



Blue Medicare Advantage (PPO) 2027 Annual Notice of Changes

Jackson, Lyon, Osage, Pottawatomie, Shawnee and Wabaunsee

Effective from January 1, 2027 through December 31, 2027

Blue Medicare Advantage (PPO) offered by Blue Cross and Blue Shield of Kansas

Annual Notice of Change for 2027

You're enrolled as a member of Blue Medicare Advantage (PPO)

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 Blue Medicare Advantage (PPO).
- To change to a **different plan**, visit [Medicare.gov](https://www.Medicare.gov) or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.bcbsks.com/medicare/welcome or call Customer Services at 1-800-222-7645 (TTY users call 711) to get a copy by mail.

More Resources

- Call Customer Services at 1-800-222-7645 (TTY users call 711). Hours of operation:
 - October 1 through March 31 – Seven days a week from 8:00 AM to 8:00 PM.
 - April 1 through September 30 – Monday through Friday 8:00 AM to 8:00 PM.
 - These calls are free.
- Our plan provides language assistance services and appropriate auxiliary aids and services free of charge. Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the Blue Medicare Advantage (PPO) and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication, such as braille, large print, or alternative formats.

About Blue Medicare Advantage (PPO)

- Blue Cross and Blue Shield of Kansas is a PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of Kansas Medicare Advantage depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means Blue Cross and Blue Shield of Kansas. When it says “plan” or “our plan,” it means Blue Medicare Advantage (PPO).

- **If you do nothing by December 7, 2026, you'll automatically be enrolled in Blue Medicare Advantage (PPO).** Starting January 1, 2027, you'll get your medical and drug coverage through Blue Medicare Advantage. Go to Section 3 for more information about how to change plans and deadlines for making a change.

H7063_001ANOC2027_M

Table of Contents

Summary of Important Costs for 2027	5
SECTION 1 Changes to Benefits & Costs for Next Year.....	8
Section 1.1 Changes to the Monthly Plan Premium	8
Section 1.2 Changes to Your Maximum Out-of-Pocket Amount	8
Section 1.3 Changes to the Provider Network	10
Section 1.4 Changes to the Pharmacy Network.....	10
Section 1.5 Changes to Benefits & Costs for Medical Services	11
Section 1.6 Changes to Part D Drug Coverage	24
Section 1.7 Changes to Prescription Drug Benefits & Costs	25
SECTION 2 Administrative Changes	28
SECTION 3 How to Change Plans	29
Section 3.1 Deadlines for Changing Plans.....	29
Section 3.2 Are there other times of the year to make a change?	30
SECTION 4 Get Help Paying for Prescription Drugs.....	30
SECTION 5 Questions?	31
Get Help from Blue Medicare Advantage (PPO).....	31
Get Free Counseling about Medicare	32
Get Help from Medicare	32

Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* *Your premium can be higher than this amount. Go to Section 1.1 for details.	\$0	\$0
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered services. (Go to Section 1.2 for details.)	From network providers: \$5,500 From network and out-of-network providers combined: \$9,200	From network providers: \$7,150 From network and out-of-network providers combined: \$10,750
Primary care office visits	In-Network: \$0 copay per visit Out-Of-Network: 40% coinsurance per visit	In-Network: \$0 copay per visit Out-Of-Network: 50% coinsurance per visit
Specialist office visits	Specialist visits: \$40 copay per visit Out-Of-Network: 40% coinsurance per visit	Specialist visits: \$40 copay per visit Out-Of-Network: 50% coinsurance per visit

	2026 (this year)	2027 (next year)
Inpatient hospital stays 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: \$350 copay per day for days 1 to 6. \$0 copay per day for days 7 and beyond. Out-of-Network: 40% coinsurance per stay.	In-Network: \$400 copay per day for days 1 to 6. \$0 copay per day for days 7 and beyond. Out-of-Network: 50% coinsurance per stay.
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible \$300 deductible except for covered insulin products and most adult Part D vaccines Copayment/Coinsurance during the Initial Coverage Stage: Your cost for a one-month supply filled at a network pharmacy: Drug Tier 1: <i>Preferred: \$0</i> <i>Standard: \$5</i> Drug Tier 2: <i>Preferred: \$0</i> <i>Standard: \$10</i> Drug Tier 3: <i>Preferred: 24% of the total cost</i> <i>Standard: 25% of the total cost</i>	Part D drug coverage deductible \$700 deductible except for covered insulin products and most adult Part D vaccines Copayment/Coinsurance during the Initial Coverage Stage: Your cost for a one-month supply filled at a network pharmacy: Drug Tier 1: <i>Preferred: \$0</i> <i>Standard: \$5</i> Drug Tier 2: <i>Preferred: \$0</i> <i>Standard: \$10</i> Drug Tier 3: <i>Preferred: 20% of the total cost</i> <i>Standard: 21% of the total cost</i>

