of Tennessee
1 Cameron Hill Circle | Chattanooga, TN 37402

# Find Your Important Plan Materials Online

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To get started, go to **medicare.bcbst.com/yourmaterials**. Then log in to or create your account. You'll need your **Subscriber ID** and **Group Number**. You can find both on your Member ID card.

### Once you're signed in, you can:

- See what benefits are changing next year in our Annual Notice of Changes (ANOC) — available **Oct. 1, 2026**.
- Find a doctor, hospital or pharmacy in our network — available **Oct. 15, 2026**.
- View a copy of our Evidence of Coverage (EOC) — available **Oct. 15, 2026**.
- Check your claims and balances anytime.
- See if your prescriptions are on our covered drug list, or formulary (if your plan includes Part D drug benefits) — available **Oct. 15, 2026**.
- Sign up to get texts and emails from us. Just select **Account** in the top menu. Then go to **Communication Settings**.

### Let us know if you:

- Need help finding a network provider or pharmacy.
- Want more information about the ANOC, EOC or drugs we cover (if your plan includes Part D drug benefits).

Just give us a call at the Member Service number on the back of your Member ID card. You can also opt out of phone calls about your plan and request plan materials in print.

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**).

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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 1-800-831-2583 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

[1] 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 1-800-831-2583 (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 1-800-831-2583 (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 1-800-831-2583 (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. 1-800-831-2583 (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 1-800-831-2583（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. 1-800-831-2583 (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 1-800-831-2583 (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 1-800-831-2583 (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। 1-800-831-2583 (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 1-800-831-2583 (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 1-800-831-2583 (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 1-800-831-2583 (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 1-800-831-2583 (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。1-800-831-2583（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。

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang a dispozisyon w gratis. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo a dispozisyon gratis tou. Rele nan 1-800-831-2583 (TTY: 711) oswa pale avèk founisè swen w lan.

ATENÇÃO: Se você fala [Português], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-831-2583 (TTY: 711) ou fale com seu provedor.

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ, ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-831-2583 (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 1-800-831-2583 (TTY: 711) o makipag-usap sa iyong provider.

## *BlueAdvantage Diamond (PPO)SM* offered by *BlueCross BlueShield of Tennessee, Inc.*

# Annual Notice of Change for 2027

You're enrolled as a member of BlueAdvantage Diamond.

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 BlueAdvantage Diamond (PPO)
- To change to a **different plan**, visit 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 Medicare.bcbst.com or call Member Service at **1-800-831-2583** (TTY users call **711**) to get a copy by mail.

**More Resources**

- Call Member Service at **1-800-831-2583** (TTY users call **711**). Hours are from **Oct. 1 to March 31**, you can call us 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. This call is free.
- This material is also available in alternate formats (e.g., braille, large print, audio).

H7917_27ANOC009_M (08/26)

OMB Approval 0938-1051 (Expires: July 31, 2029)

