BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

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

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

Annual Notice of Change for 2026

You're enrolled as a member of BCN Advantage Prime Value.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in BCN Advantage Prime Value.
- To change to a **different plan**, visit **www.Medicare.gov** or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at **www.bcbsm.com/medicare** or call Customer Service at 1-800-450-3680 (TTY users call 711) to get a copy by mail.

More Resources

- Call Customer Service at 1-800-450-3680 (TTY users call 711) for more information. 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.

About BCN Advantage Prime Value

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

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- Out-of-network/non-contracted providers are under no obligation to treat BCN Advantage Prime Value members, except in emergency situations. Please call our Customer Service number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in BCN Advantage Prime Value.** Starting January 1, 2026, you'll get your medical and drug coverage through BCN Advantage Prime Value. Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	$0	**$35.00**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	$4,200	**$5,000**
Primary care office visits	**In-network** $0 copayment per visit **Point-of-Service** $0 copayment	**In-network** **$0 copayment per visit** **Point-of-Service** **$0 copayment**
Specialist office visits	**In-network** $35 copayment per visit **Point-of-Service** $35 copayment	**In-network** **$35 copayment per visit** **Point-of-Service** **$35 copayment**
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	For Medicare-covered hospital stays: Days 1-7: $300 copayment per day. Days 8-90: $0 copayment per day. $0 copayment for additional days in a benefit period.	**For Medicare-covered hospital admissions, per admission:** **Days 1-7: $300 copayment per day.** **Days 8-90: $0 copayment per day.** **$0 copayment per day beyond 90 days.**

	2025 (this year)	2026 (next year)
Part D drug coverage deductible (Go to Section 1.7 for details.)	$0	**$150 (applies to tiers 3, 4 and 5) except for covered insulin products and most adult Part D vaccines.**
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance for a one-month supply during the Initial Coverage Stage: **Preferred** retail and **preferred** mail-order pharmacy: • Drug Tier 1: $0 • Drug Tier 2: $11 • Drug Tier 3: $42 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.	**Copayment/ 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: $5** • **Drug Tier 3: 20% coinsurance** **You pay no more than $35 for a one-month supply of each covered insulin product on this tier.** • **Drug Tier 4: 30% coinsurance** **You pay no more than $35 for a one-month supply of each covered insulin product on this tier.** • **Drug Tier 5: 31% coinsurance** **You pay no more than $35 for a one-month supply of each covered insulin product on this tier.**

	2025 (this year)	2026 (next year)
Part D drug coverage (continued)	**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. Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	**Standard retail pharmacy, standard mail-order pharmacy, network long-term care pharmacies, out-of-network pharmacy:** • **Drug Tier 1: $5** • **Drug Tier 2: $10** • **Drug Tier 3: 20% coinsurance** **You pay no more than $35 for a one-month supply of each covered insulin product on this tier.** • **Drug Tier 4: 30% coinsurance** **You pay no more than $35 for a one-month supply of each covered insulin product on this tier.** • **Drug Tier 5: 31% coinsurance** **You pay no more than $35 for a one-month supply of each covered insulin product on this tier.** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0	**$35.00**
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.		
Region 001 Allegan, Barry, Ionia, Kalamazoo, Kent, Muskegon, and Ottawa	$7.50	**$12.80**
Region 002 Berrien, Branch, Calhoun, Gratiot, Hillsdale, Jackson, Monroe, Montcalm, St. Joseph, and Van Buren	$7.00	**$23.50**
Region 004 Genesee, Lenawee, Livingston, and St. Clair	$7.00	**$21.40**
Region 005 Macomb, Oakland, Washtenaw, and Wayne	$6.50	**$11.50**
Additional premium for optional supplemental benefits If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)	Additional Dental and Vision: $20.50	**Additional Dental and Vision: <u>Not</u> offered**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about 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've paid this amount, you generally pay nothing for covered Part A and Part B services (and other health services not covered by Medicare) for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) **count** toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$4,200 Once you have paid $4,200 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year. Care received through our point-of-service benefit will count toward your maximum out-of-pocket amount.	**$5,000** **Once you have paid $5,000 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.** **Care received through our point-of-service benefit will count toward your maximum out-of-pocket amount.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* **www.bcbsm.com/providersmedicare** to see if your providers (primary care provider,

specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at **www.bcbsm.com/providersmedicare**.
- Call Customer Service at 1-800-450-3680 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at 1-800-450-3680 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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.

