BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

BCN Advantage Elements (HMO-POS) offered by Blue Care Network of Michigan

Annual Notice of Changes for 2021

You are currently enrolled as a member of BCN Advantage Elements. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.4 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

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☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at **www.medicare.gov/plan-compare** website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in BCN Advantage Elements.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in BCN Advantage Elements.
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Customer Service number at 1-800-450-3680 for additional information. (TTY users should call 711). Hours are 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31.
- This information may be available in other formats, including large print.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

About BCN Advantage Elements

- BCN Advantage Elements is an HMO-POS plan with a Medicare contract. Enrollment in BCN Advantage Elements depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Blue Care Network of Michigan. When it says “plan” or “our plan,” it means BCN Advantage Elements.
- Out-of-network/non-contracted providers are under no obligation to treat BCN Advantage Elements members, except in emergency situations. Please call our Customer Service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for BCN Advantage Elements in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at **www.bcbsm.com/medicare**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium	[*Region 1:* $8] [*Region 2:* $23.20] [*Region 3:* $33.80] [*Region 4:* $25] [*Region 5:* $30]	[*Region 1:* $8] [*Region 2:* $23.20] [*Region 3:* $33.80] [*Region 4:* $25] [*Region 5:* $30]
Deductible	$160 In-network $500 Point-of-Service	$160 In-network $500 Point-of-Service
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$4,500	$4,500
Doctor office visits	Primary care visits: $10 per visit, after deductible. Specialist visits: $40 per visit, after deductible.	Primary care visits: $0 per visit, after deductible. Specialist visits: $40 per visit, after deductible.
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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	For Medicare-covered hospital stays: Days 1-6: You pay a $205 copay per day, after deductible. Days 7-90: You pay a $0 copay per day, after deductible. You pay a $0 copay for additional days in a benefit period, after deductible.	For Medicare-covered hospital stays: Days 1-6: You pay a $205 copay per day, after deductible. Days 7-90: You pay a $0 copay per day, after deductible. You pay a $0 copay for additional days in a benefit period, after deductible.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	[*Region 1:* $8] [*Region 2:* $23.20] [*Region 3:* $33.80] [*Region 4:* $25] [*Region 5:* $30]	[*Region 1:* $8] [*Region 2:* $23.20] [*Region 3:* $33.80] [*Region 4:* $25] [*Region 5:* $30]
Optional Supplemental Package 1 monthly premium You no longer need to purchase an optional supplemental package to get comprehensive hearing benefits. For more information, see Chapter 4, Section 2.1, Medical Benefits Chart; and see Chapter 4, Section 2.2, *Extra "optional supplemental" benefits you can buy*, in your *2021 Evidence of Coverage*.	Additional Dental, Vision and Hearing: $21.40	Additional Dental and Vision: $20.40
Optional Supplemental Package 2 monthly premium You no longer need to purchase an optional supplemental package to get comprehensive hearing benefits. For more information, see Chapter 4, Section 2.1, Medical Benefits Chart; and see Chapter 4, Section 2.2, *Extra "optional supplemental" benefits you can buy*, in your *2021 Evidence of Coverage.*	Additional Dental, Vision and Hearing: $32.40	Additional Dental and Vision: $37.40

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year. In 2021 your Medicare-covered Point-of-Service spending will apply to your maximum out-of-pocket amount, whereas in 2020 it did not.