## About BlueAdvantage Diamond

- BlueAdvantage is a PPO plan with a Medicare contract. Enrollment in BlueAdvantage depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means BlueCross BlueShield of Tennessee, Inc. When it says “plan” or “our plan,” it means BlueAdvantage Diamond.
- **If you do nothing by December 7, 2026, you’ll automatically be enrolled in BlueAdvantage Diamond (PPO).** Starting January 1, 2027, you’ll get your medical and drug coverage through BlueAdvantage Diamond (PPO). 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 (this year) | 2027 (next year) |
|---|---|---|
| **Monthly plan premium*** <br> * Your premium can be higher or lower than this amount. Go to Section 1.1 for details. | **$157** | **$161** |
| **Maximum out-of-pocket amount** <br> 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.) | From network providers: **$2,975** <br> From network and out-of-network providers combined: **$5,750** | **From network providers: $4,450** <br> **From network and out-of-network providers combined: $6,700** |
| **Primary care office visits** | **In-Network:** <br> **$0** copay per visit <br> **Out-of-Network:** <br> **50% coinsurance** of the Medicare-allowed amount per visit | **In-Network:** <br> **$0 copay per visit** <br> **Out-of-Network:** <br> **50% coinsurance of the Medicare-allowed amount per visit** |
| **Specialist office visits** | **In-Network:** <br> **$20** copay per visit <br> **Out-of-Network:** <br> **50% coinsurance** of the Medicare-allowed amount per visit | **In-Network:** <br> **$30 copay per visit** <br> **Out-of-Network:** <br> **50% coinsurance of the Medicare-allowed amount per visit** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Inpatient hospital stays**<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. | **In-Network:**<br>**Medicare-covered stay**<br>**$75** copay per day for days 1-4<br>**$0** copay per day for additional days<br>**Out-of-Network:**<br>**Medicare-covered stay**<br>**50% coinsurance** of the Medicare-allowed amount per admission | **In-Network:**<br>**Medicare-covered stay**<br>**$175 copay per day for days 1-5**<br>**$0 copay per day for additional days**<br>**Out-of-Network:**<br>**Medicare-covered stay**<br>**50% coinsurance of the Medicare-allowed amount per admission** |
| **Part D drug coverage**<br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | Part D drug coverage deductible<br>Deductible: **$250**, except for covered insulin products and most adult Part D vaccines.<br>Copayment/Coinsurance during the Initial Coverage Stage:<br>Drug Tier 1: Preferred Generic<br>Standard cost sharing: **$6** copay<br>Preferred cost sharing: **$0** copay<br>Drug Tier 2: Generic Drugs<br>Standard cost sharing: **$10** copay<br>Preferred cost sharing: **$5** copay | **Part D drug coverage deductible**<br>**Deductible: $700, except for covered insulin products and most adult Part D vaccines.**<br>**Copayment/Coinsurance during the Initial Coverage Stage:**<br>**Drug Tier 1: Preferred Generic**<br>**Standard cost sharing: $6 copay**<br>**Preferred cost sharing: $0 copay**<br>**Drug Tier 2: Generic Drugs**<br>**Standard cost sharing: $10 copay**<br>**Preferred cost sharing: $5 copay** |

| | 2026<br>(this year) | 2027<br>(next year) |
|---|---|---|
| | Drug Tier 3: Preferred Brand and Insulin Drugs<br>Standard cost sharing:<br>**$33** copay<br>Preferred cost sharing:<br>**$28** copay<br>You pay no more than **$35** per one-month supply of each covered insulin product on this tier.<br>Drug Tier 4: Non-Preferred Drugs<br>Standard cost sharing:<br>**50%** coinsurance<br>Preferred cost sharing:<br>**50%** coinsurance<br>You pay no more than **$35** per one-month supply of each covered insulin product on this tier.<br>Drug Tier 5: Specialty Drugs<br>Standard cost sharing:<br>**30%** coinsurance<br>Preferred cost sharing:<br>**30%** coinsurance<br>Catastrophic Coverage Stage:<br>During this payment stage, you pay nothing for your covered Part D drugs. | **Drug Tier 3: Preferred Brand and Insulin Drugs**<br>**Standard cost sharing:**<br>**17% coinsurance**<br>**Preferred cost sharing:**<br>**17% coinsurance**<br>**You pay no more than $35 per one-month supply of each covered insulin product on this tier.**<br>**Drug Tier 4: Non-Preferred Drugs**<br>**Standard cost sharing:**<br>**40% coinsurance**<br>**Preferred cost sharing:**<br>**40% coinsurance**<br>**You pay no more than $35 per one-month supply of each covered insulin product on this tier.**<br>**Drug Tier 5: Specialty Drugs**<br>**Standard cost sharing:**<br>**25% coinsurance**<br>**Preferred cost sharing:**<br>**25% coinsurance**<br>**Catastrophic Coverage Stage:**<br>**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

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Monthly plan premium** (You must also continue to pay your Medicare Part B premium.) | **$157** | **$161** |

**Factors that could change your Part D Premium Amount**

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 1.7 for more information about Extra Help from Medicare.

