Medicare Plus Blue℠ PPO - + Meijer offered by Blue Cross Blue Shield of Michigan

Annual Notice of Changes for 2025

You are currently enrolled as a member of Medicare Plus Blue + Meijer. 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

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

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the **www.medicare.gov/plan-compare** website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in Medicare Plus Blue + Meijer.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Medicare Plus Blue + Meijer.
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

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 call is free.
- 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 + Meijer

- Blue Cross Blue Shield of Michigan is a PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Michigan 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 + Meijer.
- 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.

Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Medicare Plus Blue + Meijer in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (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	$0	$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	2024 (this year)	2025 (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
Deductible	$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: $5,200 From in-network and out-of-network providers combined: $5,200	From in-network providers: $6,750 From in-network and out-of-network providers combined: $6,750
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 $50 copay per visit.
Inpatient hospital stays	For Medicare-covered hospital stays you pay: Days 1-6: You pay a $350 copay per day. Days 7-90: You pay a $0 copay per day. You pay a $0 copay per day beyond 90 days.	For Medicare-covered hospital stays you pay: Days 1-7: You pay a $425 copay per day. Days 8-90: You pay a $0 copay per day. You pay a $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	Deductible: $0 Copays/Coinsurance for a one-month supply during

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	the Initial Coverage Stage: **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. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 4: 50% 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. **Preferred** retail and **preferred** mail-order pharmacy: • Drug Tier 1: $0 • Drug Tier 2: $11 • Drug Tier 3: $42. You pay no more than $35 for a one-month supply of each covered insulin product on this tier.	the Initial Coverage Stage: **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. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. • Drug Tier 4: 50% 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. **Preferred** retail and **preferred** mail-order pharmacy: • Drug Tier 1: $0 • Drug Tier 2: $11 • Drug Tier 3: $42. You pay no more than $35 for a one-month supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	• Drug Tier 4: 50% 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 of your covered Part D drugs. You pay nothing.	• Drug Tier 4: 50% 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, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly 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	$0	$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	2024 (this year)	2025 (next year)
Monthly premium (continued) **Region 6** Macomb, Oakland, Washtenaw and Wayne counties **Region 5** is not being used at this time	$0	$0
Optional supplemental dental and vision package monthly premium	$20.50	$21.80
Medicare Part B premium reduction	$0	$3 for Regions 1-4 $4 for Region 6

- 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	2024 (this year)	2025 (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	$5,200	$6,750 Once you have paid $6,750 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services

Cost	2024 (this year)	2025 (next year)
In-network maximum out-of-pocket amount (continued) and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		from network providers for the rest of the calendar 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.	$5,200	$6,750 Once you have paid $6,750 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

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are 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, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider/ Pharmacy Directory* at www.bcbsm.com/medicare 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 2025 *Provider/Pharmacy Directory* at www.bcbsm.com/medicare 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	2024 (this year)	2025 (next year)
Ambulance services Ground or air	**In-Network** You pay a $290 copay for each one-way emergent trip for Medicare-covered services. **Out-of-Network** You pay a $290 copay for each one-way emergent trip for Medicare-covered services.	**In-Network** You pay a $350 copay for each one-way emergent trip for Medicare-covered services. **Out-of-Network** You pay a $350 copay for each one-way emergent trip for Medicare-covered services.
Bathroom safety items	You receive up to $100 for bathroom safety items.	Bathroom safety items are not covered.
Chiropractic services Routine care services	**In-Network** You pay a $45 copay. **Out-of-Network** You pay 50% of the approved amount.	**In-Network** You pay a $50 copay. **Out-of-Network** You pay a $55 copay.
Dental services Medicare-covered dental services	**In-Network** You pay a $45 copay for each specialist visit. **Out-of-Network** You pay a $50 copay for each specialist visit.	**In-Network** You pay a $50 copay for each specialist visit. **Out-of-Network** You pay $55 copay for each specialist visit.
Preventive dental services	Full-mouth X-rays are not covered.	You pay a $0 copay for one full-mouth X-ray every 5 years.
Emergency care	You pay a $120 copay for Medicare-covered emergency room visits.	You pay a $125 copay for Medicare-covered emergency room visits.

