The 65 Plus Medicare Advantage Plan (PPO)[SM] offered by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC)

Annual Notice of Change for 2026

You're enrolled as a member of the 65 Plus Medicare Advantage Plan (PPO)[SM] through The Texas A&M University System.

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

- **During your Group's open enrollment period, you may make changes to your Medicare coverage for next year.**
- 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 www.bcbstx.com/tamus-retiree-medicare or call Customer Service at 1-855-476-4149 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call Customer Service at 1-855-476-4149 (TTY only, call 711) for more information.
- Call Customer Service at 1-855-476-4149 for additional information. (TTY users call 711) for more information. We are open October 1 through March 31, 8 a.m. - 8 p.m. local time 7 days a week. If you are calling April 1 through September 30, we are open 8 a.m. - 8 p.m. Monday through Friday. Alternate technologies (for example, voicemail) will be used on weekends and holidays. This call is free.
- Please contact the 65 Plus Medicare Advantage Plan (PPO) if you need this information in another language or format (Spanish, braille, large print or alternate formats).

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

About the 65 Plus Medicare Advantage Plan (PPO)

- PPO plan provided by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC is an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment depends on contract renewal.
- When this material says "we," "us," or "our", it means Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). When it says "plan" or "our plan," it means the 65 Plus Medicare Advantage Plan (PPO).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in *the 65 Plus Medicare Advantage Plan (PPO)*.** Starting January 1, 2026, you'll get your medical through the 65 Plus Medicare Advantage Plan (PPO). Go to Section 2 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. Go to Section 1.1 for details.	You can get information regarding your premium by going through your employer group.	**You can get information regarding your premium by going through your employer group.**
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 and out-of-network providers combined: $750	**From network and out-of-network providers combined: $750**
Primary care office visits	**In-Network** $0 copay per visit **Out-of-Network** $0 copay per visit	**In-Network** **$0 copay per visit** **Out-of-Network** **$0 copay per visit**
Specialist office visits	**In-Network** 5% of the total cost per visit **Out-of-Network** 5% of the total cost per visit	**In-Network** **5% of the total cost per visit** **Out-of-Network** **5% of the total cost per visit**

	2025 (this year)	2026 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	**In-Network** 5% of the total cost per stay **Out-of-Network** 5% of the total cost per stay	**In-Network** **5% of the total cost per stay** **Out-of-Network** **5% of the total cost per stay**

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.)	You can get information regarding your premium by going through your employer group.	**You can get information regarding your premium by going through your employer group.**

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 services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Our plan premium **doesn't count** toward your maximum out-of-pocket amount.	$750	**$750** **Once you've paid $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 in-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 Finder* www.bcbstx.com/tamus-retiree-medicare 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.bcbstx.com/tamus-retiree-medicare.
- Call Customer Service at 1-855-476-4149 (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 Service at 1-855-476-4149 (TTY users call 711) for help.

Section 1.4 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Diabetic Supplies	**In-Network:** 0% of the total cost for Medicare-covered services. 0% cost sharing is limited to diabetic testing supplies (meters and strips) obtained through the pharmacy for Lifescan branded products (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio IQ,OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2). Prior Authorization will be required for all other diabetic testing supplies (meters and strips) and will be subject to 5% cost sharing. All test strips will also be subject to a	**In-Network: 0% minimum of the total cost for Medicare-covered services. 0% cost sharing is limited to diabetic testing supplies (meters and strips) obtained through the pharmacy to Ascensia and Abbott branded products. Prior Authorization will be required for all other diabetic testing supplies (meters and strips) and will be subject to 5% cost sharing. All test strips will also be subject to a quantity limit of 204 per 30 days. Continuous Glucose**

	2025 (this year)	2026 (next year)
	quantity limit of 204 per 30 days. Continuous Glucose Monitoring (CGM) products obtained through the pharmacy are subject to Prior Authorization, Quantity Limit and 5% cost sharing. Continuous Glucose Monitoring (CGM) preferred products are Dexcom G6, Dexcom G7 when used with a Dexcom Receiver, and Abbott Freestyle Libre and Freestyle Libre 2 products,and Freestyle Libre 3 when used with a Freestyle Libre receiver. Prior approval and trial and failure of a preferred CGM product will be required for all other continuous glucose monitoring products. **Out-of-Network:** 0% of the total cost for Medicare-covered services. 0% cost sharing is limited to diabetic testing supplies (meters andstrips) obtained through the pharmacy for Lifescan branded products (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch	**Monitoring (CGM) products obtained through the pharmacy are subject to Prior Authorization, Quantity Limit and 5% cost sharing.** **Continuous Glucose Monitoring (CGM) preferred products are Dexcom G6, Dexcom G7 when used with a Dexcom Receiver, and Abbott Freestyle Libre and Freestyle Libre 2 products, and Freestyle Libre 3 when used with a Freestyle Libre receiver. Prior approval and trial and failure of a preferred CGM product will be required for all other continuous glucose monitoring products. CGM receivers are subject to a quantity limit of 1 per 365 days.** **Out-of-Network:** **0% of the total cost for Medicare-covered services.** **0% cost sharing is limited to diabetic testing supplies (meters and strips) obtained through the pharmacy to Ascensia and Abbott branded**