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

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

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **In-network maximum out-of-pocket amount** Your costs for covered medical services (such as | **$2,975** | **$4,450** **Once you've paid $4,450 out-of-pocket for covered** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| copayments) from network providers **count** toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount. | | **Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.** |
| **Combined maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services. | **$5,750** | **$6,700**<br><br>**Once you've paid $6,700 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers 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 2027 *Provider Directory* bcbst.sapphirecareselect.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 bcbst.sapphirecareselect.com.
- Call Member Service at **1-800-831-2583** (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 **1-800-831-2583** (TTY users call **711**) for help. You may have a special enrollment period if your provider leaves the plan network.

## 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 includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2027 *Pharmacy Directory* bcbst.sapphirecareselect.com to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at bcbst.sapphirecareselect.com.
- Call Member Service at **1-800-831-2583** (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 **1-800-831-2583** (TTY users call **711**) for help.

## Section 1.5 Changes to Benefits & Costs for Medical Services

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Cardiac rehabilitation services** | **In-Network:** You pay a **$15** copay per visit.<br>**Out-of-Network:** You pay 50% of the Medicare-allowed amount per visit. | **In-Network: You pay a $25 copay per visit.**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount per visit.** |
| **Dental services - Medicare covered** | **In-Network:** You pay a $20 copay per visit. | **In-Network: You pay a $30 copay per visit.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | **Out-of-Network:** You pay 50% of the Medicare-allowed amount per visit. | **Out-of-Network: You pay 50% of the Medicare-allowed amount per visit.** |
| **Dental services - Supplemental (*Annual Allowance)**<br><br>Supplemental dental includes Adjunctive General Services, Diagnostic and Preventive, Endodontics, Oral and Maxillofacial Surgery, Periodontics, Prosthodontics and Restorative services.<br><br>**For more information about covered procedures, plan cost share, service limits, coordination of benefits, locating an In-Network Provider, Out-of-Network claims submission and exclusion details, please refer to the Dental Benefits Guide at medicare.bcbst.com/documents.** | **In- and Out-of-Network:** You have a **$3,500** annual allowance per year toward all covered supplemental dental services.<br><br>You pay 100% of charges beyond the **$3,500** allowance, for noncovered services or if you exceed a service limit. | **In- and Out-of-Network: You have a $3,000 annual allowance per year toward all covered supplemental dental services.**<br><br>**You pay 100% of charges beyond the $3,000 allowance, for noncovered services or if you exceed a service limit.** |
| **Dental services - Supplemental (Adjunctive General Services)** Covered services such as sedation | **In-Network: Not covered.** | **In-Network: You pay 20% of the Plan-allowed amount through the annual allowance.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | **Out-of-Network: Not covered.** | **Out-of-Network: You pay 50% of the Plan-allowed amount through the annual allowance.**<br><br>**You are responsible for any amount above the annual allowance.** |
| **Dental services - Supplemental (Diagnostic and Preventive)**<br><br>Diagnostic and preventive services, includes but not limited to: standard diagnostic exams, problem-focused oral evaluations, cleanings, bitewing X-rays and panoramic or full-mouth X-rays<br><br>Prior authorization may be required. | **In-Network:** You pay a $0 copay through the annual allowance.<br><br>**Out-of-Network:** You pay **50% of the billed charges** through the annual allowance.<br><br>You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit. | **In-Network: You pay a $0 copay through the annual allowance.**<br><br>**Out-of-Network: You pay 50% of the Plan-allowed amount through the annual allowance.**<br><br>**You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit.** |
| **Dental services - Supplemental (Endodontics)**<br><br>Endodontics, includes but not limited to: root canals, apicoectomy, retrograde filling | **In-Network:** You pay a $0 copay through the annual allowance.<br><br>**Out-of-Network:** You pay **50% of the** | **In-Network: You pay a $0 copay through the annual allowance.**<br><br>**Out-of-Network: You pay 50% of the** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| Prior authorization may be required. | **billed charges** through the annual allowance.<br><br>You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit. | **Plan-allowed amount through the annual allowance.**<br><br>**You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit.** |
| **Dental services - Supplemental (Oral and Maxillofacial Surgery)**<br><br>Oral and maxillofacial, includes but not limited to: simple extractions and surgical extractions (including removal of impacted teeth), coronectomy and other oral surgical procedures not typically covered by a medical plan<br><br>Prior authorization may be required. | **In Network:**<br>You pay 20% of the Plan-allowed amount through the annual allowance.<br><br>**Out-of-Network:**<br>You pay **50% of the billed charges** through the annual allowance.<br><br>You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit. | **In-Network:**<br>**You pay 20% of the Plan-allowed amount through the annual allowance.**<br><br>**Out-of-Network:**<br>**You pay 50% of the Plan-allowed amount through the annual allowance.**<br><br>**You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit.** |
