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 Prime Value (HMO-POS) offered by Blue Care Network of Michigan

Annual Notice of Changes for 2023

You are currently enrolled as a member of BCN Advantage Prime Value. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at **www.bcbsm.com/medicare**. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

- **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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

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- ☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.
- ☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.
- ☐ 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 Medicare Plan Finder at **www.medicare.gov/plan-compare** website or review the list in the back of your *Medicare & You 2023* handbook.
- ☐ 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, 2022, you will stay in BCN Advantage Prime Value.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with BCN Advantage Prime Value.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

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 Prime Value

- BCN Advantage Prime Value is an HMO-POS plan with a Medicare contract. Enrollment in BCN Advantage Prime Value depends on contract renewal.
- When this document says "we," "us," or "our," it means Blue Care Network of Michigan. When it says "plan" or "our plan," it means BCN Advantage Prime Value.

- Out-of-network/non-contracted providers are under no obligation to treat BCN Advantage Prime Value 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.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for BCN Advantage Prime Value in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium * Your premium may be higher than this amount. (See Section 1.1 for details.)	$0	$0
Deductible	$0 In-network $0 Point-of-Service	$0 In-network $0 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: You pay a $0 copay per visit. Specialist visits: You pay a $45 copay per visit.	Primary care visits: You pay a $0 copay per visit. Specialist visits: You pay a $45 copay per visit.
Inpatient hospital stays	For Medicare-covered hospital stays: Days 1-6: You pay a $325 copay per day. Days 7-90: You pay a $0 copay per day. You pay a $0 copay for additional days in a benefit period.	For Medicare-covered hospital stays: Days 1-6: You pay a $325 copay per day. Days 7-90: You pay a $0 copay per day. You pay a $0 copay for additional days in a benefit period.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 deductible on Tier 1: Preferred Generic, and Tier 2: Generic	Deductible: $0 deductible

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (continued)	$50 deductible on Tiers 3, 4 and 5	
	Copays/Coinsurance for a one-month supply during the Initial Coverage Stage:	Copays/Coinsurance for a one-month supply during the Initial Coverage Stage:
	Preferred retail and **preferred** mail-order pharmacy: Drug Tier 1: $0 Drug Tier 2: $11 Drug Tier 3: $42 Select Insulin (Senior Savings Model): $35 Drug Tier 4: 50% coinsurance Drug Tier 5: 32% coinsurance	**Preferred** retail and **preferred** mail-order pharmacy: Drug Tier 1: $0 Drug Tier 2: $11 Drug Tier 3: $42 Select Insulin (Senior Savings Model): $35 Drug Tier 4: 50% coinsurance Drug Tier 5: 33% coinsurance
	Standard retail pharmacy, **standard** mail-order pharmacy, network long-term care pharmacies, out-of-network pharmacy: Drug Tier 1: $5 Drug Tier 2: $20 Drug Tier 3: $47 Select Insulin (Senior Savings Model): $35 Drug Tier 4: 50% coinsurance Drug Tier 5: 32% coinsurance	**Standard** retail pharmacy, **standard** mail-order pharmacy, network long-term care pharmacies, out-of-network pharmacy: Drug Tier 1: $5 Drug Tier 2: $20 Drug Tier 3: $47 Select Insulin (Senior Savings Model): $35 Drug Tier 4: 50% coinsurance Drug Tier 5: 33% coinsurance
		To find out which drugs are Select Insulins, review the most recent Drug List provided electronically. You can identify Select Insulins by “SSM” in the Drug List. If you have questions about the Drug List, you can also call

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (continued)		Customer Service (Phone numbers for Customer Service are in Section 7.1 of this document).

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Optional Supplemental monthly premium 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 *2023 Evidence of Coverage*.	**Package 1** Additional Dental and Vision: $20.40 **Package 2** Additional Dental and Vision: $32.40	**Package 1** Additional Dental and Vision: $20.30

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription 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 reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for	$4,500 Care received through our point-of-service benefit will 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

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount (continued) prescription drugs do not count toward your maximum out-of-pocket amount.		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 and Pharmacy Networks

Updated directories are located on our website at **www.bcbsm.com/providersmedicare**. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 *Provider/Pharmacy Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Acupuncture for chronic low back pain	You pay a $20 copay for Medicare-covered acupuncture services.	You pay a $15 copay for Medicare-covered acupuncture services.
Cardiac services	*Prior authorization required.*	*Prior authorization not required.*

