of Tennessee
1 Cameron Hill Circle | Chattanooga, TN 37402

# Find Your Important Plan Materials Online

We're sharing more info digitally than ever before. Your online member account is the fastest way to stay updated.

To get started, go to **bcbstmedicare.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, 2025**.
- Find a doctor, hospital or pharmacy in our network — available **Oct. 15, 2025**.
- View a copy of our Evidence of Coverage (EOC) — available **Oct. 15, 2025**.
- 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, 2025**.
- 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**). BlueCross BlueShield of Tennessee , Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex1. 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.

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)



H7917_26ORN_C (06/25)

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

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-831-2583 (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 مجاناً. 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.


BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association

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

# Annual Notice of Change for 2026

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, 2025, you'll stay in BlueAdvantage Diamond (PPO)
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at bcbstmedicare.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_26ANOC009_M (08/25)

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

## 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, 2025, you’ll automatically be enrolled in BlueAdvantage Diamond (PPO).** Starting January 1, 2026, you’ll get your medical and drug coverage through BlueAdvantage Diamond (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

# Table of Contents

## Summary of Important Costs for 2026

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Monthly plan premium*** * Your premium can be higher or lower than this amount. Go to Section 1.1 for details. | **$157** | **$157** |
| **Maximum out-of-pocket amount** This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Section 1.2 for details.) | From network providers: **$2,975** From network and out-of-network providers combined: **$5,750** | **From network providers: $2,975** **From network and out-of-network providers combined: $5,750** |
| **Primary care office visits** | **In-Network:** **$0** copay per visit **Out-of-Network:** **$10** copay per visit | **In-Network:** **$0 copay per visit** **Out-of-Network:** **50% of the Medicare-allowed amount per visit** |
| **Specialist office visits** | **In-Network:** **$20** copay per visit **Out-of-Network:** **$25** copay per visit | **In-Network:** **$20 copay per visit** **Out-of-Network:** **50% of the Medicare-allowed amount per visit** |
| **Inpatient hospital stays** | **In-Network:** **Medicare-covered stay** | **In-Network:** **Medicare-covered stay** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. | **$0** copay per admission<br>**Out-of-Network:**<br>**Medicare-covered stay**<br>**$50** copay per day for days 1-5<br>**$0** copay per day for additional days | **$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% of the Medicare-allowed amount per admission** |
| **Part D drug coverage deductible**<br>(Go to Section 1.7 for details.) | Deductible: **$0** | **Deductible: $250, except for covered insulin products and most adult Part D vaccines.** |
| **Part D drug coverage**<br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | Copayment/Coinsurance during the Initial Coverage Stage:<br>Drug Tier 1: Preferred Generic<br>Standard cost sharing:<br>**$6** copay<br>Preferred cost sharing:<br>**$0** copay<br>Drug Tier 2: Generic Drugs<br>Standard cost sharing:<br>**$10** copay<br>Preferred cost sharing:<br>**$5** copay<br>Drug Tier 3: Insulin Drugs:<br>Standard cost sharing:<br>**$33** copay | **Copayment/Coinsurance during the Initial Coverage Stage:**<br>**Drug Tier 1: Preferred Generic**<br>**Standard cost sharing:**<br>**$6 copay**<br>**Preferred cost sharing:**<br>**$0 copay**<br>**Drug Tier 2: Generic Drugs**<br>**Standard cost sharing:**<br>**$10 copay**<br>**Preferred cost sharing:**<br>**$5 copay**<br>**Drug Tier 3: Insulin Drugs:**<br>**Standard cost sharing:**<br>**$33 copay** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| | Preferred cost sharing:<br>**$28** copay<br>Drug Tier 3: Preferred Brand<br>Standard cost sharing:<br>**$33** copay<br>Preferred cost sharing:<br>**$28** copay<br>You pay no more than **$33** 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>**33%** coinsurance<br>Preferred cost sharing:<br>**33%** coinsurance<br>Catastrophic Coverage Stage:<br>During this payment stage, you pay nothing for your covered Part D drugs.<br>You can have cost sharing for drugs that are covered under our enhanced benefit. | **Preferred cost sharing:**<br>**$28 copay**<br>**Drug Tier 3: Preferred Brand**<br>**Standard cost sharing:**<br>**$33 copay**<br>**Preferred cost sharing:**<br>**$28 copay**<br>**You pay no more than $33 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.** |

# SECTION 1 Changes to Benefits & Costs for Next Year

## Section 1.1 Changes to the Monthly Plan Premium

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Monthly plan premium** (You must also continue to pay your Medicare Part B premium.) | **$157** | **$157** |

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

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

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **In-network maximum out-of-pocket amount** | **$2,975** | **$2,975** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| Your costs for covered medical services (such as 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. | | **Once you've paid $2,975 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 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** | **$5,750**<br><br>**Once you've paid $5,750 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 2026 *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.