| **Dental services - Supplemental (Periodontics)**<br><br>Periodontics, includes but not limited to: periodontal exam, | **In-Network:**<br>You pay a $0 copay through the annual allowance. | **In-Network:**<br>**You pay a $0 copay through the annual allowance.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| periodontal maintenance, scaling and root planing and full mouth debridement<br><br>Prior authorization may be required. | **Out-of-Network:** You pay **50% of the billed charges** through the annual allowance.<br><br>You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit. | **Out-of-Network: You pay 50% of the Plan-allowed amount through the annual allowance.**<br><br>**You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit.** |
| **Dental services - Supplemental (Prosthodontics)**<br><br>Prosthodontics, includes but is not limited to: complete dentures, partial dentures and denture restoration<br><br>Prior authorization may be required. | **In-Network:** You pay 20% of the Plan-allowed amount through the annual allowance.<br><br>**Out-of-Network:** You pay **50% of the billed charges** through the annual allowance.<br><br>You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit. | **In-Network: You pay 20% of the Plan-allowed amount through the annual allowance.**<br><br>**Out-of-Network: You pay 50% of the Plan-allowed amount through the annual allowance.**<br><br>**You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit.** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| **Dental services - Supplemental (Restorative)**<br><br>Restorative and surgical services, includes but is not limited to: fillings, crowns, bridges, and denture repair and adjustment<br><br>Prior authorization may be required. | **In-Network:**<br>You pay 20% of the Plan-allowed amount through the annual allowance.<br><br>**Out-of-Network:**<br>You pay **50% of the billed charges** through the annual allowance.<br><br>You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit. | **In-Network:**<br>**You pay 20% of the Plan-allowed amount through the annual allowance.**<br><br>**Out-of-Network:**<br>**You pay 50% of the Plan-allowed amount through the annual allowance.**<br><br>**You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit.** |
| **Health and wellness education programs**<br><br>Fitness program | **In-Network:**<br>You pay a $0 copay per visit.<br><br>**Out-of-Network:**<br>**Not covered.** | **In-Network:**<br>**You pay a $0 copay per visit.**<br><br>**Out-of-Network:**<br>**You must pay the full cost at the time of service. The Plan will reimburse you for 20% of the total cost, up to $150 annually, after you submit proof of payment for a qualifying fitness center location. To be eligible for reimbursement, the fitness center must offer use of cardiovascular exercise** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | | **equipment (e.g., treadmills, exercise bicycles, stair climbers, etc.), strength or resistance training equipment (e.g., weight/resistance machines, free weights, etc.), and/or instructor-led classes (such as aerobic dance, Pilates, "step" classes, yoga, etc.). Approved fitness centers must have staff oversight, be open to the public, and must offer a membership agreement (or equivalent thereof). Rehabilitation or physical therapy services, personal training sessions, social clubs, country clubs, sports teams, and leagues are excluded. You will not be reimbursed for Out-of-Network fitness center fees if you were enrolled at an In-Network fitness center during the same time period.** |
| **Hearing services - Supplemental** | **In-Network:** Routine hearing exam: You pay a $0 copay per | **In-Network: Routine hearing exam: You pay a $0 copay per** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| Covered services include: routine hearing exam and hearing aid | visit.<br><br>Hearing aid:<br>You pay a $99 copay per aid for Standard TruHearing® model<br>You pay a $299 copay per aid for Advanced TruHearing® model<br>You pay a $599 copay per aid for Premium TruHearing® model<br><br>**Out-of-Network:**<br>**Not covered.** | **visit.**<br><br>**Hearing aid:**<br>**You pay a $99 copay per aid for Standard TruHearing® model**<br>**You pay a $299 copay per aid for Advanced TruHearing® model**<br>**You pay a $599 copay per aid for Premium TruHearing® model**<br><br>**Out-of-Network:**<br>**Routine hearing exam: You must pay the full cost of the hearing exam at the time of service. To receive reimbursement, you must submit a Direct Member Reimbursement (DMR) claim, including proof of payment. The Plan will reimburse 10% of the amount you paid for a covered hearing exam related to hearing aid evaluation or fitting.**<br><br>**Hearing aid:**<br>**You must pay the full cost of the hearing aid at the time of purchase. To receive reimbursement, you must submit a Direct** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | | **Member Reimbursement (DMR) claim, including proof of payment. The Plan will reimburse 10% of the amount you paid for a covered hearing aid.** |
| **Inpatient hospital care** | **In-Network:** You pay a **$75** copay per day for **days 1-4**. You pay a $0 copay per day for additional days.<br><br>**Out-of-Network:** You pay 50% of the Medicare-allowed amount per admission. | **In-Network: You pay a $175 copay per day for days 1-5. You pay a $0 copay per day for additional days.**<br><br>**Out-of-Network: You pay 50% of the Medicare-allowed amount per admission.** |
| **Inpatient services in a psychiatric hospital**<br><br>Limited to a 190-day lifetime benefit | **In-Network:** You pay a **$75** copay per day for **days 1-4**. You pay a $0 copay per day for days **5-190**.<br><br>**Out-of-Network:** You pay 50% of the Medicare-allowed amount per admission. | **In-Network: You pay a $175 copay per day for days 1-5. You pay a $0 copay per day for days 6-190.**<br><br>**Out-of-Network: You pay 50% of the Medicare-allowed amount per admission.** |
| **Meals**<br><br>This benefit provides 14 meals after discharge from an acute inpatient hospital, skilled nursing | **In-Network:** You pay a $0 copay. | **In-Network: You pay a $0 copay.**<br><br>**Out-of-Network: You must pay the full** |