Cost	2024 (this year)	2025 (next year)
Health and wellness education programs Telemonitoring services	You pay a $0 copay for telemonitoring services.	Telemonitoring is not covered as a plan benefit. Eligible members will continue to receive telemonitoring services through a Care Management program.
Hearing services Medicare-covered hearing services	**In-Network** You pay a $45 copay for each specialist visit. **Out-of-Network** You pay a $50 copay for each specialist visit.	**In-Network** You pay a $50 copay for each specialist visit. **Out-of-Network** You pay a $55 copay for each specialist visit.
Inpatient hospital care	Days 1-6: You pay a $350 copay per day. Days 7-90: You pay a $0 copay per day.	Days 1-7: You pay a $425 copay per day. Days 8-90: You pay a $0 copay per day.
Inpatient services in a psychiatric hospital	Days 1-6: You pay a $300 copay per day. Days 7-90: You pay a $0 copay per day.	Days 1-7: You pay a $300 copay per day. Days 8-90: You pay a $0 copay per day.
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network** You pay a $45 copay for Medicare-covered diagnostic procedures and tests in a professional setting. **Out-of-Network** You pay 50% of the approved amount for Medicare-covered diagnostic procedures and tests in a professional setting.	**In-Network** You pay a $50 copay for Medicare-covered diagnostic procedures and tests in a professional setting. **Out-of-Network** You pay a $55 copay for Medicare-covered diagnostic procedures and tests in a professional setting.

Cost	2024 (this year)	2025 (next year)
Outpatient hospital services	**In-Network** You pay a $275 copay for Medicare-covered outpatient hospital services.	**In-Network** You pay a $375 copay for Medicare-covered outpatient hospital services.
Outpatient substance use disorder services	**In-Network** You pay a $45 copay for outpatient group therapy or individual therapy visits provided in a specialist's office. **Out-of-Network** You pay 50% of the approved amount for outpatient group therapy or individual therapy visits provided in a specialist's office.	**In-Network** You pay a $50 copay for outpatient group therapy or individual therapy visits provided in a specialist's office. **Out-of-Network** You pay a $55 copay for outpatient group therapy or individual therapy visits provided in a specialist's office.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** You pay a $200 copay for Medicare-covered surgery in an ambulatory surgical center.	**In-Network** You pay a $325 copay for Medicare-covered surgery in an ambulatory surgical center.
Over-the-Counter (OTC): Advantage Dollars	You receive $165 per quarter. An allowance is added per quarter (January 1, April 1, July 1, October 1). Unused amounts will carry forward into the next quarter but not into the next calendar year. The final day to spend allowance dollars is December 31, 2024, and any unspent allowance dollars will not carry over to 2025.	You receive $160 per quarter. An allowance is added per quarter (January 1, April 1, July 1, October 1). Unused amounts will not carry over into the next quarter or the next calendar year. The final day to spend allowance dollars is December 31, 2025, and any unspent allowance dollars will not carry over to 2026.

Cost	2024 (this year)	2025 (next year)
Partial hospitalization services and Intensive outpatient services	**Out-of-Network** You pay 50% of the approved amount per day for Medicare-covered services.	**Out-of-Network** You pay a $55 copay for Medicare-covered services.
Physician/Practitioner services, including doctor's office visits	**In-Network** You pay a $45 copay for each specialist visit for Medicare-covered services. **Out-of-Network** You pay a $50 copay for each specialist visit for Medicare-covered services.	**In-Network** You pay a $50 copay for each specialist visit for Medicare-covered services. **Out-of-Network** You pay a $55 copay for each specialist visit for Medicare-covered services.
Podiatry services	**In-Network** You pay a $45 copay for each Medicare-covered podiatry visit. **Out-of-Network** You pay 50% of the approved amount for each Medicare-covered podiatry visit.	**In-Network** You pay a $50 copay for each Medicare-covered podiatry visit. **Out-of-Network** You pay a $55 copay for each Medicare-covered podiatry visit.
Retail health clinic services	**Out-of-Network** You pay 50% of the approved amount for retail health clinic services.	**Out-of-Network** You pay a $55 copay for retail health clinic services.
Skilled nursing facility (SNF) care	Days 21-100: You pay a $203 copay per day.	Days 21-100: You pay a $214 copay per day.

