Medicare Plus Blue^{SM} PPO – Essential offered by Blue Cross Blue Shield of Michigan

Annual Notice of Changes for 2023

You are currently enrolled as a member of Medicare Plus Blue PPO – Essential. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 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.

☐ 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.

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☐ 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 Medicare Plus Blue PPO – Essential.
   - 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 Medicare Plus Blue PPO – Essential.
   - 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 1-877-241-2583 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 9 p.m. Eastern time, seven days a week (October 1 through March 31) and from 8 a.m. to 9 p.m. Eastern time, Monday through Friday (April 1 through September 30).
- This information is available for free in a different format, including large print and audio CD. Please call Customer Service at the number listed in Section 7.1 of this booklet.
- **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 Medicare Plus Blue PPO – Essential

- Medicare Plus Blue PPO is a health plan with a Medicare contract. Enrollment in Medicare Plus Blue PPO depends on contract renewal.
- When this document says "we," "us," or "our", it means Blue Cross Blue Shield of Michigan. When it says "plan" or "our plan," it means Medicare Plus Blue PPO – Essential.
- Out-of-network/non-contracted providers are under no obligation to treat Medicare Plus Blue 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 Medicare Plus Blue PPO – Essential 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.)		
Region 1 Allegan, Barry, Ionia, Kalamazoo, Mason, Muskegon, Newaygo, Oceana and Ottawa counties	$0	$0
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren counties	$0	$0
Region 3 Alcona, Alger, Alpena, Arenac, Baraga, Bay, Charlevoix, Cheboygan, Chippewa, Clare, Crawford, Gladwin, Huron, Iosco, Kalkaska, Keweenaw, Luce, Mackinac, Montmorency, Ogemaw, Ontonagon, Oscoda, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee and Tuscola counties	$10	$0
Region 4 Antrim, Benzie, Cass, Clinton, Delta, Dickinson, Emmet, Genesee, Gogebic, Grand Traverse, Houghton, Iron, Isabella, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Marquette, Mecosta, Menominee, Midland, Missaukee, Osceola, Otsego, St. Clair and Wexford counties	$0	$0

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* (continued) **Region 6** Macomb, Oakland, Washtenaw and Wayne counties **Region 5** is not being used at this time	$0	$0
Maximum out-of-pocket amounts 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.)	From in-network providers: $6,000 From in-network and out-of-network providers combined: $6,000	From in-network providers: $5,200 From in-network and out-of-network providers combined: $5,200
Doctor office visits	Primary care visits: In-network: You pay a $0 copay per visit. Specialist visits: In-network: You pay a $45 copay per visit.	Primary care visits: In-network: You pay a $0 copay per visit. Specialist visits: In-network: You pay a $45 copay per visit.
Inpatient hospital stays	In-network: For Medicare-covered hospital stays you pay: Days 1-6: $325 copay per day Days 7-90: $0 copay per day You pay $0 copay per day beyond 90 days.	In-network: For Medicare-covered hospital stays you pay: Days 1-6: $325 copay per day Days 7-90: $0 copay per day You pay $0 copay per day beyond 90 days.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copays/Coinsurance for a one-month supply during the Initial Coverage Stage: **Standard** retail pharmacy, **standard** mail-order pharmacy, network long-term care	Deductible: $0 Copays/Coinsurance for a one-month supply during the Initial Coverage Stage: **Standard** retail pharmacy, **standard** mail-order pharmacy, network long-term care

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (continued)	pharmacies, out-of-network pharmacy: Drug Tier 1: $5 Drug Tier 2: $20 Drug Tier 3: $47 Drug Tier 4: 50% coinsurance Drug Tier 5: 33% coinsurance **Preferred** retail and **preferred** mail-order pharmacy: Drug Tier 1: $0 Drug Tier 2: $11 Drug Tier 3: $42 Drug Tier 4: 50% coinsurance Drug Tier 5: 33% coinsurance	pharmacies, out-of-network pharmacy: Drug Tier 1: $5 Drug Tier 2: $20 Drug Tier 3: $47 Drug Tier 4: 50% coinsurance Drug Tier 5: 33% coinsurance **Preferred** retail and **preferred** mail-order pharmacy: Drug Tier 1: $0 Drug Tier 2: $11 Drug Tier 3: $42 Drug Tier 4: 50% coinsurance Drug Tier 5: 33% coinsurance