| | 2026<br>(this year) | 2027<br>(next year) |
|---|---|---|
| facility, or observation stay to a home setting. | **Out-of-Network:**<br>**Not covered.** | **cost at the time of service. The Plan will reimburse you for 20% of the total cost after you submit proof of payment for qualifying meals. Meals must be provided by an authorized home meal delivery service. Meals must be ready-to-eat or require minimal preparation. Meals may be frozen, refrigerated, or shelf-stable and must be provided in compliance with applicable food safety standards. Restaurant meals and homemade meals are not covered.** |
| **Outpatient diagnostic tests and therapeutic services and supplies** | **In-Network:**<br>X-rays: Specialist:<br>You pay a **$20** copay per service.<br><br>Diagnostic tests:<br>Specialist:<br>You pay a **$20** copay per service<br><br>Therapeutic Radiology (all locations): | **In-Network:**<br>**X-rays: Specialist:**<br>**You pay a $30 copay per service.**<br><br>**Diagnostic tests:**<br>**Specialist:**<br>**You pay a $30 copay per service.**<br><br>**Therapeutic Radiology (all locations):**<br>**You pay 20% of the** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | You pay a **$30** copay per service.<br><br>**Out-of-Network:**<br>You pay 50% of the Medicare-allowed amount per service. | **Plan-allowed amount per service.**<br><br>**Out-of-Network:**<br>**You pay 50% of the Medicare-allowed amount per service.** |
| **Outpatient rehabilitation services**<br><br>Covered services include physical therapy, occupational therapy and speech language therapy | **In-Network:**<br>You pay a **$10** copay per visit.<br><br>**Out-of-Network:**<br>You pay 50% of the Medicare-allowed amount per visit. | **In-Network:**<br>**You pay a $25 copay per visit.**<br><br>**Out-of-Network:**<br>**You pay 50% of the Medicare-allowed amount per visit.** |
| **Outpatient surgery services**<br><br>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers | **In-Network:**<br>Outpatient hospital:<br>You pay a **$175** copay per visit.<br><br>Ambulatory surgical center:<br>You pay a **$125** copay per visit.<br><br>**Out-of-Network:**<br>Outpatient hospital:<br>You pay 50% of the Medicare-allowed amount per visit.<br><br>Ambulatory surgical center:<br>You pay 50% of the | **In-Network:**<br>**Outpatient hospital:**<br>**You pay a $275 copay per visit.**<br><br>**Ambulatory surgical center:**<br>**You pay a $175 copay per visit.**<br><br>**Out-of-Network:**<br>**Outpatient hospital:**<br>**You pay 50% of the Medicare-allowed amount per visit.**<br><br>**Ambulatory Surgical Center:**<br>**You pay 50% of the** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| | Medicare-allowed amount per visit. | **Medicare-allowed amount per visit.** |
| **Over-the-counter (OTC) benefit** | **In-Network:** You have a **$131** quarterly allowance for OTC benefits.<br><br>**Out-of-Network: Not covered.** | **In-Network: Not covered.**<br><br>**Out-of-Network: Not covered.** |
| **Physician/Practitioner services, including doctor's office visits** | **In-Network:** Specialist office or telehealth visit: You pay a **$20** copay per visit.<br><br>Wound care: You pay a **$20** copay per visit.<br><br>**Out-of-Network:** You pay 50% of the Medicare-allowed amount per visit. | **In-Network: Specialist office or telehealth visit: You pay a $30 copay per visit.**<br><br>**Wound care: You pay a $30 copay per visit.**<br><br>**Out-of-Network: You pay 50% of the Medicare-allowed amount per visit.** |
| **Podiatry services**<br><br>Covered services include: Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). | **In-Network:** You pay a **$20** copay per visit.<br><br>**Out-of-Network:** You pay 50% of the | **In-Network: You pay a $30 copay per visit.**<br><br>**Out-of-Network: You pay 50% of the** |