	2026 (this year)	2027 (next year)
	You pay no more than \$30 Preferred/ \$35 Standard per month supply of each covered insulin product on this tier. Drug Tier 4: <i>Preferred:</i> 31% of the total cost. <i>Standard:</i> 33% of the total cost. You pay no more than \$30 Preferred/ \$35 Standard per month supply of each covered insulin product on this tier. Drug Tier 5: <i>Preferred:</i> 29% of the total cost. <i>Standard:</i> 29% of the total cost. Once your total drug costs have reached \$2,100, you will move to the next stage (Catastrophic Coverage Stage). Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.	You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 4: <i>Preferred:</i> 31% of the total cost. <i>Standard:</i> 32% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier. Drug Tier 5: <i>Preferred:</i> 25% of the total cost. <i>Standard:</i> 25% of the total cost. Once your total drug costs have reached \$2,400, you will move to the next stage (Catastrophic Coverage Stage). Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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.)	\$0	\$0
Additional premium for optional supplemental benefits 1 If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)	\$25	\$30

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.

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 (and other health services not covered by Medicare) 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 copayments and coinsurance) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$5,500	\$7,150 Once you've paid \$7,150 out of pocket for covered services, you'll pay nothing for your covered services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments and coinsurance) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs don't count toward your maximum out-of-pocket amount for medical services.	\$9,200	\$10,750 Once you've paid \$10,750 out of pocket for covered services, you'll pay nothing for your covered 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* www.bcbsks.com/medicare/find-a-provider.shtml 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 www.bcbsks.com/medicare/ma-welcome.
- Call Customer Services at 1-800-222-7645 (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 Customer Services at 1-800-222-7645 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network 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* www.bcbsks.com/medicare/ma-welcome to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at www.bcbsks.com/medicare/ma-welcome.
- Call Customer Services at 1-800-222-7645 (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 Customer Services at 1-800-222-7645 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2026 (this year)	2027 (next year)
Ambulance Services- Medicare-covered Air Ambulance	In-Network: You pay \$300 copay for this benefit. Out-of-Network: You pay \$300 copay for this benefit.	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 20% of the total cost.
Ambulance Services- Medicare-covered Ground Ambulance	In-Network: You pay \$300 copay for this benefit. Out-of-Network: You pay \$300 copay for this benefit.	In-Network: You pay \$350 copay for this benefit. Out-of-Network: You pay \$350 copay for this benefit.
Ambulatory Surgical Center (ASC Services)	In-Network: You pay \$300 copay for this benefit. Out-of-Network: You pay \$300 copay for this benefit.	In-Network: You pay \$300 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Annual Physical Exam	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Chiropractic Services	In-Network: You pay \$15 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$15 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Dental Service	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost. Up to a maximum benefit of \$2,500 every year for non-Medicare-covered preventive and comprehensive dental services.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost. Up to a maximum benefit of \$1,200 every year for non-Medicare-covered preventive and comprehensive dental services.
Doctor Office Visit	In-Network: Primary Care: You pay \$0 copay for this benefit. Specialist Care: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: Primary Care: You pay \$0 copay for this benefit. Specialist Care: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Eye Exams	Medicare covered: In-Network: You pay \$0 - \$45 copay for this benefit. Out-of-Network: You pay 40% of the total cost. Non-Medicare covered: Out-of-Network: You pay 40% of the total cost.	Medicare covered: In-Network: You pay \$0 - \$45 copay for this benefit. Out-of-Network: You pay 50% of the total cost. Non-Medicare covered: Out-of-Network: You pay 50% of the total cost.
Eyewear	Medicare covered: In-Network: You pay \$45 copay for this benefit. Out-of-Network: You pay 40% of the total cost. Non-Medicare covered: \$0 copayment for all other supplemental eyewear up to a \$250 annual allowance.	Medicare covered: In-Network: You pay \$45 copay for this benefit. Out-of-Network: You pay 50% of the total cost. Non-Medicare covered: \$0 copayment for all other supplemental eyewear up to a \$150 annual allowance.
Fitness Benefit	In-Network and Out-of-Network: You pay nothing for this benefit.	In-Network and Out-of-Network: Not Covered