Cost	2022 (this year)	2023 (next year)
Chiropractic services	You pay a $20 copay for each Medicare-covered chiropractic service.	You pay a $15 copay for each Medicare-covered chiropractic service.
Dental services		
• Preventive	There was no annual maximum for preventive dental.	The benefit provides a $1,500 annual maximum for preventive and comprehensive dental services combined in- and out-of-network per calendar year.
	Fluoride treatment not covered.	One fluoride treatment every calendar year.
• Comprehensive	Comprehensive dental services not covered.	**In-network (Tier 1)** 0% coinsurance for: • Periodic oral exams • Routine cleanings and periodontal maintenance • One set of x-rays • Fluoride treatments • Brush biopsies • Resin and amalgam fillings • Crowns • Crown repairs • Root canals • Deep cleanings • Extractions • Oral surgery **Out-of-network (two options):** 1. Tier 2 Blue Par Select participating dentist: You pay 50% of the approved amount for

Cost	2022 (this year)	2023 (next year)
Dental services (continued)		covered services. 2. Nonparticipating Dentist: You pay 50% of the approved amount for covered services plus any difference between the approved and charged amount.
Enhanced disease management (EDM) For qualified members residing in Allegan, Barry, Ionia, Kalamazoo, Kent, Mason, Muskegon, Newaygo, Oceana, and Ottawa counties, BCN Advantage offers an enhanced disease management program for those with specific conditions.	You pay a $0 copay	Enhanced disease management not covered.
Outpatient mental health care	You pay a $40 copay for each Medicare-covered outpatient mental health and psychiatric individual or group session.	You pay a $20 copay for each Medicare-covered outpatient mental health and psychiatric individual or group session.
Outpatient substance abuse services	*Prior authorization required.*	*Prior authorization not required.*
Over-the-counter items	For members residing in Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair, Wexford counties, you receive a $25 allowance per quarter. No carry forward.	$85 allowance per quarter. Unused amounts carry forward, expiring at the end of the calendar year.

Cost	2022 (this year)	2023 (next year)
Over-the-counter items (continued)	For all other members, you receive a $75 allowance per quarter. No carry forward. The food benefit will be available to members with a history of any of the following chronic conditions: diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), stroke, hypertension, coronary artery disease (CAD), and/or rheumatoid arthritis. The food benefit will also be available to members who have been exposed to or are at risk of exposure to COVID-19 and/or respiratory illness.	The food benefit will be available to members diagnosed with any of the following chronic conditions: diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), stroke, hypertension, coronary artery disease (CAD), and/or rheumatoid arthritis.
Special supplemental benefits for the chronically ill	For members residing in Antrim, Benzie, Clinton, Emmet, Genesee, Grand Traverse, Isabella, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mecosta, Midland, Missaukee, Osceola, Otsego, St. Clair, Wexford counties, you receive a $25 allowance per quarter. No carry forward. For all other members, you receive a $75 allowance per quarter. No carry forward.	$85 allowance per quarter. Unused amounts carry forward, expiring at the end of the calendar year.

Cost	2022 (this year)	2023 (next year)
Special supplemental benefits for the chronically ill (continued)	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 or members who have been exposed to or are at risk of exposure to COVID-19 and/or respiratory illness.	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.
Transportation services	One round trip per calendar year to an Annual Wellness Visit only within the state of Michigan not covered.	You pay a $0 copay One round trip per calendar year to an Annual Wellness Visit only within the state of Michigan.
Vision care	$100 allowance for enhanced vision services benefit for elective contact lenses or one frame.	$150 allowance for enhanced vision services benefit for elective contact lenses or one frame.
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 *2023 Evidence of Coverage.*		
Optional supplemental dental	**Package 1** The benefit provides a $1,500 annual maximum for combined in- and out-of-network dental services per calendar year.	**Package 1** The benefit provides a total $3,000 annual maximum (adding $1,500 annual maximum to the $1,500 annual maximum

Cost	2022 (this year)	2023 (next year)
Optional supplemental dental (continued)		included in your health plan). This annual maximum can be used for combined in- and out-of-network dental services per calendar year. **In-network (Tier 1)** 0% coinsurance for • Fluoride treatments • Brush biopsies 50% coinsurance for • Resin and amalgam fillings • Crowns • Crown repairs • Root canals • Extractions
		The following services are **now covered under your comprehensive dental** in your health plan at 0% coinsurance in-network and 50% coinsurance out-of-network: • Fluoride treatments • Brush biopsies • Resin and amalgam fillings • Crowns • Crown repairs • Root canals • Extractions **In-network (Tier 1)** 25% coinsurance for additional comprehensive dental services (in addition to the preventive and comprehensive dental services in your health plan) • Onlays • Periodontics • Bridges • Dentures • Denture adjustments • Denture repairs • Denture relines