Cost	2024 (this year)	2025 (next year)
Special Supplemental Benefits for the Chronically Ill The benefits described are Special Supplemental Benefits for the Chronically Ill. Those with qualifying chronic conditions can purchase food items with your allowance. Qualifying chronic conditions include hypertension, diabetes, chronic cardiovascular disorders, chronic lung disorders, and chronic heart failure. Other qualifying conditions may apply. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. Your plan will notify you when you're eligible. For details, please contact us.	**Allowance Amount** You receive $165 per quarter. An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will carry forward into the next quarter but not into the next calendar year. The final day to spend allowance dollars is December 31, 2024 and any unspent allowance will not carry over to 2025.	**Allowance Amount** You receive $160 per quarter. An allowance is added each quarter (January 1, April 1, July 1, October 1). Unused amounts will not carry forward into the next quarter or the next calendar year. The final day to spend allowance dollars is December 31, 2025 and any unspent allowance dollars will not carry over to 2026.
Support for caregivers of enrollees	You pay a $0 copay for support for caregivers of enrollees.	Support for caregivers of enrollees coverage is not covered as a plan benefit. Eligible members will continue to receive support for caregivers of enrollee's services through a Care Management program.
Urgently needed services	You pay a $60 copay for urgently needed services provided in an urgent care center.	You pay a $55 copay for urgently needed services provided in an urgent care center.

Cost	2024 (this year)	2025 (next year)
Vision care	**In-Network**	**In-Network**
Exam to diagnose and treat diseases and conditions of the eye	You pay a $45 copay for a Medicare-covered specialist exam.	You pay a $50 copay for a Medicare-covered specialist exam.
	Out-of-Network	**Out-of-Network**
	You pay 50% coinsurance for a Medicare-covered specialist exam.	You pay a $55 copay for a Medicare-covered specialist exam.
	In-Network	**In-Network**
Elective LASIK or RK surgery	You pay a $45 copay.	You pay a $50 copay.
	Out-of-Network	**Out-of-Network**
	You pay 50% coinsurance.	You pay a $55 copay.
Worldwide emergency coverage	You pay a $120 copay for worldwide emergency coverage.	You pay a $125 copay for worldwide emergency coverage.
	You pay a $60 copay for worldwide urgent coverage.	You pay a $55 copay for worldwide urgent coverage.

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, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If

we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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.

We currently can immediately remove a brand-name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand-name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: **https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients**. You may also contact Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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*.

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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	2024 (this year)	2025 (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.** 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. Most adult Part D vaccines are covered at no cost to you.	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. **Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. You pay no more than $35 for a one-month supply of each covered insulin product on this tier.	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. **Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. You pay no more than $35 for a one-month supply of each covered insulin product on this tier.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage (continued)	*Preferred cost sharing:* You pay $42 per prescription. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. **Tier 4 – Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 50% of the total cost. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. **Tier 5 – Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 33% of the total cost. You pay no more than $35 for a one-month	*Preferred cost sharing:* You pay $42 per prescription. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. **Tier 4 – Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 50% of the total cost. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. **Tier 5 – Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost. You pay no more than $35 for a one-month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay 33% of the total cost. You pay no more than $35 for a one-month

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage (continued)	supply of each covered insulin product on this tier. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	supply of each covered insulin product on this tier. Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand-name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please

Description	2024 (this year)	2025 (next year)
		contact us at 1-877-241-2583 or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Medicare Plus Blue + Meijer

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 + Meijer.

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 2025 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 2025* 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 + Meijer.
- 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 + Meijer.

- 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, 2025.

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, 2025, 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

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 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 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 Assistance Program at 1-800-803-7174. You can learn more about Michigan Medicare 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a 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.
- **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. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. 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, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call 1-888-826-6565 (toll-free). Be sure, when calling, to inform them of your Medicare Advantage plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-877-241-2583 or visit **Medicare.gov**.

SECTION 7 Questions?

Section 7.1 – Getting Help from Medicare Plus Blue + Meijer

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 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). Calls to these numbers are free.

Read your *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Medicare Plus Blue + Meijer. 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 2025*

Read the *Medicare & You 2025* 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.