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

Annual Notice of Changes for 2024

You are currently enrolled as a member of BCN Advantage Classic. 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 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 2024 "Drug List" to make sure the drugs you currently take are still covered.

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- ☐ 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 2024* 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, 2023, you will stay in BCN Advantage Classic.
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with BCN Advantage Classic.
   - 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 call is free.
- 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 Classic

- BCN Advantage Classic is an HMO-POS plan with a Medicare contract. Enrollment in BCN Advantage Classic 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 Classic.
- Out-of-network/non-contracted providers are under no obligation to treat BCN Advantage Classic 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 2024

The table below compares the 2023 costs and 2024 costs for BCN Advantage Classic in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. (See Section 1.1 for details.)	[*Region 1:* $78.00] [*Region 2:* $110.00] [*Region 3:* $122.00] [*Region 4:* $102.00] [*Region 7:* $127.00]	[*Region 1:* $78.00] [*Region 2:* $110.00] [*Region 3:* $122.00] [*Region 4:* $102.00] [*Region 7:* $127.00]
Deductible	$0 In-network $500 Point-of-Service	$0 In-network $500 Point-of-Service except for insulin furnished through an item of durable medical equipment.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$3,800	$3,800
Doctor office visits	Primary care visits: You pay a $0 copay per visit. Specialist visits: You pay a $35 copay per visit.	Primary care visits: You pay a $0 copay per visit. Specialist visits: You pay a $35 copay per visit.
Inpatient hospital stays	For Medicare-covered hospital stays: Days 1-6: You pay a $225 copay per day. Days 7-90: You pay a $0 copay per day.	For Medicare-covered hospital stays: Days 1-6: You pay a $225 copay per day. Days 7-90: You pay a $0 copay per day.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays (continued)	You pay a $0 copay for additional days in a benefit period.	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 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: $7 • Drug Tier 3: $38 You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 4: 45% coinsurance You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance You pay no more than $35 for a one-month supply of each covered insulin product on this tier. **Standard** retail pharmacy, **standard** mail-order pharmacy, network long-term care pharmacies, out-of-network pharmacy: • Drug Tier 1: $5 • Drug Tier 2: $12	Deductible: $0 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: $7 • Drug Tier 3: $38 You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 4: 45% coinsurance You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance You pay no more than $35 for a one-month supply of each covered insulin product on this tier. **Standard** retail pharmacy, **standard** mail-order pharmacy, network long-term care pharmacies, out-of-network pharmacy: • Drug Tier 1: $5 • Drug Tier 2: $12

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	• Drug Tier 3: $43 You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 4: 45% coinsurance You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance You pay no more than $35 for a one-month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	• Drug Tier 3: $43 You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 4: 45% coinsurance You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance You pay no more than $35 for a one-month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	[*Region 1:* $78.00] [*Region 2:* $110.00] [*Region 3:* $122.00] [*Region 4:* $102.00] [*Region 7:* $127.00]	[*Region 1:* $78.00] [*Region 2:* $110.00] [*Region 3:* $122.00] [*Region 4:* $102.00] [*Region 7:* $127.00]
Optional Supplemental monthly premium For more information, see Chapter 4, Section 2.2, *Extra "optional supplemental" benefits you can buy*, in your *2024 Evidence of Coverage*.	Additional Dental and Vision: $20.30	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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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	2023 (this year)	2024 (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.	$3,800 Care received through our point-of-service benefit will count toward your maximum out-of-pocket.	$3,800 Once you have paid $3,800 out-of-pocket for covered Part A and Part B services, you will pay

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount (continued) Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		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 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, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *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 2024 *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	2023 (this year)	2024 (next year)
Ambulance services		
Ambulance services not requiring transportation	Ambulance services not requiring transportation are <u>not</u> covered.	You pay a $90 for each ambulance no transport service.

Cost	2023 (this year)	2024 (next year)
Annual wellness visit	The annual wellness visit is available once every 12 months.	The enhanced wellness visit can occur anytime throughout the calendar year, regardless of the date of your previous annual wellness visit.
Colorectal cancer screening	If further testing and/or subsequent procedures are required your out-of-pocket costs will apply.	If further testing and/or subsequent procedures are required you won't be charged additional out-of-pocket costs.
Hearing services	Over-the-Counter (OTC) hearing aids are not covered	Over-the-Counter (OTC) hearing aids may be purchased using the OTC allowance.
Meal benefit	**In-network** Blue Cross nurse care manager referral required.	**In-network** No referral required.
Mobile crisis and crisis stabilization for behavioral health For members who reside in: Allegan, Antrim, Barry, Benzie, Berrien, Branch, Calhoun, Clinton, Eaton, Emmet, Genesee, Grand Traverse, Gratiot, Hillsdale, Ingham, Ionia, Isabella, Jackson, Kalamazoo, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Osceola, Otsego, Ottawa, St. Clair, St. Joseph, Van Buren, Washtenaw, Wayne, Wexford counties **only**.	Mobile crisis and crisis stabilization for behavioral health is not covered.	You pay a $20 copay for each mobile crisis and crisis stabilization for behavioral health service.