	2025 (this year)	2026 (next year)
	Verio IQ,OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2). Prior Authorization will be required for all other diabetic testing supplies (meters and strips) and will be subject to 5% cost sharing. All test strips will also be subject to a quantity limit of 204 per 30 days. Continuous Glucose Monitoring (CGM) products obtained through the pharmacy are subject to Prior Authorization, Quantity Limit and 5% cost sharing. Continuous Glucose Monitoring (CGM) preferred products are Dexcom G6, Dexcom G7 when used with a Dexcom Receiver, and Abbott Freestyle Libre and Freestyle Libre 2 products,and Freestyle Libre 3 when used with a Freestyle Libre receiver. Prior approval and trial and failure of a preferred CGM product will be required for all other continuous glucose monitoring products.	**products. Prior Authorization will be required for all other diabetic testing supplies (meters and strips) and will be subject to 5% cost sharing. All test strips will also be subject to a quantity limit of 204 per 30 days.** **Continuous Glucose Monitoring (CGM) products obtained through the pharmacy are subject to Prior Authorization, Quantity Limit and 5% cost sharing.** **Continuous Glucose Monitoring (CGM) preferred products are Dexcom G6, Dexcom G7 when used with a Dexcom Receiver, and Abbott Freestyle Libre and Freestyle Libre 2 products,and Freestyle Libre 3 when used with a Freestyle Libre receiver. Prior approval and trial and failure of a preferred CGM product will be required for all other continuous glucose monitoring products. CGM receivers are**

	2025 (this year)	2026 (next year)
		subject to a quantity limit of 1 per 365 days.
Health and Wellness education programs SilverSneakers Membership	Includes access to Burnalong program of interactive online classes.	**Burnalong program is not available. See your *Evidence of Coverage* for more details on programs that are available. This change does not impact your SilverSneakers membership.**

SECTION 2 How to Change Plans

To stay in the 65 Plus Medicare Advantage Plan (PPO), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by the open enrollment timeframe as defined by your employer, you'll automatically be enrolled in our the 65 Plus Medicare Advantage Plan (PPO).

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 the 65 Plus Medicare Advantage Plan (PPO).
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from the 65 Plus Medicare Advantage Plan (PPO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at 1-855-476-4149 (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 2.2).

- Contact your employer/union benefits administrator for more information on how to do so.

- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 4), or call 1-800-MEDICARE. Your coverage is provided through a contract with your current employer or former employer or union. Please contact your employer/union benefits administrator for more information on opting out.

Section 2.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage during your Group's specified Open Enrollment period. Contact your Employer Group Plan Benefit Administrator to understand what happens if you disenroll from the group plan 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). Your coverage is provided through a contract with your current employer or former employer or union. Please contact your employer/union benefits administrator for more information.

Section 2.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

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

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

SECTION 3 Get Help Paying for Prescription Drugs

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

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan, yearly deductibles, and coinsurance. Also, those who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week;
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users can, call 1-800-325-0778; or
  - Your State Medicaid Office.

SECTION 4 Questions?

Get Help from the 65 Plus Medicare Advantage Plan (PPO)

- **Call Customer Service at 1-855-476-4149. (TTY users call 711).**

  We are open October 1 through March 31, 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, we are open 8 a.m. - 8 p.m. Monday through Friday. Alternate technologies (for example, voicemail) will be used on weekends and holidays. 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, look in the 2026 *Evidence of Coverage* for the 65 Plus Medicare Advantage Plan (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 www.bcbstx.com/tamus-retiree-medicare or call Customer Service at 1-855-476-4149. (TTY users call 711 to ask us to mail you a copy.

- **Visit www.bcbstx.com/tamus-retiree-medicare**

  Our website has the most up-to-date information about our provider network (*Provider Directory*).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Texas, the SHIP is called Health Information, Counseling, and Advocacy Program (HICAP).

Call Health Information, Counseling, and Advocacy Program (HICAP) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Health Information, Counseling, and Advocacy Program (HICAP) at 1-800-252-9240. Learn more about Health Information, Counseling, and Advocacy Program (HICAP) by visiting (https://www.tdi.texas.gov/consumer/hicap/).

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.