Our network of pharmacies has changed for next year. Review the 2026 *Provider/Pharmacy Directory* at **www.bcbsm.com/medicare** to see which pharmacies are in our network. Here's how to get an updated *Provider/Pharmacy Directory*:

- Visit our website at **www.bcbsm.com/medicare**.
- Call Customer Service at 1-800-450-3680 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider/Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-800-450-3680 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Chiropractic services	$35 copayment for routine office visit, one per year. $20 copayment for one set of routine X-rays (up to 3 views) per year.	**Chiropractic services are <u>not</u> covered.**

	2025 (this year)	2026 (next year)
Dental services	**Medicare covered dental services** **In-network** $275 copayment for Medicare-covered dental surgery. **Point-of-service** $0 copayment for Medicare-covered services from a primary care provider. $275 copayment for Medicare-covered dental surgery. **Preventive dental services and comprehensive dental services.** We provide a $1,500 annual maximum for combined in-network and out-of-network dental services per calendar year.	**Medicare covered dental services** **In-network** **$375 copayment for Medicare-covered dental surgery.** **Point-of-service** **$35 copayment for Medicare-covered services from a primary care provider or specialist.** **$375 copayment for Medicare-covered dental surgery.** **Preventive dental services and comprehensive dental services.** **We provide a $950 annual maximum for combined in-network and out-of-network dental services per calendar year.**
Diabetes self-management training, diabetic services and supplies	**In-network** 0% coinsurance for diabetic supplies. **Point-of-Service** 0% coinsurance for diabetic supplies.	**In-network** **0% coinsurance for preferred diabetic supplies.** **20% coinsurance for non-preferred diabetic supplies** **Point-of-Service** **0% coinsurance for preferred diabetic supplies.**

	2025 (this year)	2026 (next year)
Diabetes self-management training, diabetic services and supplies (continued)	0% coinsurance for Medicare-covered shoes and inserts.	**40% coinsurance for non-preferred diabetic supplies.** **40% coinsurance for Medicare-covered shoes and inserts.**
Emergency care	$125 copayment for Medicare-covered emergency room visits.	**$130 copayment for Medicare-covered emergency room visits.**
Health fitness program	$0 copayment for health fitness program.	**Health fitness program is <u>not</u> covered.**
Hearing services	**Non-Medicare-covered hearing services** $35 copayment for services from a specialist. **Hearing aid fitting and evaluation** (once every 3 years) $0 copayment for services from a primary care provider or specialist. **Hearing Aids** $1,200 maximum allowance for both ears (up to $600 per ear) every 3 years for new hearing aids, including applicable dispensing fee.	**Non-Medicare-covered hearing services are <u>not</u> covered.**
Meal Benefit	$0 copayment for qualified members for 28 meals over 14 days from plan-approved meal provider.	**Meal benefit is <u>not</u> covered.**

	2025 (this year)	2026 (next year)
Medicare Part B drugs	**In-network** Coverage for Part B drugs is not subject to step therapy requirements that specify a trial of Part D drugs prior to eligibility for a Part B drug.	**In-network** **Coverage for Part B drugs may be subject to step therapy requirements that specify a trial of Part D drugs prior to eligibility for a Part B drug.**
Non-Medicare-covered mobile mental health services	Available for members in Allegan, Barry, Berrien, Branch, Calhoun, Genesee, Gratiot, Hillsdale, Ionia, Jackson, Kalamazoo, Kent, Lenawee, Livingston, Macomb, Monroe, Montcalm, Muskegon, Oakland, Ottawa, St. Clair St. Joseph, Van Buren, Washtenaw, and Wayne counties only.	**Available for members in the BCN Advantage service area.**
Outpatient hospital observation	**In-network** $0 copayment for Medicare-covered outpatient hospital observation services. **Point-of-Service** $0 copayment for Medicare-covered outpatient hospital observation services.	**In-network** **$130 copayment per stay for Medicare-covered outpatient hospital observation services.** **Point-of-Service** **$130 copayment per stay for Medicare-covered outpatient hospital observation services.**