## 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 2026 *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

| | **2025 (this year)** | **2026 (next year)** |
|---|---|---|
| **Abdominal aortic aneurysm screening** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Annual Wellness Visit** | **In-Network:** You pay $0 copay | **In-Network: You pay a $0 copay** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| | **Out-of-Network:** You pay **$0** copay | **Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Bone mass measurement** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Breast cancer screening (mammograms)** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Cardiac rehabilitation services** | **In-Network:** You pay a **$20** copay per visit<br>**Out-of-Network:** You pay 50% of the Medicare-allowed amount | **In-Network: You pay a $15 copay per visit**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Cardiovascular disease screening tests** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Cervical and vaginal cancer screening** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Colorectal cancer screening** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Dental services* - Supplemental (Annual Allowance)** Supplemental dental includes Diagnostic and Preventive, Endodontics, Oral and Maxillofacial Surgery, Periodontics, Prosthodontics and Restorative services. **Please refer to the information below for current services affiliated with each category**. | **In- and Out-of-Network:** You have a **$4,500** annual allowance per year toward all covered supplemental dental services.<br>You pay 100% of charges beyond the **$4,500** allowance, for non-covered services or if you exceed a service limit. | **In- and Out-of-Network: You have a $3,500 annual allowance per year toward all covered supplemental dental services.**<br>**You pay 100% of charges beyond the $3,500 allowance, for non-covered services or if you exceed a service limit.** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Dental services* - Supplemental (Diagnostic and Preventive)** 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>**Out-of-Network:** You pay 50% of the billed charges through the annual allowance<br><br>You pay 100% of charges beyond the annual allowance, for non-covered services or if you exceed a service limit. | **In-Network: You pay a $0 copay through the annual allowance**<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.** |
| **Dental services* - Supplemental (Endodontics)** Endodontics, includes but not limited to: **root canals, apicoectomy, retrograde filling**<br><br>**Prior authorization may be required.** | **In-Network:** You pay a $0 copay through the annual allowance<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>**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.** |
| **Dental services* - Supplemental (Oral and Maxillofacial Surgery)** Oral and maxillofacial, includes but not limited to: | **In-Network:** You pay a $0 copay through the annual allowance<br>**Out-of-Network:** You pay 50% of the billed | **In-Network: You pay 20% of the Plan-allowed amount through the annual allowance** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **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.** | 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 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.** |
| **Dental services* - Supplemental (Periodontics)**<br>Periodontics, includes but not limited to: **periodontal exam, periodontal maintenance, scaling and root planning and full mouth debridement**<br><br>**Prior authorization may be required.** | **In-Network:**<br>You pay a $0 copay through the annual allowance<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: You pay a $0 copay through the annual allowance**<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.** |
| **Dental services* - Supplemental (Prosthodontics)**<br>Prosthodontics, includes but is not limited to: **complete dentures, partial dentures and denture restoration**<br><br>**Prior authorization may be required.** | **In-Network:**<br>You pay a **$0** copay through the annual allowance<br>**Out-of-Network:**<br>You pay 50% of the billed charges through the annual allowance<br><br>You pay 100% of charges | **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** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| | beyond the allowance, for non-covered services or if you exceed a service limit. | **You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit.** |
| **Dental services* - Supplemental (Restorative)** 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:** You pay a **$0** copay through the annual allowance<br>**Out-of-Network:** You pay 50% of the billed charges through the allowance<br><br>You pay 100% of charges beyond the allowance, for non-covered services or if you exceed a service limit.<br><br>**Note:** For 2025, **dental implants** were a **covered service**. | **In-Network: You pay 20% of the Plan-allowed amount through the annual allowance**<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.**<br><br>**Note: For 2026, dental implants are a non-covered service.** |
