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℠ HMO-POS Group Annual Notice of Change for 2026

You're an enrolled member of BCN Advantage HMO-POS.

This document describes changes to our plan's costs and benefits next year if you stay in BCN Advantage. These changes will take effect on January 1, 2026. Note this is only a summary of changes. More information about costs, benefits and rules is in the *Group Evidence of Coverage*. Call Customer Service at 1-800-450-3680 (TTY users, call 711) to get a copy by mail.

To decide what's best for you, compare this information with the benefits and costs of other Medicare Advantage health plans your group offers, as well as the benefits and costs of Original Medicare.

About BCN Advantage

Blue Care Network is an HMO-POS plan with a Medicare contract. BCN Advantage is offered by Blue Care Network. When this Annual Notice of Change says "we," "us," or "our," it means Blue Care Network of Michigan. When it says "plan" or "our plan," it means BCN Advantage.

Customer Service has free language interpreter services available for non-English speakers. This information may be available in other formats, including large print. Call Customer Service at 1-800-450-3680 if you need plan information in an alternate format. TTY users should call 711. We are available 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours Oct. 1 through March 31. Calls to these numbers are free.

What should you do?

We want you to know what's ahead for next year, so **read this document to see how the changes in benefits and costs will affect you.**

Changes to your cost sharing ("out-of-pocket" costs)

Cost sharing is your share of the cost of covered medical services. It is the amount you pay "out-of-pocket" for deductibles, coinsurance and copayments. You usually pay these amounts when you receive services. **Please refer to your *Group Evidence of Coverage* and riders for details.**

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

Changes to benefits and costs for next year

This *Annual Notice of Change* is only a summary.

This *Annual Notice of Change* gives you a brief summary of the changes in your benefits, not a comprehensive description of benefits. For more information, contact your plan administrator or see the *2026 Group Evidence of Coverage* and riders for details.

For **medical services** coverage and costs, see the *2026 Group Evidence of Coverage* and any riders attached to your coverage. The *Group Evidence of Coverage* and riders are the legal, detailed description of your benefits for 2026. They also explain your rights and the rules you need to follow to get your covered services.

The Group Evidence of Coverage also explains the rights and the rules you need to follow to get your covered **prescription drugs**.

If you don't have these documents and need a copy mailed to you, or if you have questions and would like more information, please call Customer Service at 1-800-450-3680, 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users should call 711. Calls to these numbers are free.

Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* **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 **bcbsm.com/providersmedicare**.
- Call Customer Service at the number listed on the back of your ID card 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 the number listed on the back of your ID card for help. For more information on your rights when a network provider leaves our plan, see your *Group Evidence of Coverage*.

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. To see the most current listing of our network pharmacies, go to **bcbsm.com/pharmaciesmedicare**.

You may also call Customer Service for updated pharmacy information or to ask us to mail you a *Provider/Pharmacy Directory* to see which pharmacies are in our network.

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 the number on the back of your ID card for help.

Changes to Benefits & Costs for Medical Services

If you stay enrolled in BCN Advantage for 2026, there will be some changes to your benefits and to what you pay.

Each year, your group may decide to change the premiums, cost-sharing amounts and benefits it offered. These changes may include increasing or decreasing cost-sharing amounts, adding or subtracting benefits or changing copay amounts.

You can receive care from even more plan providers, including 6,700 primary care physicians, 149 hospitals and more than 23,000 specialists.

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 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 your *Group 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 for more information.

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year. To learn what you must do to ask for an exception, see Chapter 9 of the *Group Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)) or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 108 days of the plan year or the first 108 days of membership to avoid a gap in therapy. (To learn more

about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Group Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you have a current formulary exception approval, please refer to your approval letter to verify the expiration date for your formulary exception. If your formulary exception expires in 2025, you will need to submit a new formulary exception request for review.

Changes to Prescription Drug Benefits and Costs

Changes to your "out-of-pocket" costs

There are changes that could affect what you pay for your drugs next year. We moved some of the drugs on the Formulary to a lower or higher drug tier. To see if your drugs will be in a different tier, look them up on the *Formulary for Groups*.

The *Group Evidence of Coverage* and *Prescription Drug Rider* show what you will pay as your share of the cost of covered prescription drugs when you're in the Initial Coverage Stage.

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 may 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 you don't get this material by *[insert date,]* call Customer Service at **1-800-450-3680**, 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users should 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.

The information below shows the three drug payment stages. Your cost share is determined by your group copays. You can also look in your *Group Evidence of Coverage* for more information about the stages.

	2025 (this year)	**2026 (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.
Stage 2: 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 out-of-pocket costs for your Part D drugs reach **$2,000**,	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 out-of-pocket costs for your Part D drugs reach **$2,100**, then you will move into the Catastrophic

	then you will move into the Catastrophic Coverage Stage.	Coverage Stage.
Stage 3: Catastrophic coverage stage	This is the third and final drug payment stage. When your total out-of-pocket costs reach **$2,000**, you pay $0. You generally stay in this stage for the rest of the calendar year.	This is the third and final drug payment stage. When your total out-of-pocket costs reach **$2,100**, you pay $0. You generally stay in this stage for the rest of the calendar year.

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Administrative changes

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 Customer Service at the number on the back of your ID card or visit **Medicare.gov**. TTY users, call 711.

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 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;
  - 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; or
  - Your State Medicaid Office
- **Help from your state's pharmaceutical assistance program (SPAP).** Michigan has a program called *State Pharmaceutical Assistance Program* that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.
- **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 help through the Michigan Drug Assistance Program (MIDAP). For information on eligibility criteria, covered drugs or how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-888-826-6565 Monday through Friday, 8 a.m. to 5 p.m. Eastern time. TTY users call 711. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

Questions?

Get help from BCN Advantage

Questions?

- We're here to help. Call Customer Service at 1-800-450-3680 from 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours Oct. 1 through March 31. TTY users should call 711. 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 *Group Evidence of Coverage.* The *Group 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. Call Customer Service at 1-800-450-3680 to ask us to mail you a copy. TTY users should call 711.
- **Visit our website bcbsm.com/medicare.** It has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (*Formulary/Drug List*).

Get free counseling about Medicare

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

Michigan Medicare/Medicaid Assistance Program is independent (not connected with any insurance company or health plan). It's 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 (**mmapinc.org**).

Get help from Medicare

To get information directly from Medicare:

- **Call 1-800-MEDICARE (1-800-633-4227).** You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **Chat live with Medicare.gov.** You can chat live at **Medicare.gov/talk-to-someone**.
- **Write to Medicare** at P.O. Box 1270, Lawrence, KS 66044.
- **Visit Medicare.gov**.
- **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 **Medicare.gov** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.