	2025 (this year)	2026 (next year)
Outpatient hospital services	$275 copayment for Medicare-covered outpatient hospital services.	**$150 copayment for Medicare-covered outpatient hospital non-surgical services.** **$375 copayment for Medicare-covered outpatient hospital surgical services.**
Outpatient rehabilitation services	**In-network** $30 copayment per visit for Medicare-covered occupational therapy, physical therapy, and speech language therapy visits. **Point-of-Service** $30 copayment per visit for Medicare-covered occupational therapy, physical therapy, and speech language therapy visits.	**In-network** **$35 copayment per visit for Medicare-covered occupational therapy, physical therapy, and speech language therapy visits.** **Point-of-Service** **$35 copayment per visit for Medicare-covered occupational therapy, physical therapy, and speech language therapy visits.**
Over-the-Counter Allowance (OTC): Advantage Dollars	Regions 1 and 5: you receive $60 per quarter. Regions 2, 3, 4: you receive $95 per quarter.	**Over-the-Counter Allowance (OTC): Advantage Dollars is not covered.**
Skilled nursing facility (SNF) care	**In-network** Days 21–100: $214 copayment per day. **Point-of-Service** Days 21–100: $214 copayment per day.	**In-network** **Days 21–100: $218 copayment per day.** **Point-of-Service** **Days 21–100: $218 copayment per day.**

	2025 (this year)	2026 (next year)
Special supplemental benefits for the chronically ill Food and Produce allowance The benefits described are Special Supplemental Benefits for the Chronically Ill. Those with qualifying chronic conditions can purchase food and produce items with your allowance. Qualifying chronic conditions include chronic 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. For details, please contact us.	Regions 1 and 5: you receive $60 per quarter Regions 2, 3, 4: you receive $95 per quarter.	**Special supplemental benefits for the chronically ill Food and Produce allowance is <u>not</u> covered.**
Transportation services	$0 copayment for transportation for one round trip to an annual physical exam per calendar year within the State of Michigan; no referral needed. $0 copayment for qualified members who reside in Wayne, Oakland, Macomb and Washtenaw counties, non-emergency medical transportation is covered for up to 28 days after a hospital discharge.	**Transportation services are <u>not</u> covered.**

	2025 (this year)	2026 (next year)
Vision care	**Enhanced vision services** $0 copayment for up to 1 Non-Medicare-covered routine eye exam once every calendar year. $0 copayment for either elective contact lenses or 1 frame once every calendar year. The eyewear benefit provides a $150 in-network maximum benefit once per calendar year	**Enhanced vision services are not covered.**
Worldwide emergency coverage	$125 copayment for each worldwide emergency service visit.	**$130 copayment for each worldwide emergency service visit.**

Section 1.6 Changes to Part D 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 calendar 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're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out

your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Service at 1-800-450-3680 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and didn't get this material with this packet, call Customer Service at 1-800-450-3680 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 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 no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Part D drugs until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our 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 don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	The deductible is $0.	**The deductible is $150.** **During this stage, you pay standard or preferred cost sharing for drugs on Tier 1: Preferred Generic and Tier 2: Generic, and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you've reached the yearly deductible.**

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 3, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (31-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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. For more information about the costs of vaccines, or information about the costs for a long-term supply, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

Initial Coverage Stage	2025 (this year)	2026 (next year)
Tier 1: **Preferred Generic** 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.	*Standard cost sharing:* $5 per prescription. Your cost for a one-month mail-order prescription is $5. *Preferred cost sharing:* $0 per prescription.	***Standard cost sharing:*** **$5 per prescription.** **Your cost for a one-month mail-order prescription is $5.** ***Preferred cost sharing:*** **$0 per prescription.**

