Blue Cross Group
Medicare Advantage Open Access℠

The advantage is yours.

Look inside for details about your HCSC retiree Medicare Advantage plan.

Keep this information for reference.

Estos materiales están disponibles en español. Póngase en contacto con Servicio al Cliente para obtener ayuda.

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Medicare coverage for retirees made easy

Blue Cross Group Medicare Advantage Open Access (PPO)SM is your all-in-one group retiree plan.

HCSC offers Blue Cross Group Medicare Advantage Open Access (PPO) for your retiree Medicare coverage. This plan bundles Medicare Part A, Part B and Part D, plus extra health and wellness benefits not offered by Original Medicare. It covers most common services such as provider visits, inpatient hospital and outpatient services, emergency care, as well as prescription drugs. It coordinates your care and offers disease prevention and management resources. The plan also takes care of claims, coordinates with Medicare and provides one number to call with questions.

Think of this Open Access PPO as a national plan.

You can see any providers who accept Medicare. That is about 98 percent of them across the country. They do not need to be part of the Blue Cross and Blue Shield network. Your benefits are the same at home or when traveling in the United States. Providers will send claims to their local BCBS plan. If a provider says they are out of network or do not take the plan, show them the **`Your Providers, Your Personal Network'** flyer included in this kit. It explains your group retiree plan and how to submit claims. Call before your visit to be sure your providers understand and will see you as a patient. **Please note: Even providers that accept Medicare can decide which patients they want to see, except in an emergency. Some medical services may need prior authorization from the plan before the provider can proceed.***

Pay Less with a HCSC Retiree Medicare Plan

A group retiree Medicare plan is one of your retirement benefits. HCSC has made sure to provide you with flexible options for your health care coverage. This Open Access PPO Medicare Advantage plan is different from an individual Medicare plan you could buy on your own. The benefits are richer and you can seek care across the country. And because it's a group plan, your costs will be lower.

Starting Jan. 1, 2025, all HCSC retirees and their covered dependents who are Medicare-eligible, age 65 or older, will need to be enrolled in one of the HCSC Retiree Medicare plan options. In past years, HCSC has shared there would come a time when Medicare-eligible retirees and covered dependents would have to move off a Traditional plan (PPO, HSA or HMO).

This change means you will save money by no longer paying the full-cost difference between the Traditional plan and the group retiree Medicare plan, on top of your base premium contribution percentage. You will only pay your percentage costs of your new group retiree Medicare plan for 2025.

Important!

- You must be a HCSC retiree enrolled in Medicare Part A and Part B. If you have not signed up yet, contact your local Social Security office or go to **www.ssa.gov** to enroll online.
- You must continue to pay any Part A or Part B premiums, Income-Related Monthly Adjustment Amount (IRMAA) surcharges and late enrollment penalties as required by the federal government.
- Medicare must approve your enrollment in this plan before you are officially a member. This takes about 10 business days.
- Review all the items in this packet to learn about your group retiree plan.
- Follow the enrollment instructions provided by the Corporate Benefits Team.

More advantages to Medicare Advantage: Extra health and wellness benefits.

While your HCSC group retiree Medicare Advantage plan coordinates with Medicare to provide Medicare Part A, Part B and Part D, members also enjoy these extra health and wellness benefits not covered by Original Medicare. Please read the enclosed Health & Wellness Benefit flyer or your plan documents for coverage details.

Fitness Designed for You

The SilverSneakers®† Fitness Program helps you achieve your health and fitness goals with access to thousands of fitness locations plus in-person and online classes led by certified instructors.

Virtual Visits

Virtual Visits allow you to consult an independently contracted, board-certified doctor or therapist for non-emergency situations by phone, mobile app or online video anytime, anywhere. Speak to a doctor or schedule an appointment at a time that works best for you. Your current provider may offer virtual visits.

24/7 Nurseline

Your call is taken by a registered nurse who can help if you are sick or hurt and not sure what to do.

Rewards Program

Put up to $100 worth of gift cards in your pocket for choosing healthy activities. Earn gift cards for completing Healthy Actions throughout the year, like having your Annual Wellness Visit, getting your flu shot or taking a Fall Risk assessment.††

Gift card options include major national retailers. They may offer physical and/or eCards. The maximum annual rewards you can earn is $100 worth of gift cards. ***Please note:*** *Healthy Actions are subject to change.*

* Non-contracted providers are not required to adhere to our prior authorization requirements; however, the member and/or provider may elect to request a medical necessity determination in advance as services should meet medical necessity criteria to be covered.