| **Depression screening** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Diabetes screening** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Diabetes self-management training, diabetic services and supplies** | **In-Network:**<br>Diabetes self-management training:<br>You pay a $0 copay<br><br>Diabetic testing supplies:<br>You pay 0% of the Plan-allowed amount for **preferred (Ascencia's Contour and Johnson & Johnson's Lifescan OneTouch**) diabetic supplies<br>You pay 20% of the Plan-allowed amount for other diabetic testing supplies with an exception<br><br>Continuous glucose monitors (CGMs):<br>You pay **15%** of the Plan-allowed amount for **preferred (Dexcom G6 and G7 and Abbott Freestyle Libre**) CGMs<br>**Out-of-Network:**<br>Diabetes self-management training:<br>You pay 20% of the Medicare-allowed amount<br><br>Diabetic testing supplies:<br>You pay 50% of the Medicare-allowed amount for diabetic testing supplies<br><br>Continuous glucose monitors (CGMs): | **In-Network:**<br>**Diabetes self-management training:**<br>**You pay a $0 copay**<br><br>**Diabetic testing supplies:**<br>**You pay 0% of the Plan-allowed amount for preferred (Ascencia's Contour and Roche Accu-Chek) diabetic testing supplies**<br>**You pay 20% of the Plan-allowed amount for other diabetic testing supplies with an exception**<br><br>**Continuous glucose monitors (CGMs):**<br>**You pay 20% of the Plan-allowed amount for preferred (Dexcom products) CGMs**<br>**You pay 50% of the Plan-allowed amount for all other CGMs with an exception**<br>**Out-of-Network:**<br>**Diabetes self-management training:**<br>**You pay 20% of the Medicare-allowed amount**<br><br>**Diabetic testing supplies:**<br>**You pay 50% of the Medicare-allowed amount for diabetic testing supplies** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| | You pay 50% of the Medicare-allowed amount for CGMs<br><br>All supplies listed above are available only at a pharmacy. | **Continuous glucose monitors (CGMs): You pay 50% of the Medicare-allowed amount for CGMs**<br><br>**Prior authorization may be required.**<br><br>**All supplies listed above are available only at a pharmacy.** |
| **Durable medical equipment (DME) and related supplies** | **In-Network:** You pay **15%** of the Plan-allowed amount for DME<br>**Out-of-Network:** You pay 50% of the Medicare-allowed amount for DME<br><br>Prior authorization may be required. | **In-Network: You pay 20% of the Plan-allowed amount for DME**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount for DME**<br><br>**Prior authorization may be required.** |
| **Emergency care - Domestic** | **In- and Out-of-Network:** You pay a **$140** copay per visit | **In- and Out-of-Network: You pay a $150 copay per visit** |
| **HIV screening** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Immunizations**<br><br>Limited to Part B immunizations | **In-Network:**<br>You pay $0 copay<br>**Out-of-Network:**<br>You pay **$0** copay | **In-Network:**<br>**You pay a $0 copay**<br>**Out-of-Network:**<br>**You pay 50% of the Medicare-allowed amount** |
| **In-Home Support Services** | **In-Network:**<br>You pay a $0 copay per visit (60 hours per calendar year through Papa Pals)<br>**Out-of-Network:**<br>Not covered - must use designated vendor | **This is no longer a covered service.** |
| **Inpatient hospital care** | **In-Network:**<br>You pay a **$0** copay per admission<br>**Out-of-Network:**<br>You pay a **$50** copay per day for days 1-5<br>You pay a **$0** copay for additional days | **In-Network:**<br>**You pay a $75 copay per day for days 1-4**<br>**You pay a $0 copay for additional days**<br>**Out-of-Network:**<br>**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:**<br>You pay a **$0** copay per day for the 190-day lifetime benefit<br>**Out-of-Network:**<br>You pay a **$50** copay per day for days 1-5 | **In-Network:**<br>**You pay a $75 copay per day for days 1-4**<br>**You pay a $0 copay per day for days 5-190**<br>**Out-of-Network:**<br>**You pay 50% of the Medicare-allowed amount** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| | You pay a **$0** copay per day for days 6-190 | **per day for the 190-day lifetime benefit** |
| **Medical nutrition therapy** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Medicare Diabetes Prevention Program (MDPP)** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Obesity screening and therapy to promote sustained weight loss** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Outpatient diagnostic tests and therapeutic services and supplies** | **In-Network:**<br>X-Rays:<br>You pay a $0 copay at a PCP's office<br>You pay a $20 copay at a Specialist's office<br><br>Laboratory tests:<br>You pay a $0 copay at a PCP's office<br>You pay a $0 copay at a Specialist's office | **In-Network:**<br>**X-Rays:**<br>**You pay a $0 copay at a PCP's office**<br>**You pay a $20 copay at a Specialist's office**<br><br>**Laboratory tests:**<br>**You pay a $0 copay at a PCP's office**<br>**You pay a $0 copay at a Specialist's office** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| | Other diagnostic tests:<br>You pay a $0 copay at a PCP's office<br>You pay a $20 copay at a Specialist's office<br><br>Coumadin services:<br>You pay a $0 copay at a PCP's office<br>You pay a $0 copay at a Specialist's office<br><br>**Out-of-Network:**<br>X-Rays:<br>You pay a **$10** copay at a PCP's office<br>You pay a **$25** copay at a Specialist's office<br><br>Laboratory tests:<br>You pay a **$10** copay at a PCP's office<br>You pay a **$25** copay at a