| | 2026 (this year) | 2027 (next year) |
|---|---|---|
| Routine foot care for members with certain medical conditions affecting the lower limbs. | Medicare-allowed amount per visit. | **Medicare-allowed amount per visit.** |
| **Pulmonary rehabilitation services** | **In-Network:** You pay a **$15** copay per visit.<br><br>**Out-of-Network:** You pay 50% of the Medicare-allowed amount per visit. | **In-Network: You pay a $25 copay per visit.**<br><br>**Out-of-Network: You pay 50% of the Medicare-allowed amount per visit.** |
| **Skilled nursing facility (SNF) care** | **In-Network:** You pay a $0 copay per day for days 1-20. You pay a **$218** copay per day for days 21-100.<br><br>**Out-of-Network:** You pay 50% of the Medicare-allowed amount per admission. | **In-Network: You pay a $0 copay per day for days 1-20. You pay a $221 copay per day for days 21-100.**<br><br>**Out-of-Network: You pay 50% of the Medicare-allowed amount per admission.** |

## 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 medicare.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 **1-800-831-2583** (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 **1-800-831-2583** (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***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your brand name drugs until you reach the yearly deductible.

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

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date 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 (this year)** | **2027 (next year)** |
|---|---|---|
| **Yearly Deductible** | The deductible is **$250**.<br><br>During this stage, you pay: **$0-$6** cost sharing for drugs on Tier 1 (Preferred Generic), **$5-$10** cost sharing for drugs on Tier 2 (Generic), **$33** cost sharing for drugs on Tier 3 (Insulin Drugs), and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drugs) and Tier 5 (Specialty Drugs) until you've reached the yearly deductible. | **The deductible is $700.**<br><br>**During this stage, you pay: $0-$6 cost sharing for drugs on Tier 1 (Preferred Generic), $5-$10 cost sharing for drugs on Tier 2 (Generic), $35 cost sharing for drugs on Tier 3 (Insulin Drugs), and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drugs) and Tier 5 (Specialty Drugs) until you've reached the yearly deductible.** |