† Classes and amenities vary by location.

†† Registration is required to participate. Visit www.BlueRewardsIL.com to register and see what Healthy Actions earn rewards. If you do not have internet access, call customer service using the phone number on the back of your insurance card. Maximum annual rewards of $100 in gift cards. One reward per Healthy Action per year. Healthy Action dates of service must be in the current plan year. Healthy Actions that earn rewards are subject to change.

Part D rounds out your coverage.

Your plan includes prescription drug coverage, so you will not need a separate Medicare Part D plan. It covers common outpatient medications, like those used to treat blood pressure, cholesterol, depression and arthritis. Your HCSC-sponsored plan has copays for your Part D prescriptions. And there is a deductible to meet before benefits start.

Due to Medicare reforms, the most out-of-pocket costs you will pay in 2025 for Part D drugs is $2,000. In the years that follow, annual limits will be adjusted based on inflation. This cap does not apply to out-of-pocket spending on Part B drugs. Your monthly premium is also not included in your out-of-pocket costs. Review the Summary of Benefits to understand your costs.

List of Covered Drugs (Formulary)

Within the formulary, you will see that prescription drugs are placed into tiers. The costs for drugs in each tier are different. Tier 1 includes the drugs prescribed for common conditions and usually cost the least.

Transition Benefit

During the first 90 days of coverage, you may be able to fill a one-month supply of Part D eligible, non-formulary drugs or drugs that have restrictions. You and your provider will be alerted via mail of the transition fill and the requirements needed to continue receiving your drug. Such requirements include your provider submitting a formulary exception by calling the number on your new member ID card or filling out the formulary exception form found on **www.myprime.com**. If the formulary exception is approved, you will pay the non-preferred drug tier cost-share.

Insulin and Vaccine Costs

Insulin: You will not pay more than $35 for a one-month supply of each covered insulin product. It does not matter what cost-sharing tier it is on.

Vaccines: Your plan covers most Part D vaccines at no cost to you. The following vaccines are covered under Medicare Part D: Shingles, Tetanus/diphtheria (Td), Tetanus, diphtheria, and pertussis (whooping cough) (Tdap), Hepatitis A, Hepatitis B and other vaccines recommended by Advisory Committee on Immunization Practices.

You do not need to meet any required deductible for these items.

Pharmacies Near and Far

Our national pharmacy network includes thousands of locations. All major national retail and grocery pharmacy chains participate in the network.

The following mail order and specialty pharmacies are in the network.

Once you enroll in your new plan, you will want to bookmark these websites and save the numbers to your phone:

Mail-Order Pharmacies

Walgreens Mail Service Visit **https://walgreensmailservice.com/**	Call **1-877-277-7895** TTY 711
Amazon Pharmacy Visit **https://pharmacy.amazon.com**	Call **1-855-393-4279** TTY 711
Express Scripts Pharmacy Visit **www.express-scripts.com/rx**	Call **1-833-599-0729** TTY 711

Specialty Pharmacies

Walgreens Specialty Pharmacy Visit **https://walgreensspecialtyrx.com/**	Call **1-877-627-6337** TTY 711
Accredo Visit **www.accredo.com**	Call **1-833-721-1619** TTY 711

Please note: Federal law forbids people who have Medicare from using coupons or other discounts with their Part D plan. These may only be used outside of your Part D benefit.

Prime Therapeutics LLC provides pharmacy solutions for Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics LLC.

Accredo is a specialty pharmacy that is contracted to provide services to members of Blue Cross and Blue Shield of Illinois. Accredo is a trademark of Express Scripts Strategic Development, Inc.

Amazon Pharmacy is contracted to provide pharmacy home delivery services to Blue Cross and Blue Shield of Illinois.

Walgreens Specialty Pharmacy is contracted to provide specialty pharmacy services to members of Blue Cross and Blue Shield of Illinois.

Walgreens Mail Service is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Illinois.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Illinois. Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

Managing your medications.