Cost	2022 (this year)	2023 (next year)
Optional supplemental dental (continued)		• Denture rebase • Implants • Implant maintenance and repairs • Anesthesia • Consultation exams
	Out-of-network (two options): 1. Tier 2 Blue Par Select participating dentist: You pay 50% of the approved amount for covered services. 2. Nonparticipating Dentist: You pay 50% of the approved amount for covered services plus any difference between the approved and charged amount Additional comprehensive dental services not covered.	**Out-of-network (two options):** 1. Tier 2 Blue Par Select participating dentist: You pay 50% of the approved amount for covered services. 2. Nonparticipating Dentist: You pay 50% of the approved amount for covered services plus any difference between the approved and charged amount
	Package 2 The benefit provides a $2,500 annual maximum for combined in- and out-of-network dental services per calendar year	**Package 2** Our plan only offers one optional supplemental package for 2023. See optional supplemental package above for details on Package 1.

Cost	2022 (this year)	2023 (next year)
Optional supplemental dental (continued)		See Section 1.4 - Changes to Benefits and Costs for Medical Services for information on Dental Services for your new dental coverage.
	0% coinsurance for • Fluoride treatments • Brush biopsies 25% coinsurance for • Resin and amalgam fillings • Crowns • Crown repairs • Root canals • Extractions	The following services are **now covered under your comprehensive dental** in your health plan at 0% coinsurance in-network and 50% coinsurance out-of-network: • Fluoride treatments • Brush biopsies • Resin and amalgam fillings • Crowns • Crown repairs • Root canals • Extractions
	25% coinsurance for • Onlays • Periodontics • Bridges • Dentures • Denture adjustments • Denture repairs • Denture relines • Denture rebase • Anesthesia • Consultation exams **Out-of-network (two options):** 1. Tier 2 Blue Par Select participating	The following services are now covered under your **Optional supplemental dental Package** at 25% coinsurance in-network and 50% coinsurance out-of-network: • Onlays • Periodontics • Bridges • Dentures • Denture adjustments • Denture repairs • Denture relines • Denture rebase

Cost	2022 (this year)	2023 (next year)
Optional supplemental dental (continued)	dentist: You pay 50% of the approved amount for covered services. 2. Nonparticipating Dentist: You pay 50% of the approved amount for covered services plus any difference between the approved and charged amount	• Implants • Implant maintenance and repairs • Anesthesia • Consultation exams
Optional supplemental vision	**Package 1** **In-network** The optional eyewear benefit provides a $200 (in addition to the enhanced vision benefit) combined in- and out-of-network benefit maximum every 12 months and may be used for either (a) elective contact lenses or (b) one frame. Polycarbonate lenses are not covered. Anti-reflective coating is not covered. **Out-of-Network** The optional eyewear benefit provides (in addition to the enhanced vision benefit) a combined in- and out-of-network benefit maximum with 50% coinsurance up to $200 every 12 months and may	**Package 1** **In-network** The optional eyewear benefit provides a $250 (in addition to the enhanced vision benefit) combined in- and out-of-network benefit maximum every 12 months and may be used for either (a) elective contact lenses or (b) one frame. Polycarbonate lenses are covered. Anti-reflective coating is covered. **Out-of-Network** The optional eyewear benefit provides (in addition to the enhanced vision benefit) a combined in- and out-of-network benefit maximum with 50% coinsurance up to $250 every 12 months and may

Cost	2022 (this year)	2023 (next year)
Optional supplemental vision (continued)	be used for either (a) elective contact lenses or (b) frames. **Package 2** **In-network** You have an allowance for either elective contact lenses or one frame. The optional eyewear benefit provides a $300 (in addition to the enhanced vision benefit) combined in- and out-of-network benefit maximum every 12 months and may be used for either (a) elective contact lenses or (b) one frame. Standard eyeglass lenses are covered in full every 12 months. **Out-of-network** You have an allowance for either elective contact lenses or one frame. The optional eyewear benefit provides (in addition to the enhanced vision benefit) a combined in- and out-of-network benefit maximum 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	be used for either (a) elective contact lenses or (b) frames. **Package 2** Our plan only offers one optional supplemental package for 2023. See optional supplemental package above for details on Package 1.

Cost	2022 (this year)	2023 (next year)
Optional supplemental vision (continued)	amounts every 12 months, as part of the Enhanced Vision benefit. Exams are reimbursed at 50% coinsurance up to allowed amounts. Routine eye exams are limited to 1 every 12 months.	