**Drug Costs in Stage 2: Initial Coverage**

For drugs on Preferred Brand and Insulin Drugs, 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 (30-day) supply filled at a network pharmacy with standard and preferred 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) |
|---|---|---|
| **Preferred Generic Drugs:** | Standard cost sharing:<br>You pay **$6** per prescription<br><br>Preferred cost sharing:<br>You pay **$0** per prescription | **Standard cost sharing:**<br>**You pay $6 per prescription**<br><br>**Preferred cost sharing:**<br>**You pay $0 per prescription** |
| **Generic Drugs:** | Standard cost sharing:<br>You pay **$10** per prescription<br><br>Preferred cost sharing:<br>You pay **$5** per prescription | **Standard cost sharing:**<br>**You pay $10 per prescription**<br><br>**Preferred cost sharing:**<br>**You pay $5 per prescription** |
| **Preferred Brand and Insulin Drugs:** | Standard cost sharing:<br>You pay **$33** per prescription<br>You pay **$33** per month supply of each covered **insulin product** on this tier.<br>Your cost for a one-month mail-order prescription is **$33**.<br>Preferred cost sharing:<br>You pay **$28** per prescription<br>You pay **$28** per month supply of each covered **insulin product** on this tier.<br>Your cost for a one-month mail-order prescription is **$28**. | **Standard cost sharing:**<br>**You pay 17% coinsurance per prescription**<br>**You pay $35 per month supply of each covered insulin product on this tier.**<br>**Your cost for a one-month mail-order prescription is 17% coinsurance.**<br>**Preferred cost sharing:**<br>**You pay 17% coinsurance**<br>**You pay $35 per month supply of each covered insulin product on this tier.**<br>**Your cost for a one-month mail-order prescription is 17% coinsurance.** |

| | 2026<br>(this year) | 2027<br>(next year) |
|---|---|---|
| **Non-Preferred Drugs:**<br>**This tier is limited to a 30-day supply.** | Standard cost sharing:<br>You pay **50%** coinsurance<br>You pay **$35** per month supply of each covered insulin product on this tier.<br>Your cost for a one-month mail-order prescription is **50%** coinsurance.<br>Preferred cost sharing:<br>You pay **50%** coinsurance<br>You pay **$35** per month supply of each covered insulin product on this tier.<br>Your cost for a one-month mail-order prescription is **50%** coinsurance. | **Standard cost sharing:**<br>**You pay 40% coinsurance**<br>**You pay $35 per month supply of each covered insulin product on this tier.**<br>**Your cost for a one-month mail-order prescription is 40% coinsurance.**<br>**Preferred cost sharing:**<br>**You pay 40% coinsurance**<br>**You pay $35 per month supply of each covered insulin product on this tier.**<br>**Your cost for a one-month mail-order prescription is 40% coinsurance.** |
| **Specialty Tier:**<br>**This tier is limited to a 30-day supply.** | Standard cost sharing:<br>You pay **30%** coinsurance<br>Preferred cost sharing:<br>You pay **30%** coinsurance | **Standard cost sharing:**<br>**You pay 25% coinsurance**<br>**Preferred cost sharing:**<br>**You pay 25% coinsurance** |

## SECTION 2 How to Change Plans

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

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 BlueAdvantage Diamond. 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 BlueAdvantage Diamond.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Service at **1-800-831-2583** (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 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit Medicare.gov, check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 4), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, BlueCross BlueShield of Tennessee, Inc. (plan/Part D sponsor) offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

## 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 can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

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

## SECTION 3 Get Help Paying for Prescription Drugs

You can 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 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): 1-615-741-7500, Monday – Friday 8:00 a.m. to 4:30 p.m. CT. 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 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 **1-800-831-2583** (TTY users should call **711**) or visit Medicare.gov.

## SECTION 4 Questions?

### Get Help from BlueAdvantage Diamond

- **Call Member Service at 1-800-831-2583. (TTY users call 711.)**

  We're available for phone calls from **Oct. 1 to March 31**, you can call us 7 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 BlueAdvantage Diamond. 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 Medicare.bcbst.com or call Member Service at **1-800-831-2583** (TTY users call **711**) to ask us to mail you a copy.

- **Visit Medicare.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 Tennessee State Health Insurance Assistance Program.

Call Tennessee State Health Insurance Assistance Program to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer

questions about switching plans. Call Tennessee State Health Insurance Assistance Program at 1-877-801-0044, (Toll-Free). Learn more about Tennessee State Health Insurance Assistance Program by visiting (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

  You can chat live at Medicare.gov/talk-to-someone.

- **Write to Medicare**

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

- **Visit** 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 or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.