Your prescription drug plan includes programs designed to encourage safe, cost-effective and appropriate use of medications. These include prior authorization, step therapy and quantity limits. If a drug requires one or more of these programs, it will be noted in the formulary.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option starting in 2025 to help you manage your budget when it comes to out-of-pocket drug costs. It spreads them across monthly payments that vary throughout the plan year, instead of you paying all at once at the pharmacy. The new payment option might help you manage your expenses, it doesn't save you money or lower your drug costs. While the program is for anyone with Part D, it might not be right for everyone.

Do you need financial support for your drugs?

You can apply for Extra Help any time before or after you enroll in Part D. Visit Social Security to learn more at **www.ssa.gov**. Choose 'Medicare,' then 'Apply for Part D Extra Help.'

Before you enroll, you can search for your medicines online at **www.myprime.com**.*

Select 'Medicines,' then:

- 'Find medicines,' followed by
- 'Continue without sign in.'

Under 'Select Your Health Plan':

- Select BCBS Illinois.
- Answer 'Yes.'
- Select Blue Cross Group Medicare Advantage (PPO)℠ – 5T Standard.
- Click 'Continue.'

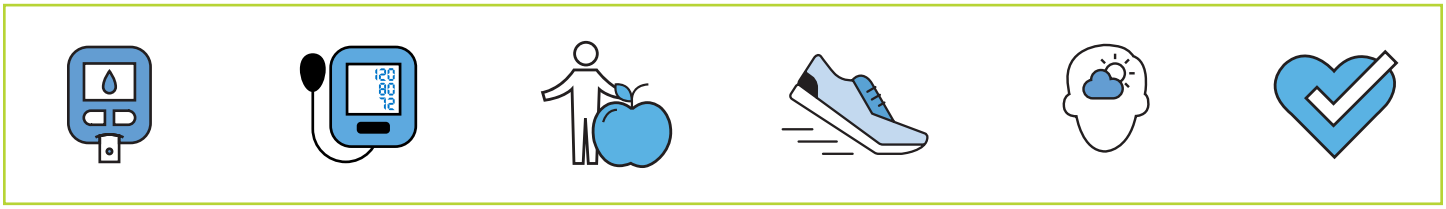
Type your medicine and dosage.

- Review the drug tier and requirements.
- Refer to the Summary of Benefits for your cost.

* MyPrime.com is a pharmacy benefit website owned and operated by Prime Therapeutics LLC, a separate company providing pharmacy solutions for your plan.

Medicare Advantage helps manage both your health and your care.

Medicare Advantage plans are managed care plans. They can lower your costs and improve your health by helping to coordinate care with your providers. If you have not been in a managed care plan before or currently have Original Medicare alone, you may find some things about the plan are different.



Managing your health.

Once you are a member, your plan becomes your partner in health. You can expect us to call, welcoming you to the plan. You will receive your member ID card and welcome guide in two separate mailings. And we will reach out during the year with helpful reminders and health tips. If you have a special health issue, you may get personal communications from our health care experts. Our Care Coordinators can help you manage your health and find support just for you. Some of the other ways we can help are:

- In-home health assessments.
- Diabetes self-care.
- Managing blood pressure.
- Eating well and staying at a healthy weight.
- Stopping tobacco or substance use.
- Stress management and mental health.
- Safety tips at home.

While it's not required, members who don't have one are encouraged to find a primary care provider. A PCP can get to know you over time and understand your unique health needs. This relationship can improve health outcomes and reduce care costs.

Your plan also encourages prevention. Not only are many services such as yearly health exams, routine screenings and certain vaccines covered at 100%, but they also count towards the Rewards Program. Each year you are eligible to earn up to $100 in gift cards.

You may hear from companies who work with us to manage your care and offer extra health and wellness benefits. Feel free to reach out to Customer Service with questions or if you are unsure about any communications you get about your plan. And please tell us if you have any special needs we should know about.

Managing your care.

Using the network

Managed care plans often have a network of providers for members to use. Your plan does not. As an Open Access plan, it lets you see any provider who accepts Medicare, will treat you and will send claims to the plan. Some providers may be unfamiliar with 'Open Access' plans, but instead know them as a 'passive PPO' or 'non-differential' plans. If your providers have any concerns about taking your plan, they can call us at the number on the back of your member ID card. We will explain how it works.