	2026 (this year)	2027 (next year)
Inpatient Acute Medicare-covered stay	In-Network: \$350 copay per day for days 1-6. \$0 copay per day for days 7-90. Out-of-Network: You pay 40% of the total cost.	In-Network: \$400 copay per day for days 1-6. \$0 copay per day for days 7-90. Out-of-Network: You pay 50% of the total cost.
Inpatient services in a psychiatric hospital	In-Network: \$350 copay per day for days 1-6. \$0 copay per day for days 7-90. Out-of-Network: You pay 40% of the total cost.	In-Network: \$350 copay per day for days 1-6. \$0 copay per day for days 7-90. Out-of-Network: You pay 50% of the total cost.
Meal benefit	In-Network: You pay nothing for this benefit. Out-of-Network: Not covered if the meals are not obtained from Mom's Meals.	In-Network: You pay nothing for this benefit. Out-of-Network: Members will be reimbursed up to \$108 maximum after each discharge from an inpatient hospital after submitting a reimbursement request and purchase receipt.

	2026 (this year)	2027 (next year)
Medicare Part B Chemotherapy/Radiation Drugs	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 50% of the total cost.
Medicare Part B Insulin Drug	In-Network: You pay 0%-20% of the total cost. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay 0%–20% of the total cost. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Cardiac Rehabilitation Services	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Diabetes Self-Management Training	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Diabetic Supplies	In-Network: You pay 0%-20% of the total cost. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay 0%–20% of the total cost. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Medicare-covered Diabetic Therapeutic Shoes or Inserts	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Diagnostic Procedures Tests	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Digital Rectal Exams	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered DME	In-Network: You pay 15% of the total cost. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 50% of the total cost.
Medicare-covered EKG following Welcome Visit	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Medicare-covered Glaucoma screening	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Hearing Services	In-Network: You pay \$45 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$45 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Home Health Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Intensive Cardiac Rehabilitation Services	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Intensive Outpatient Program Services	In-Network: You pay \$30 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$150 copay for this benefit. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Medicare-covered Kidney Disease Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Lab Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Medical Supplies	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Observation Services	In-Network: You pay \$300 copay for this benefit. Out-of-Network: You pay \$300 copay for this benefit.	In-Network: You pay \$375 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Occupational Therapy Services	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Medicare-covered Opioid Treatment Services	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Outpatient Blood Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Outpatient Hospital Services	In-Network: You pay \$300 copay for this benefit. Out-of-Network: You pay \$300 copay for this benefit.	In-Network: You pay \$375 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Partial Hospitalization	In-Network: You pay \$30 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$150 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Prosthetic Devices	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Medicare-covered Pulmonary Rehabilitation Services	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Therapeutic Radiological Services	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay 20% of the total cost. Out-of-Network: You pay 50% of the total cost.
Medicare-covered X-Ray Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$0–\$150 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Medicare-covered Zero Dollar Preventive Services	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Mental Health Specialty Services Medicare-covered Group Sessions	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Mental Health Specialty Services Medicare-covered Individual Sessions	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Non-Medicare covered Hearing Aids (all types)	In-Network: You pay \$295 minimum copay for this benefit. You pay \$1,495 maximum copay for this benefit. Out-of-Network: Not covered.	In-Network: You pay \$295 minimum copay for this benefit. You pay \$1,495 maximum copay for this benefit. Out-of-Network: You pay 80% of the total cost.
Non-Medicare covered Routine Hearing Exams	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 80% of the total cost.
OTC Items	\$47.50 allowance every three months.	Not covered.

	2026 (this year)	2027 (next year)
Other Health Care Professional Services	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Outpatient Diagnostic Radiology Services	In-Network: You pay \$40-\$250 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$0-\$350 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Outpatient Substance Abuse Services Medicare-covered Group Sessions	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Outpatient Substance Abuse Services Medicare-covered Individual Sessions	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Physical Therapy and Speech Language Pathology	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Podiatry Services	In-Network: You pay \$30 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Psychiatric Services	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Psychiatric Services Medicare-covered Group Sessions	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay \$40 copay for this benefit. Out-of-Network: You pay 50% of the total cost.
Remote Access Technologies	In-Network: You pay \$10 copay for this benefit. Out-of-Network: You pay 40% of the total cost.	In-Network: You pay nothing for this benefit. Out-of-Network: You pay 50% of the total cost.

	2026 (this year)	2027 (next year)
Skilled Nursing Facility (SNF) Medicare-covered stay	In-Network: \$10 copay per day for days 1-20. \$218 copay per day for days 21-100. Out-of-Network: You pay 40% of the total cost.	In-Network: \$10 copay per day for days 1-20. \$221 copay per day for days 21-100. Out-of-Network: You pay 50% of the total cost.
Urgently Needed Services	In-Network: You pay \$35 copay for this benefit.	In-Network: You pay \$50 copay for this benefit.

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 posted online at www.MyPrime.com.