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$4,500 Care received through our point-of-service benefit will not count toward your maximum out-of-pocket.	$4,500 Once you have paid $4,500 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. Care received through our point-of-service benefit will count toward your maximum out-of-pocket.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at **www.bcbsm.com/providersmedicare**. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2021 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Acupuncture for chronic low back pain	Effective January 21, 2020. You pay a $20 copay for each Medicare-covered visit, after deductible.	You pay a $20 copay for each Medicare-covered visit, after deductible.
Ambulance services	You pay a $230 copay for each one-way trip, after deductible.	You pay a $250 copay for each one-way trip, after deductible.
Hearing services	You pay a $10 copay for each primary care provider visit for Medicare-covered basic diagnostic hearing evaluations, after deductible. Additional routine hearing services and hearing aid benefits are not covered. You may purchase additional coverage by paying an additional premium for the Optional Supplemental Benefit Package.	You pay a $0 copay for each primary care provider visit for Medicare-covered basic diagnostic hearing evaluations, after deductible. Your plan now covers additional routine hearing services and hearing aid benefits for no additional premium. Covered services include a routine hearing exam, hearing aids and hearing aid fittings. You pay a $0 copay for services from a primary care provider for one hearing exam every year, after deductible.

Cost	2020 (this year)	2021 (next year)
Hearing services (continued)		You pay a $40 copay for services from a specialist for one hearing exam every year, after deductible. You pay a $0 copay for one hearing aid fitting and evaluation every three years, after deductible. Plan covers a $1,200 allowance maximum for both ears (up to $600 per ear) every three years for new hearing aids. If your hearing aids exceed the allowance, you must pay the difference between the benefit and the cost of the hearing aid.
Meal benefit	Meal benefits are not covered.	Qualified members pay $0 for 28 meals over 14 days if eligibility requirements are met. Members who have been selected to be a part of our Blue Cross care management program for members with special health needs and have been discharged from a hospital may be eligible for a two-week (14 day) meal benefit. Members are eligible for this benefit during the 30-day period after they return home from the hospital. An assessment with your Blue Cross nurse care

Cost	2020 (this year)	2021 (next year)
Meal benefit (continued)		manager is required to determine eligibility for the meal benefit.
Opioid treatment program services	You pay a $40 copay for Medicare-covered benefits.	You pay a $0 copay for Medicare-covered benefits.
Outpatient diagnostic tests and therapeutic services and supplies	You pay a $20 copay for most Medicare-covered outpatient diagnostic procedures and tests, after deductible.	You pay a $0 copay for Medicare-covered COVID-19 testing after deductible. You continue to pay a $20 copay for other Medicare-covered outpatient diagnostic procedures and tests after deductible.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a $100 copay for each Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center.	You pay a $0 copay for each Medicare-covered arthroplasty knee and hip services in an ambulatory surgical center, after deductible.
Over-the-counter items (from authorized retailers and vendor catalog only)	Members may use their over-the counter benefit allowance of $15 per quarter to purchase certain over-the-counter items. No carry over. You can access your benefit in the following ways: • Online at **www.bcbsm.com/medicareotc**. • By phone using catalog provided by authorized vendor.	$25 allowance per quarter. Unused amounts do not carry over from one quarter to the next. You can access your benefit in the following ways: • In-store at participating locations with benefit card provided by authorized vendor. • Online by following the prompts on **www.bcbsm.com/medicareotc**.

Cost	2020 (this year)	2021 (next year)
Over-the-counter items (from authorized retailers and vendor catalog only) (continued)	• By mail using catalog provided by authorized vendor.	• By phone using requested printed or online catalog provided by authorized vendor. • By mail using catalog provided by authorized vendor. • Additional materials will be mailed to you before beginning of plan year.
Physician/Practitioner services, including doctor's office visits	You pay a $10 copay for each primary care doctor visit for Medicare-covered benefits, after deductible. You pay a $10 copay for each primary care doctor visit for Medicare-covered dental benefits, after deductible. You pay a $10 copay for each telehealth medical visit through plan contracted vendor, after the deductible. You pay a $40 copay for each telehealth mental health visit, after deductible.	You pay a $0 copay for each primary care doctor visit for Medicare-covered benefits, after deductible. You pay a $0 copay for each primary care doctor visit for Medicare-covered dental benefits, after deductible. You pay a $0 copay for each telehealth medical visit, after deductible. You pay a $0 copay for each telehealth mental health visit, after deductible.
Special supplemental benefits for the chronically ill	Special supplemental benefits for the chronically ill are <u>not</u> covered.	You pay $0 for special supplemental benefits for the chronically ill. Plan-identified members with certain health conditions can use their quarterly over-the-counter allowance of $25 per