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions**.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	The deductible is $0 on Tier 1: Preferred Generic and Tier 2: Generic; the deductible is $50 on Tiers 3, 4 and 5. During this stage, you pay $0 cost sharing for a 31-day supply at **preferred** retail pharmacies and **preferred** mail-order pharmacies, for all Tier 1: Preferred Generic, $11 for Tier 2: Generic, and the full cost of your Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug and Tier 5: Specialty Tier until you have reached the yearly deductible. During this stage, you pay $5 cost sharing for a 31-day supply at **standard** retail pharmacies, **standard** mail-order pharmacies, network long-term care pharmacies and out-of-network pharmacies for all Tier 1: Preferred Generic, $20 for Tier 2: Generic, and the full cost of your Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug and	Because we have no deductible, this payment stage does not apply to you.

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage (continued)	Tier 5: Specialty Tier until you have reached the yearly deductible.	

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply, or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage.* 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.	Your cost for a one-month supply at a network pharmacy: **Drug Tier 1 – Preferred Generic:** *Standard cost sharing:* You pay $5 per prescription *Preferred cost sharing:* You pay $0 per prescription **Drug Tier 2 – Generic:** *Standard cost sharing:* You pay $20 per prescription *Preferred cost sharing:* You pay $11 per prescription	Your cost for a one-month supply at a network pharmacy: **Drug Tier 1 – Preferred Generic:** *Standard cost sharing:* You pay $5 per prescription *Preferred cost sharing:* You pay $0 per prescription **Drug Tier 2 – Generic:** *Standard cost sharing:* You pay $20 per prescription *Preferred cost sharing:* You pay $11 per prescription

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	**Drug Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription *Preferred cost sharing:* You pay $42 per prescription Select Insulin (Senior Savings Model): You pay a copayment of no more than $35 prescriptions for Select Insulins. **Drug Tier 4 – Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost *Preferred cost sharing:* You pay 50% of the total cost **Drug Tier 5 – Specialty Tier:** *Standard cost sharing:* You pay 32% of the total cost *Preferred cost sharing:* You pay 32% of the total cost _____ Once your total drug costs have reached $4,430, you	**Drug Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription *Preferred cost sharing:* You pay $42 per prescription Select Insulin (Senior Savings Model): You pay a copayment of no more than $35 per prescription for Select Insulins. **Drug Tier 4 – Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost *Preferred cost sharing:* You pay 50% of the total cost **Drug Tier 5 – Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost *Preferred cost sharing:* You pay 33% of the total cost _____ Once your total drug costs have reached $4,660, you

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	will move to the next stage (the Coverage Gap Stage).	will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – 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.

SECTION 2 Administrative Changes

Description	2022 (this year)	2023 (next year)
Your mail-order pharmacy is changing.	Express Scripts Pharmacy provides your mail-order drugs for preferred cost sharing. Call 1-800-229-0832. TTY users call 1-800-716-3231; 24 hours a day, 7 days a week for mail-order support. AllianceRx Walgreens Prime Home Delivery provides your mail-order drugs for standard cost sharing.	Optum Home Delivery provides your mail-order drugs for preferred cost sharing. Call 1-855-810-0007. TTY users call 711; 24 hours a day, 7 days a week for mail-order support. AllianceRx Walgreens Pharmacy provides your mail-order drugs for standard cost sharing.

Description	2022 (this year)	2023 (next year)
Your pharmacy benefits will be administered by a different pharmacy benefit manager.	Express Scripts administers your pharmacy benefits.	Optum Rx administers your pharmacy benefits.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in BCN Advantage Prime Value

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 Prime Value.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *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, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (**www.medicare.gov/plan-compare**), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Blue Care Network of Michigan offers other Medicare health plans and Medicare prescription drug 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 Prime Value.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from BCN Advantage Prime Value.

- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll or visit our website to disenroll online. Contact Customer Service if you need more information on how to do so.
  - – *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 4 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, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of 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 (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

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 6 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. 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 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Prescription Cost sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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. 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)**. 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 7 Questions?

Section 7.1 – Getting Help from BCN Advantage Prime Value

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 *2023 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 *2023*. For details, look in the 2023 *Evidence of Coverage* for BCN Advantage Prime Value. 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. You can review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you. 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/Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – 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

Visit the Medicare website (**www.medicare.gov**). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to **www.medicare.gov/plan-compare**.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (**https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf**) 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.