Initial Coverage Stage	2025 (this year)	2026 (next year)
Tier 1: **Preferred Generic (continued)**	Your cost for a one-month mail-order prescription is $0.	**Your cost for a one-month mail-order prescription is $0.**
Tier 2: **Generic** 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.	*Standard cost sharing:* $20 per prescription. Your cost for a one-month mail-order prescription is $20. *Preferred cost sharing:* $11 per prescription. Your cost for a one-month mail-order prescription is $11.	***Standard cost sharing:*** **$10 per prescription.** **Your cost for a one-month mail-order prescription is $10.** ***Preferred cost sharing:*** **$5 per prescription.** **Your cost for a one-month mail-order prescription is $5.**
Tier 3: **Preferred Brand** 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.	*Standard cost sharing:* $47 per prescription. Your cost for a one-month mail-order prescription is $47. *Preferred cost sharing:* $42 per prescription. Your cost for a one-month mail-order prescription is $42. You pay no more than $35 for a one-month supply of each covered insulin product on this tier.	***Standard cost sharing:*** **20% of the total cost.** **Your cost for a one-month mail-order prescription is 20% of the total cost.** ***Preferred cost sharing:*** **20% of the total cost.** **Your cost for a one-month mail-order prescription is 20% of the total cost.** **You pay no more than $35 for a one-month supply of each covered insulin product on this tier.**
Tier 4: **Non-Preferred Drug** We changed the tier for some of the drugs on our Drug List. To see	*Standard cost sharing:* 50% of the total cost. Your cost for a one-month mail-order prescription is 50% of the total cost.	***Standard cost sharing:*** **30% of the total cost.** **Your cost for a one-month mail-order prescription is 30% of the total cost.**

Initial Coverage Stage	2025 (this year)	2026 (next year)
Tier 4: **Non-Preferred Drug (continued)** if your drugs will be in a different tier, look them up on the Drug List.	*Preferred cost sharing:* 50% of the total cost. Your cost for a one-month mail-order prescription is 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:*** **30% of the total cost. Your cost for a one-month mail-order prescription is 30% 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** 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.	*Standard cost sharing:* 33% of the total cost. Your cost for a one-month mail-order prescription is 33% of the total cost. *Preferred cost sharing:* 33% of the total cost. Your cost for a one-month mail-order prescription is 33% of the total cost. You pay no more than $35 for a one-month supply of each covered insulin product on this tier.	***Standard cost sharing:*** **31% of the total cost. Your cost for a one-month mail-order prescription is 31% of the total cost.** ***Preferred cost sharing:*** **31% of the total cost. Your cost for a one-month mail-order prescription is 31% of the total cost.** **You pay no more than $35 for a one-month supply of each covered insulin product on this tier.**

Changes to the Catastrophic Coverage Stage

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

SECTION 2 Administrative Changes

Description	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	**If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** **To learn more about this payment option, call us at Customer Service 1-800-450-3680 (TTY users call 711) or visit www.Medicare.gov**.

SECTION 3 How to Change Plans

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

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from BCN Advantage Prime Value.
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from BCN Advantage Prime Value.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at 1-800-450-3680 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit **www.Medicare.gov**, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE

(1-800-633-4227). As a reminder, Blue Care Network of Michigan offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.

- Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
- Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Michigan Drug Assistance Program (MIDAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-888-826-6565. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **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 ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-800-450-3680 (TTY users call 711) or visit **www.Medicare.gov**.

SECTION 5 Questions?

Get Help from BCN Advantage Prime Value

- **Call Customer Service at 1-800-450-3680. (TTY users call 711.)**

  We're 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 2026 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for BCN Advantage Prime Value. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at

www.bcbsm.com/medicare or call Customer Service at 1-800-450-3680 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.bcbsm.com/medicare**

  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).

Get 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 MI Options.

Call MI Options to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call MI Options at 1-800-803-7174 (TTY 711). Learn more about MI Options by visiting (**www.michigan.gov/MDHHSMIOptions).**

Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

  You can chat live at **www.Medicare.gov/talk-to-someone**.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at **www.Medicare.gov** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.