Utilization Management

Part of the plan's job is to make sure treatments and medicines are the best fit for your individual needs. You may be asked to try a different medicine or type of care first. Or your provider may ask for 'prior authorization' or 'pre-approval' from the plan before you can receive some services.

Covered drugs

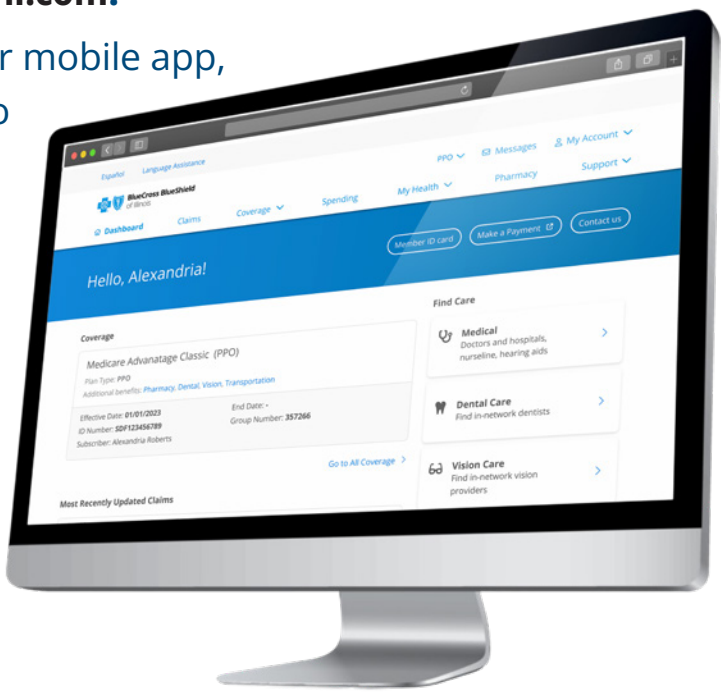
Another feature of managed care plans is the formulary. Covered drugs are placed in tiers. The tiers may range from generic drugs in a lower tier, to brand drugs in a middle tier and specialty drugs in a higher tier. Your cost is based on the drug's tier. Those in the lower tiers usually cost less and can be generic or brand drugs. Generic drugs can cost much less than brand drugs. There are two types of generic drugs: 1) generic equivalents – drugs with the same active ingredients as brand drugs and 2) generic alternatives – drugs that treat the same condition as the brand drug but use different active ingredients. This is one way the managed care plan helps to control your costs while maintaining quality.

Blue Access for Members℠

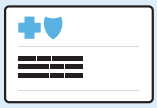
Register for BAM℠ at www.bluememberil.com.

BAM is a secure website and, along with our mobile app, is designed to give you quick, easy access to the health information you need. You can:

- Access your Evidence of Coverage.
- Search for providers and pharmacies.
- See your prescription history.
- Link to **www.myprime.com** to view your drug list/formulary.
- View claims status and up to 18 months of activity.
- Request an ID card or print a temporary ID.
- and much more.



If you already have a BAM account, you will not need to create a new one.



Your new member ID card will have this information:

Your member ID card will be mailed to you. You can also find it on BAM.

- **Your name**
- **The name of your group retiree Medicare plan**
- **Your new member ID number** - this number is unique to you.
- **Plan and Group numbers** - these numbers are used by the plan only.
- **Copays** - These are the fixed amounts you may have to pay when you visit a provider.
- **Customer service phone number**
- **Our website**

Be sure to show the new card to your providers and pharmacy. Remind them that your old ID and number are no longer valid, even if you were a BCBSIL member before enrolling in this Medicare Advantage plan. If they do not use the new card and number, your benefits cannot be confirmed and there may be delays in processing your claims.

Remember to keep your ID card safe like you would a credit or debit card. You will not need to use your red, white and blue Medicare card to receive services, so don't carry it with you. Keep it secure, not in your wallet.

You may want to update the customer service number you have saved in your phone or other devices with the number listed on the back of your new card.

Frequently Asked Questions about Medicare and Open Access Medicare Advantage plans.