Cost	2020 (this year)	2021 (next year)
Special supplemental benefits for the chronically ill (continued)		quarter to buy approved foods. Your OTC account will be loaded automatically with your quarterly benefit allowance on January 1, April 1, July 1 and October 1. Benefit allowance doesn't roll over. This benefit will be available only to plan-identified members who have been diagnosed with: • Diabetes • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Stroke • Hypertension • Coronary artery disease (CAD) • Rheumatoid arthritis • Have known risk factors associated with exposure to COVID-19 See your *Evidence of Coverage* for more information.
Transportation services	Transportation services are not covered.	Qualified members pay $0. Qualified members who have been selected to be a part of Blue Cross Coordinated Care program may be eligible

Cost	2020 (this year)	2021 (next year)
Transportation services (continued)		for non-emergency medical transportation provided by a plan-approved transportation provider, to medical appointments, physical therapy, a pharmacy or other plan-approved locations. For members who reside in Wayne, Oakland, Macomb and Washtenaw counties, transportation is covered for up to 28 days after each acute care hospital discharge. For members who reside in Allegan, Barry, Ionia, Kalamazoo, Kent, Mason, Muskegon, Newaygo, Oceana and Ottawa counties only, transportation is limited to 2 trips per month and each trip is limited to up to 100 miles round trip.
Urgently needed services	You pay a $45 copay for each Medicare-covered urgent care visit.	You pay a $45 copay for each Urgent Care Center Medicare-covered visit. You pay $0 copay for urgently needed Medicare-covered visits provided by a primary care physician.
Worldwide emergency transportation	Worldwide emergency transportation services are not covered.	You pay a $250 copay per worldwide emergency transportation service.

Cost	2020 (this year)	2021 (next year)
Optional supplemental benefits Optional supplemental benefits are non-Medicare-covered dental, hearing, and vision services available through this plan for an extra premium. For more information, see Chapter 4, Section 2.2, Extra "optional supplemental" benefits you can buy, in your 2021 *Evidence of Coverage*.		
Optional supplemental dental Package 1	**In-network** Adjunct crown services not covered. **Out-of-network** Adjunct crown services not covered.	**In-network** You pay 50% coinsurance of the allowed amount for adjunct crown services. **Out-of-network** You pay 50% coinsurance of the allowed amount for adjunct crown services.
Optional supplemental hearing Package 1	**In-network** You pay 0% coinsurance for up to one hearing exam every year. You pay 0% coinsurance for up to one hearing aid fitting evaluation every three years. You pay 50% coinsurance on hearing aids. Plan covers a $1,200 benefit maximum for both ears (up to $600 per ear) every three years for new hearing aids. You must pay the difference between the benefit and the cost of the hearing aid.	**In-network** Included in medical benefits. See Hearing Services in Section 1.4.

Cost	2020 (this year)	2021 (next year)
Optional supplemental vision Package 1	**In-network** The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit up to $300 every 24 months and may be used for either (a) elective contact lenses or (b) frames. Standard eyeglass lenses covered in full every 24 months. **Out-of-network** The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit with 50% coinsurance up to $300 every 24 months and may be used for either (a) elective contact lenses or (b) frames. Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts every 24 months. Exams are reimbursed up to allowed amounts.	**In-network** The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit up to $200 every 12 months and may be used for either (a) elective contact lenses or (b) frames. Standard eyeglass lenses covered in full every 12 months. **Out-of-network** The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit with 50% coinsurance up to $200 every 12 months and may be used for either (a) elective contact lenses or (b) frames. Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts every 12 months. Exams are reimbursed at 50% coinsurance up to allowed amounts. Routine eye exams are limited to one every 12 months.
Optional supplemental dental Package 2	**In-network** Adjunct crown services not covered.	**In-network** You pay 25% coinsurance of the allowed amount for adjunct crown services.