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 Customer Services at 1-800-222-7645 (TTY users call 711) for more information.

Starting in 2027, 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:

[FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients](https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients).

You can also call Customer Services at 1-800-222-7645 (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.**

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 Part D 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 also pay nothing for excluded drugs that are covered under our enhanced benefit. 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	This plan has a \$300 pharmacy deductible on Tier 4-5 drugs. Tier 1-3 drugs are not included in the deductible.	This plan has a \$700 pharmacy deductible on Tier 3-5 drugs. Tier 1 and Tier 2 drugs are not included in the deductible.

Drug Costs in Stage 2: Initial Coverage

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.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. 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; at a network pharmacy that offers preferred cost sharing; 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 (this year)	2027 (next year)
Tier 1 (Preferred Generic):	Your cost for a one-month supply is: <i>Preferred: \$0</i> <i>Standard: \$5</i>	Your cost for a one-month supply is: <i>Preferred: \$0</i> <i>Standard: \$5</i>
Tier 2 (Generic):	Your cost for a one-month supply is: <i>Preferred: \$0</i> <i>Standard: \$10</i>	Your cost for a one-month supply is: <i>Preferred: \$0</i> <i>Standard: \$10</i>
Tier 3 (Preferred Brand):	Your cost for a one-month supply is: <i>Preferred: 24% of the total cost</i> <i>Standard: 25% of the total cost</i> You pay no more than \$30 <i>Preferred/ \$35 Standard</i> per month supply of each covered insulin product on this tier.	Your cost for a one-month supply is: <i>Preferred: 20% of the total cost</i> <i>Standard: 21% of the total cost</i> You pay no more than \$35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Tier 4 (Non-Preferred Drug):	Your cost for a one-month supply is: <i>Preferred:</i> 31% of the total cost. <i>Standard:</i> 33% of the total cost. You pay \$30 <i>Preferred</i>/ \$35 <i>Standard</i> per month supply of each covered insulin product on this tier.	Your cost for a one-month supply is: <i>Preferred:</i> 31% of the total cost. <i>Standard:</i> 32% of the total cost. You pay no more than \$35 per month supply of each covered insulin product on this tier.
Tier 5 (Specialty Tier):	Your cost for a one-month supply is: <i>Preferred:</i> 29% of the total cost. <i>Standard:</i> 29% of the total cost.	Your cost for a one-month supply is: <i>Preferred:</i> 25% of the total cost. <i>Standard:</i> 25% of the total cost.

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Geographic/Service Area	Service area consists of Chase, Coffey, Douglas, Franklin, Geary, Jackson, Jefferson, Leavenworth, Linn, Lyon, Miami, Morris, Osage, Pottawatomie, Riley, Shawnee, Wabaunsee counties.	Service area consists of Jackson, Lyon, Osage, Pottawatomie, Shawnee, Wabaunsee counties.

SECTION 3 How to Change Plans

To stay in Blue Medicare Advantage (PPO), 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 Blue Medicare Advantage (PPO).

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 Blue Medicare Advantage (PPO). 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 Blue Medicare Advantage (PPO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Services at 1-800-222-7645 (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).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit [Medicare.gov](https://www.medicare.gov), check the Medicare & You 2027 handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Blue Cross and Blue Shield of Kansas offer other Medicare health plans *AND/OR* Medicare drug 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, 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 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 Kansas Ryan White Part B 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 1-785-296-6174. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-800-222-7645 (TTY users should call 711) or visit [Medicare.gov](https://www.medicare.gov).

SECTION 5 Questions?

Get Help from Blue Medicare Advantage (PPO)

- **Call Customer Services at 1-800-222-7645. (TTY users call 711.)**

We're available for phone calls 8:00 AM to 8:00 PM seven days a week from October 1 through March 31. We are available 8:00 AM to 8:00 PM Monday through Friday April 1 through September 30. 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 Blue Medicare Advantage (PPO). 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 <https://www.bcbsks.com/medicare/forms> or call Customer Services at 1-800-222-7645

(TTY users call 711) to ask us to mail you a copy. You can also review the separately mailed *Evidence of Coverage* to see if other benefits or cost changes affect you.

- **Visit www.bcbsks.com/medicare/ma-welcome**

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 Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK).

Call SHICK to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call SHICK at 1-800-860-5260. Learn more about SHICK by visiting www.kdads.ks.gov/SHICK.

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with [Medicare.gov](https://www.medicare.gov)**

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

- **Write to Medicare**

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

- **Visit [Medicare.gov](https://www.medicare.gov)**

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

- **Read *Medicare & You 2027***

The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [Medicare.gov](https://www.Medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.