for a one-month 30-day supply is 25% coinsurance of the total cost of the drug.</b></p> <p><b>Your cost for a one-month 30-day supply mail-order prescription is 25% coinsurance of the total cost for Non-Preferred Drugs.</b></p>                                                                                                                                                                 |

|                                                                                                                                                                                                                                                                                                                                    | 2026<br>(this year) | 2027<br>(next year)                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Drugs in Tier 5:<br/>Specialty Drugs:</b></p> <p>Cost for a one-month 30-day supply of a drug in Tier 5 that's filled at a network pharmacy.</p> <p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p>                         | N/A                 | <p><b><u>Specialty Drugs:</u></b></p> <p><b>Your copay for a one-month 30-day supply is 25% coinsurance of the total cost of the drug.</b></p>                                                                                  |
| <p><b>Drugs in Tier 6:<br/>Select Care Drugs:</b></p> <p>Cost for a one-month 30-day supply of a drug in Tier 6 that's filled at a network pharmacy or through mail-order.</p> <p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p> | N/A                 | <p><b><u>Select Care Drugs:</u></b></p> <p><b>Your copay for a one-month 30-day supply is \$0 per prescription.</b></p> <p><b>Your copay for a one-month 30-day supply mail-order prescription is \$0 per prescription.</b></p> |

## SECTION 2 How to Change Plans

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

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from BlueCare Plus Select. Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage**, you can enroll in a Part D plan, and you'll automatically be disenrolled from BlueCare Plus Select.
- **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.
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [Medicare.gov](https://www.medicare.gov), check the Medicare & You 2027 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 2.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

## Section 2.2 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 3 Get Help Paying for Prescription Drugs

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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. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at **1-800-332-5762** (TTY users call **711**) or visit [Medicare.gov](https://www.Medicare.gov).

## SECTION 4 Questions?

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### 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 2027 Evidence of Coverage**

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for 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](https://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](https://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 [Medicare.gov](https://www.medicare.gov)**

You can chat live at [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone).

- **Write to Medicare**

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

- **Visit [Medicare.gov](https://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 2027***

The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [Medicare.gov](https://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 help with Medicaid enrollment or questions about your TennCare (Medicaid) benefits, call TennCare (Medicaid) at 1-800-342-3145, Monday through Friday, 7 a.m. to 6 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.

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