Specialist's office<br><br>Other diagnostic tests:<br>You pay a **$10** copay at a PCP's office<br>You pay a **$25** copay at a Specialist's office<br><br>Coumadin services:<br>You pay a **$10** copay at a PCP's office<br>You pay a **$25** copay at a Specialist's office | **Other diagnostic tests:**<br>**You pay a $0 copay at a PCP's office**<br>**You pay a $20 copay at a Specialist's office**<br><br>**Coumadin services:**<br>**You pay a $0 copay at a PCP's office**<br>**You pay a $0 copay at a Specialist's office**<br><br>**Out-of-Network:**<br>**X-Rays:**<br>**You pay 50% of the Medicare-allowed amount at a PCP's or Specialist's office**<br><br>**Laboratory tests:**<br>**You pay 50% of the Medicare-allowed amount at a PCP's or Specialist's office**<br><br>**Other outpatient diagnostic tests:**<br>**You pay 50% of the Medicare-allowed amount at a PCP's or Specialist's office**<br><br>**Coumadin services:**<br>**You pay 50% of the Medicare-allowed amount at a PCP's or Specialist's office** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Outpatient surgery services - Outpatient hospital facility** | **In-Network:** You pay a $175 copay<br>**Out-of-Network** You pay a **$225** copay | **In-Network: You pay a $175 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Over-the-Counter (OTC) Benefits** | **In-Network:** You have a **$130** quarterly allowance toward OTC benefits<br>**Out-of-Network:** Not covered - must use designated vendor | **In-Network: You have a $131 quarterly allowance for OTC benefits**<br>**Out-of-Network: Not covered - must use designated vendor** |
| **Physician/Practitioner services - Telehealth**<br>Certain telehealth services, including those for specific urgently needed medical services and individual sessions for specific mental health specialty services. | **In-Network:** You pay a $0 copay per visit<br>**Out-of-Network:** Not covered - must use designated vendor | **In-Network: You pay a $0 copay per visit**<br>**Out-of-Network: Not covered - must use designated vendor**<br>**Prior authorization may be required.** |
| **Physician/Practitioner services, including doctor's office visits** | **In-Network:** You pay a $0 copay per visit at a PCP's office<br>You pay a $20 copay per visit at a Specialist's office<br>You pay a $20 copay per visit for Wound care | **In-Network: You pay a $0 copay per visit at a PCP's office**<br>**You pay a $20 copay per visit at a Specialist's office**<br>**You pay a $20 copay per visit for Wound care** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| | **Out-of-Network:** You pay a **$10** copay per visit at a PCP's office You pay a **$25** copay per visit at a Specialist's office You pay a **$25** copay per visit for Wound care | **Out-of-Network: You pay 50% of the Medicare-allowed amount per visit at a PCP's or Specialist's office or for Wound care** |
| **Prostate cancer screening exams** | **In-Network:** You pay $0 copay **Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay** **Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Screening and counseling to reduce alcohol misuse** | **In-Network:** You pay $0 copay **Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay** **Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Screening for Hepatitis C Virus infection** | **In-Network:** You pay $0 copay **Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay** **Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Screening for lung cancer with low dose computed tomography (LDCT)** | **In-Network:** You pay $0 copay **Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay** **Out-of-Network: You pay 50% of the Medicare-allowed amount** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Services to treat kidney disease - Dialysis** | **In-Network:** You pay 20% of the Plan-allowed amount for dialysis<br>**Out-of-Network:** You pay 20% of the Medicare-allowed amount for dialysis | **In-Network You pay 20% of the Plan-allowed amount for dialysis**<br>**Out-of-Network: You pay 20% of the Medicare-allowed amount for dialysis**<br>**Prior authorization may be required.** |
| **Skilled Nursing Facility (SNF) care** | **In-Network:** You pay a $0 copay per day for days 1-20<br>You pay a **$214** copay per day for days 21-100<br>**Out-of-Network:** You pay 50% of the Medicare-allowed per 100-day benefit period | **In-Network: You pay a $0 copay per day for days 1-20**<br>**You pay a $218 copay per day for days 21-100**<br>**Out-of-Network: You pay 50% of the Medicare-allowed per 100-day benefit period** |
| **Smoking and tobacco use cessation (counseling to** | **In-Network:** You pay $0 copay | **In-Network: You pay a $0 copay** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **stop smoking or tobacco use)** | **Out-of-Network:** You pay **$0** copay | **Out-of-Network: You pay 50% of the Medicare-allowed amount** |
| **Vision care* - Supplemental (Eyewear allowance)** | **In- and Out-of-Network:** You have a **$250** allowance for eyewear (contacts or frames and lenses) **per year** | **In- and Out-of-Network: You have a $300 allowance for eyewear (contacts or frames and lenses) every two years** |
| **Welcome to Medicare preventive visit** | **In-Network:** You pay $0 copay<br>**Out-of-Network:** You pay **$0** copay | **In-Network: You pay a $0 copay**<br>**Out-of-Network: You pay 50% of the Medicare-allowed amount** |

