BlueCross BlueShield of Illinois

HCSC

Summary of Benefits

Blue Cross Group MedicareRx (PDP)[SM]

January 1 – December 31, 2024

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage Benefits Insert."

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Blue Cross Group MedicareRx (PDP) is a Medicare Prescription Drug Plan (PDP) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-877-688-1795 (TTY 711) and request the "Evidence of Coverage" or access it online at www.bcbsil.com/retiree-medicare-tools.

To join Blue Cross Group MedicareRx (PDP), you must be entitled to Medicare Part A, and/or in Medicare Part B, and be a retiree, or Medicare-eligible dependent of a retiree, of HCSC.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services unless otherwise noted in your Evidence of Coverage (EOC).

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-877-688-1795 (TTY users should call 711), 7 days a week, 8 a.m. to 8 p.m. or visit us at www.bcbsil.com/retiree-medicare-tools.

Understanding the Benefits

Blue Cross Group MedicareRx (PDP) has a network of pharmacies. You may seek care from any provider that accepts Medicare and agrees to bill us. Your benefit levels are the same whether or not you utilize a network provider.

- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can see our plan's Pharmacy Directory at www.bcbsil.com/retiree-medicare-tools.

NOTE: Services with a * may require prior authorization or a referral from your doctor.

SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

	Blue Cross Group MedicareRx (PDP)[SM]
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	For information concerning the actual premiums you will pay, please contact your employer or your employer group benefits plan administrator. In addition, you must keep paying your Medicare Part B premium, if you are enrolled.
Stage 1: Part D Deductible	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you. **Important Message About What You Pay for Insulin** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.
Stage 2: Initial Coverage	You stay in the Intial Coverage Stage until your yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Cost Shares During the Initial Coverage Stage

Initial Coverage Stage: Standard Retail Pharmacy	
Standard Retail	**Blue Cross Group MedicareRx (PDP)℠**
Tier 1: Preferred Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 2: Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 3: Preferred Brand	**One-month supply:** $30
	Three-month supply: $90
Tier 4: Non-Preferred Drug	**One-month supply:** $45
	Three-month supply: $135
Tier 5: Specialty Tier	**One-month supply:** $45
	Three-month supply: $135

Initial Coverage Stage: Preferred Retail Pharmacy	
Preferred Retail	**Blue Cross Group MedicareRx (PDP)℠**
Tier 1: Preferred Generic	**One-month supply:** $0
	Three-month supply: $0
Tier 2: Generic	**One-month supply:** $0
	Three-month supply: $0
Tier 3: Preferred Brand	**One-month supply:** $25
	Three-month supply: $75
Tier 4: Non-Preferred Drug	**One-month supply:** $40
	Three-month supply: $120
Tier 5: Specialty Tier	**One-month supply:** $40
	Three-month supply: $120

Initial Coverage Stage: Standard Mail Order Pharmacy	
Standard Mail Order	**Blue Cross Group MedicareRx (PDP)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 2: Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 3: Preferred Brand	**One-month supply:** $30
	Three-month supply: $90
Tier 4: Non-Preferred Drug	**One-month supply:** $45
	Three-month supply: $135
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	Three-month supply: $75
Tier 4: Non-Preferred Drug	**One-month supply:** $40
	Three-month supply: $120
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Initial Coverage Stage: Long-term Care and Out-of-network Pharmacies (one-month supply)	
	Blue Cross Group MedicareRx (PDP)[SM]
Long-term Care Tiers 1-5	If you reside in a long-term facility, you pay the same as at a standard retail pharmacy.
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy in specific situations. You generally must use a network pharmacy to fill your prescription.

	Blue Cross Group MedicareRx (PDP)[SM]
Stage 3: Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. See the table(s) below for your costs during this stage. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $8,000.

Coverage Gap Stage: Standard Retail Pharmacy	
Standard Retail	**Blue Cross Group MedicareRx (PDP)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 2: Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 3: Preferred Brand	**One-month supply:** $30
	Three-month supply: $90
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Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs reach your out-of-pocket limit (refer to the Evidence of Coverage Benefit Insert for your yearly limit), you pay nothing for covered Part D drugs.

BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-688-1795** (TTY/TDD: **711**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-688-1795** (TTY/TDD: **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-688-1795** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-688-1795**（TTY/TDD：**711**）。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-688-1795** (TTY/TDD: **711**) 번으로 전화해 주십시오

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-688-1795** (TTY/TDD: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-688-1795** (رقم هاتف الصم والبكم: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-688-1795** (телетайп: **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-688-1795** (TTY: **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-877-688-1795** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-688-1795** (TTY/TDD: **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-688-1795** (TTY/TDD: **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-688-1795** (TTY/TDD: **711**) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-688-1795** (ATS : **711**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-688-1795** (TTY: **711**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-688-1795** (TTY/TDD: **711**).

BlueCross BlueShield of Illinois

This information is not a complete description of benefits. Call 1-877-688-1795 (TTY: 711) for more information.

Prescription drug plans provided by HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plans depends on contract renewal.