Cost	2023 (this year)	2024 (next year)
Over-the-Counter Allowance (OTC): Advantage Dollars	You receive $25 per quarter.	You receive $50 per quarter.
Personal Emergency Response System (PERS)	Personal Emergency Response System (PERS) is not covered.	Qualified members pay a $0 copay.
Special supplemental benefits for the chronically ill food allowance	Qualified members receive an $25 allowance per quarter. 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.	Qualified members receive a $50 allowance per quarter. This benefit will be available only to plan-identified members who have been diagnosed with: Arthritis, autoimmune disorders (polyarteritis nodosa, polymyositis rheumatica, polymyositis, systemic lupus erythematosus), cancer (excluding pre-cancer conditions or in-situ status), chronic alcohol and/or other drug dependence, chronic cardiovascular disorders (coronary artery disease [CAD], peripheral vascular, chronic venous thromboembolic disorder), chronic and disabling mental health conditions, chronic heart failure, chronic lung disorders (chronic obstructive pulmonary disease [COPD]), cardiac arrhythmias, dementia, diabetes, pre-diabetes, end-stage liver disease, end-stage renal disease

Cost	2023 (this year)	2024 (next year)
Special supplemental benefits for the chronically ill food allowance (continued)		(ESRD) requiring dialysis, HIV/AIDS, hypertension, severe hematologic disorders (aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease [excluding having the sickle-cell trait], chronic venous thromboembolic disorder), neurologic disorders, and/or stroke.
Transportation services	**In-network** One round trip per calendar year to an Annual Wellness Visit only within the state of Michigan; no referral needed.	**In-network** One round trip per calendar year to an Enhanced Wellness Visit only within the state of Michigan; no referral needed.
Vision care **Vision Care - Enhanced Vision Services**	Routine eye exam - 1 exam every 12 months Non-Medicare-covered (extra) vision services: You are also eligible for ONE of the following, every 12 months: • Elective contact lenses OR • One pair standard eyeglass lenses OR • One frame OR • One complete pair of eyeglasses	Routine eye exam - Once per calendar year Non-Medicare-covered (extra) vision services: You are also eligible for ONE of the following, every calendar year: • Elective contact lenses OR • One pair standard eyeglass lenses OR • One frame OR • One complete pair of eyeglasses

Cost	2023 (this year)	2024 (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 *2024 Evidence of Coverage.*		
Optional supplemental vision	Non-Medicare-covered (extra) vision services: You are also eligible for ONE of the following, every 12 months: • Elective contact lenses OR • One pair standard eyeglass lenses OR • One frame OR • One complete pair of eyeglasses	Non-Medicare-covered (extra) vision services: You are also eligible for ONE of the following, every calendar year: • Elective contact lenses OR • One pair standard eyeglass lenses OR • One frame OR • One complete pair of eyeglasses

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," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier**.

Most of the changes in the "Drug List" are new for the beginning of each year. However, 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	2023 (this year)	2024 (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	2023 (this year)	2024 (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	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	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

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued) see if your drugs will be in a different tier, look them up on the "Drug List." Most adult Part D vaccines are covered at no cost to you.	**Drug Tier 2 – Generic:** *Standard cost sharing:* You pay $12 per prescription *Preferred cost sharing:* You pay $7 per prescription **Drug Tier 3 – Preferred Brand:** You pay no more than $35 for a one-month supply of each covered insulin product on this tier. *Standard cost sharing:* You pay $43 per prescription *Preferred cost sharing:* You pay $38 per prescription **Drug Tier 4 – Non-Preferred Drug:** You pay no more than $35 for a one-month supply of each covered insulin product on this tier. *Standard cost sharing:* You pay 45% of the total cost *Preferred cost sharing:* You pay 45% of the total cost	**Drug Tier 2 – Generic:** *Standard cost sharing:* You pay $12 per prescription *Preferred cost sharing:* You pay $7 per prescription **Drug Tier 3 – Preferred Brand:** You pay no more than $35 for a one-month supply of each covered insulin product on this tier. *Standard cost sharing:* You pay $43 per prescription *Preferred cost sharing:* You pay $38 per prescription **Drug Tier 4 – Non-Preferred Drug:** You pay no more than $35 for a one-month supply of each covered insulin product on this tier. *Standard cost sharing:* You pay 45% of the total cost *Preferred cost sharing:* You pay 45% of the total cost

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Drug Tier 5 – Specialty Tier:** You pay no more than $35 for a one-month supply of each covered insulin product on this 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).	**Drug Tier 5 – Specialty Tier:** You pay no more than $35 for a one-month supply of each covered insulin product on this 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 $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Your way of accessing virtual care through the plan is changing	Use Blue Cross Online Visits to access telehealth services. Visit **bcbsmonlinevisits.com** for more information.	Virtual Care is available through Teladoc Health® an independent company and our plan-approved vendor. Visit **www.bcbsm.com/virtualcare** for more information or call 1-800-835-2362, 24 hours a day, 7 days a week, 365 days a year. TTY users call 1-855-636-1578.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in BCN Advantage Classic

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 Classic.

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 2024 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 2024* 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 Classic.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from BCN Advantage Classic.
- 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 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, 2024.

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, 2024, 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, 2024.

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. Below we list different kinds of help:

- "**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 am and 7 pm, 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 Drug Assistance Program (MIDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-888-826-6565 9 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users call 711.

SECTION 7 Questions?

Section 7.1 – Getting Help from BCN Advantage Classic

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 2024 *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 2024. For details, look in the *2024 Evidence of Coverage* for BCN Advantage Classic. 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/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 2024*

Read the *Medicare & You 2024* 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.