## Section 1.6 Changes to Part D Drug Coverage

### Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

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

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-

date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Service at **1-800-831-2583** (TTY users call **711**) for more information.

Starting in 2026, we can immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we can decide to keep the brand name drug or original biological product on our Drug List but immediately move it to a different cost-sharing tier or add new restrictions or both.

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

Some of these drug types may be new to you. For definitions of drug types, go to Chapter 12 of your Evidence of Coverage. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: www.FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You can also call Member Service at **1-800-831-2583** (TTY users call **711**) or ask your health care provider, prescriber, or pharmacist for more information.

## Section 1.7 Changes to Prescription Drug Benefits & Costs

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

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and you don't get this material by Sept. 30, 2025, call Member Service **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. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your 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 $2,100.

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

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

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

**Drug Costs in Stage 1: Yearly Deductible**

The table shows your cost per prescription during this stage

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

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

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

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Preferred Generic Drugs:** | Standard cost sharing:<br>You pay **$6** per prescription<br>Preferred cost sharing:<br>You pay **$0** per prescription | **Standard cost sharing:**<br>**You pay $6 per prescription**<br>**Preferred cost sharing:**<br>**You pay $0 per prescription** |
| **Generic Drugs:** | Standard cost sharing:<br>You pay **$10** per prescription<br>Preferred cost sharing:<br>You pay **$5** per prescription | **Standard cost sharing:**<br>**You pay $10 per prescription**<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>Preferred cost sharing:<br>You pay **$28** per prescription<br>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>Preferred cost sharing:<br>You pay **$28** per prescription<br>You pay **$28** per month supply of each covered **insulin product** on this tier. | **Standard cost sharing:**<br>**You pay $33 per prescription**<br>**Preferred cost sharing:**<br>**You pay $28 per prescription**<br>**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>**Preferred cost sharing:**<br>**You pay $28 per prescription**<br>**You pay $28 per month supply of each covered insulin product on this tier.** |

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Non-Preferred Drugs:**<br>**For 2026, this tier is now 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 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.** |
| **Specialty Tier:** | Standard cost sharing:<br>You pay **33%** coinsurance<br>Preferred cost sharing:<br>You pay **33%** coinsurance | **Standard cost sharing:**<br>**You pay 30% coinsurance**<br>**Preferred cost sharing:**<br>**You pay 30% coinsurance** |

**Changes to the Catastrophic Coverage Stage**

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

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

## SECTION 2 Administrative Changes

| | 2025 (this year) | 2026 (next year) |
|---|---|---|
| **Medicare Prescription Payment Plan** | The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January - December).<br><br>You may be participating in this payment option. | **If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.**<br><br>**To learn more about this payment option, call us at 1-800-831-2583 (TTY users call 711) or visit www.Medicare.gov.** |

## SECTION 3 How to Change Plans

**To stay in BlueAdvantage Diamond, you don't need to do anything.** Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our BlueAdvantage Diamond.

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from BlueAdvantage Diamond.
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically 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 www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), 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 3.1 Deadlines for Changing Plans

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

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

## Section 3.2 Are there other times of the year to make a change?

In certain situations, people 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 4 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. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All

members are eligible to participate 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 www.Medicare.gov.

## SECTION 5 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 2026 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for 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 bcbstmedicare.com or call Member Service **1-800-831-2583** (TTY users call **711**) to ask us to mail you a copy.

- **Visit bcbstmedicare.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 www.Medicare.gov**

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

- **Write to Medicare**

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

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2026**

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.