Cost	2020 (this year)	2021 (next year)
Optional supplemental dental Package 2 (continued)	**Out-of-network** Adjunct crown services not covered.	**Out-of-network** You pay 50% coinsurance of the allowed amount for adjunct crown services.
Optional supplemental hearing Package 2	**In-network** You pay 0% coinsurance for up to one hearing exam every year. You pay 0% coinsurance for up to one hearing aid fitting evaluation every three years. You pay 50% coinsurance on hearing aids. Plan covers a $2,500 benefit maximum for both ears (up to $1,250 per ear) every three years for new hearing aids. You must pay the difference between the benefit and the cost of the hearing aid.	**In-network** Included in medical benefits. See Hearing Services in Section 1.4.
Optional supplemental vision Package 2	**In-network** The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit up to $400 every 24 months and may be used for either (a) elective contact lenses or (b) frames. Standard eyeglass lenses covered in full every 24 months. **Out-of-network** The optional eye wear benefit provides a combined in and out-of-network maximum vision	**In-network** The optional eye wear benefit provides a combined in and out-of-network maximum vision benefit up to $300 every 12 months and may be used for either (a) elective contact lenses or (b) frames. Standard eyeglass lenses covered in full every 12 months. **Out-of-network** The optional eye wear benefit provides a combined in and out-of-network maximum vision

Cost	2020 (this year)	2021 (next year)
Optional supplemental vision Package 2 (continued)	benefit with 50% coinsurance up to $400 every 24 months and may be used for either (a) elective contact lenses or (b) frames. Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts every 24 months. Exams are reimbursed up to allowed amounts.	benefit with 50% coinsurance up to $300 every 12 months and may be used for either (a) elective contact lenses or (b) frames. Standard eyeglass lenses are reimbursed at 50% coinsurance up to allowed amounts every 12 months. Exams are reimbursed at 50% coinsurance up to allowed amounts. Routine eye exams are limited to one every 12 months.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in BCN Advantage Elements

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our BCN Advantage Elements.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- -- *OR* -- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (SHIP) (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to **www.medicare.gov/plan-compare**. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Blue Care Network of Michigan offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from BCN Advantage Elements.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from BCN Advantage Elements.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2021.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Michigan, the SHIP is called Michigan Medicare/Medicaid Assistance Program.

Michigan Medicare/Medicaid Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Michigan Medicare/Medicaid Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Michigan Medicare/Medicaid Assistance Program at 1-800-803-7174 (TTY 711). You can learn more about Michigan Medicare/Medicaid Assistance Program by visiting their website (**www.mmapinc.org**).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- "**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 prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the **Michigan HIV/AIDS Drug Assistance Program (MIDAP)**. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. You can call the **Michigan HIV/AIDS Drug Assistance Program (MIDAP)** at 1-888-826-6565 Monday through Friday Eastern time, 8 a.m. to 5 p.m. TTY users call 711.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-888-826-6565 Monday through Friday Eastern time, 8 a.m. to 5 p.m. TTY users call 711.

SECTION 6 Questions?

Section 6.1 – Getting Help from BCN Advantage Elements

Questions? We're here to help. Please call Customer Service at 1-800-450-3680. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31. Calls to these numbers are free.

Read your 2021 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 *Evidence of Coverage* for BCN Advantage Elements. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **www.bcbsm.com/medicare**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit Our Website

You can also visit our website at **www.bcbsm.com/medicare**. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*).

Section 6.2 – Getting Help from Medicare

To get information directly 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 should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (**www.medicare.gov**). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to **www.medicare.gov/plan-compare**).

Read Medicare & You 2021

You can read the *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (**www.medicare.gov**) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.