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 plan premium (You must also continue to pay your Medicare Part B premium.)		
Region 1 Allegan, Barry, Ionia, Kalamazoo, Mason, Muskegon, Newaygo, Oceana and Ottawa counties	$0	$0
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren counties	$0	$0
Region 3 Alcona, Alger, Alpena, Arenac, Baraga, Bay, Charlevoix, Cheboygan, Chippewa, Clare, Crawford, Gladwin, Huron, Iosco, Kalkaska, Keweenaw, Luce, Mackinac, Montmorency, Ogemaw, Ontonagon, Oscoda, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee and Tuscola counties	$10	$0
Region 4 Antrim, Benzie, Cass, Clinton, Delta, Dickinson, Emmet, Genesee, Gogebic, Grand Traverse, Houghton, Iron, Isabella, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Marquette, Mecosta, Menominee, Midland, Missaukee, Osceola, Otsego, St. Clair and Wexford counties	$0	$0
Region 6 Macomb, Oakland, Washtenaw and	$0	$0

Cost	2022 (this year)	2023 (next year)
Monthly plan premium (continued) Wayne counties **Region 5** is not being used at this time		
Optional supplemental dental and vision package monthly premium	$22.40	$20.50

- 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 Amounts

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. These limits are called the "maximum out-of-pocket amounts." 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)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$6,000	$5,200 Once you have paid $5,200 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2022 (this year)	2023 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$6,000	$5,200 Once you have paid $5,200 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at **www.bcbsm.com/medicare**. 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	**In-network:** You pay a $20 copay for Medicare-covered acupuncture services.	**In-network:** You pay a $15 copay for Medicare-covered acupuncture services.
Chiropractic services	**In-network:** You pay a $20 copay for Medicare-covered chiropractic services. Routine chiropractic services not covered. **Out-of-network:** Routine chiropractic services not covered.	**In-network:** You pay a $15 copay for Medicare-covered chiropractic services. You pay a $45 copay for one routine chiropractic service per year. **Out-of-network:** You pay 50% coinsurance for one routine chiropractic service per year.
Dental services		
• Preventive	There is no annual maximum for preventive dental Fluoride treatment not covered	The benefit provides a $1,500 annual maximum for preventive and comprehensive dental services combined in- and out-of-network per calendar year.
• Comprehensive	Comprehensive dental services not covered	**In-network** 0% coinsurance for: • Periodic oral exams • Routine cleanings and periodontal maintenance • One set of X-rays • Fluoride treatments • Brush biopsies • Resin and amalgam fillings

Cost	2022 (this year)	2023 (next year)
Dental services (continued)		• Crowns • Crown repairs • Root canals • Deep cleanings • Extractions • Oral surgery **Out-of-network** 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.
Outpatient mental health care • Mental health specialty services non-physician • Psychiatric services	**In-network:** You pay a $40 copay for each Medicare-covered outpatient mental health and psychiatric individual session. You pay a $40 copay for each Medicare-covered outpatient mental health and psychiatric group session. Prior authorization required.	**In-network:** You pay a $20 copay for each Medicare-covered outpatient mental health and psychiatric individual session. You pay a $20 copay for each Medicare-covered outpatient mental health and psychiatric group session. Prior authorization not required.

Cost	2022 (this year)	2023 (next year)
Outpatient rehabilitation services	**In-network:** Prior authorization required.	**In-network:** Prior authorization not required.
Over-the-counter (OTC) items	**In- and Out-of-network:** There is a $50 allowance per quarter. No carry over. 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 had a COVID-19 diagnosis, been exposed to, or are at risk of exposure to COVID-19 and/or respiratory illness.	**In- and Out-of-network:** There is a $85 allowance per quarter. Unused amounts carry forward, expiring at the end of the calendar year. 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 chronically ill Food Benefit	Qualified members receive a $50 per quarter allowance for OTC and food. No carry over. This benefit will be available only to plan-identified members who have been diagnosed	Qualified members receive a $85 per quarter allowance for OTC and food. Unused amounts carry forward, expiring at the end of the calendar year. The food benefit will be available to members diagnosed with any of the following chronic

Cost	2022 (this year)	2023 (next year)
Special supplemental benefits for chronically ill (continued)	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.	conditions: diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), stroke, hypertension, coronary artery disease (CAD), and/or rheumatoid arthritis.
Transportation services Transportation services for Annual Wellness Visit	Transportation for one round trip to an annual wellness visit not covered	You pay a $0 copay for one round trip to an annual wellness visit within the state of Michigan.
Vision care **Enhanced vision benefits**	**In-network:** There is a $100 allowance every year for elective contact lenses or eyeglass frames. **Out-of-network:** There is a $100 allowance every year for elective contact lenses or eyeglass frames with 50% coinsurance.	**In-network:** There is a $150 allowance every year for elective contact lenses or eyeglass frames. **Out-of-network:** There is a $150 allowance every year for elective contact lenses or eyeglass frames with 50% coinsurance.
Worldwide emergency coverage	**In- and Out-of-network:** Worldwide emergency and urgently needed services and emergency transportation are subject to a combined $250 annual deductible.	**In- and Out-of-network:** Worldwide emergency and urgently needed services and emergency transportation: there is no deductible.

Cost	2022 (this year)	2023 (next year)
Optional supplemental benefits Optional supplemental benefits are non-Medicare-covered dental 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	The benefit provides a $2,500 annual maximum for combined in- and out-of-network dental services per calendar year. **In-network (Tier 1):** 0% coinsurance for: • Fluoride treatments • Brush biopsies 25% coinsurance for: • Resin and amalgam fillings • Crowns • Crown repairs • Root canals • Extractions **Out-of-network (two options):** 1. Tier 2 Blue Par Select participating dentist: You pay 50% coinsurance of the approved amount for covered services. 2. Nonparticipating Dentist: You pay 50% of the approved amount for covered services plus any difference	The benefit provides a total $3,000 annual maximum (adding $1,500 annual maximum to the $1,500 annual maximum included in your health plan). This annual maximum can be used for combined in- and out-of-network dental services per calendar year. 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

Cost	2022 (this year)	2023 (next year)
Optional supplemental dental (continued)	between the approved and charged amount. Additional comprehensive dental services not covered.	dental services: • Onlays • Periodontics • Bridges • Dentures • Denture adjustments • Denture repairs • Denture relines • 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% coinsurance 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.

Cost	2022 (this year)	2023 (next year)
Optional supplemental vision	**In-network:** Polycarbonate lenses are not covered. Anti-reflective coating is not covered.	**In-network:** Polycarbonate lenses are covered. Anti-reflective coating is covered.

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 does 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	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

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 31-day supply filled at a network pharmacy: **Tier 1 – Preferred Generic:** *Standard cost sharing:* You pay $5 per prescription *Preferred cost sharing:* You pay $0 per prescription **Tier 2 – Generic:** *Standard cost sharing:* You pay $20 per prescription *Preferred cost sharing:* You pay $11 per prescription	Your cost for a 31-day supply filled at a network pharmacy: **Tier 1 – Preferred Generic:** *Standard cost sharing:* You pay $5 per prescription *Preferred cost sharing:* You pay $0 per prescription **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)	**Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription *Preferred cost sharing:* You pay $42 per prescription **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 **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 $4,430, you will move to the next stage (the Coverage Gap Stage).	**Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription *Preferred cost sharing:* You pay $42 per prescription **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 **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 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.

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.
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 Medicare Plus Blue PPO – Essential

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 Medicare Plus Blue PPO – Essential.

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 Cross Blue Shield 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 Medicare Plus Blue PPO – Essential.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Medicare Plus Blue PPO – Essential.
- 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. 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 (applications); 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.

SECTION 7 Questions?

Section 7.1 – Getting Help from Medicare Plus Blue PPO – Essential

Questions? We're here to help. Please call Customer Service at 1-877-241-2583. (TTY only, call 711.) We are available for phone calls from 8 a.m. to 9 p.m. Eastern time, seven days a week from October 1 - March 31 and from 8 a.m. to 9 p.m. Eastern time, Monday through Friday from April 1 - September 30. 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 Medicare Plus Blue PPO – Essential. 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 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*.

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 document 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.