Q. What is Medicare?

A. Medicare is the Federal government health care program designed for people ages 65 and over. Most U.S. citizens earn the right to enroll in Medicare by working and paying their taxes for a minimum of 10 years. The earliest someone who is turning age 65 can sign up for Original Medicare Parts A and B is three months before the month they will turn age 65. Under certain circumstances, people under age 65 may be eligible for Medicare.

There are four parts of Medicare related to specific services:

Part A — Hospital coverage

Part B — Medical coverage

Part C — Medicare Advantage Plans (private insurers like BCBSIL that contract with the government to provide Medicare coverage through a variety of insurance products). HCSC's Open Access PPO plan is a Medicare Advantage plan.

Part D — Prescription drug coverage

IMPORTANT: To participate in a group retiree Medicare plan, you will need to enroll in both Parts A and B. If you do not enroll in Medicare Parts A, B and D when you are first eligible, you may be subject to late enrollment penalties.

Q. Where can I find additional Medicare resources?

A. The following websites may be helpful: **www.medicare.gov**; **www.ssa.gov**; **www.cms.gov**.

Q. How do I enroll in Medicare?

A. Medicare enrollment is done through the Social Security Administration. It takes time to process. If you plan to retire at 65, we recommend enrolling three months prior to your 65th birthday.

Most people should enroll in Medicare Part A (hospital coverage) during the Initial Enrollment Period. This is the period during which you can enroll in Medicare for the first time. It is a 7-month period that begins three months before the month you turn 65, includes the month you turn 65 and runs for three months after the month you turned 65. For example, if you were born in June, your window to enroll is March 1 through September 30. SSA will send you enrollment instructions at the beginning of your IEP.

If you are already receiving Social Security benefits, you will be automatically enrolled in Medicare Part A at the start of your IEP. However, you will need to contact SSA to sign up for Part B. If you do not receive instructions from the SSA, please call **1-800-772-1213** (TTY **1-800-325-0778**) or go to **www.ssa.gov** to enroll in Medicare.

Q. When will my Medicare Parts A and B coverage be effective?

A. Coverage is effective on the first day of the month following the date the application was processed or the Medicare Parts A and B effective date, whichever is later.

Q. Do I need to enroll in both Original Medicare and this Medicare Advantage plan?

A. You have two separate enrollments: Original Medicare and this plan. Enrollment in Medicare Part A and Part B through the Federal government is required to be eligible for any Medicare plans, including this group retiree plan. To have full coverage, you must sign up for Medicare Parts A and B and continue to pay any required Part A or Part B premiums. You will need to do this first and get your 11-character Medicare Beneficiary Identifier before you can enroll in your group retiree plan.

When enrolling in your Medicare Advantage plan, you will provide your MBI located on your red, white and blue Medicare card, along with your effective date.

Q. I am already enrolled in a Medicare plan. Will it continue?

A. You can only be enrolled in one Medicare plan at a time. When your enrollment in this group retiree plan is final, Medicare will automatically cancel your previous Medicare Advantage or Medicare Supplement Insurance plan coverage. We can offer support as you go through this change.

Q. When will my group retiree Medicare Advantage plan start?

A. Coverage is effective on the first day of the month following the date your application was processed or your Medicare Part A and Part B effective date, whichever is later.

Q. When will I get my new Medicare Advantage member ID card?

A. You should receive it within 10-14 days after Medicare approves your enrollment. You will receive three mailings: an acknowledgment letter, followed by a confirmation letter and then your new card.

Q. What are the costs of Medicare outside my group retiree plan?

A. Part A will not cost you anything if you or your spouse paid into Social Security for a minimum of 10 years. You pay a premium each month for Part B. Most people will pay the standard premium amount. Your Part B premium will be automatically deducted from your benefit payment if you get benefits from one of these:

- Social Security
- Railroad Retirement Board
- Office of Personnel Management

If you do not get these benefit payments, you will receive a Part B premium bill.

Part B and Part D monthly premiums change each year. And, if your income is above a certain limit, you will pay a surcharge to the government in addition to your premium. This is called **IRMAA**: Income-Related Monthly Adjustment Amount. Any Part B and Part D IRMAA surcharge is based on the modified adjusted gross income reported on your IRS tax return from two years ago. A notice from Medicare will be mailed to those who will pay the IRMAA surcharge(s).

If you have had a life-changing event that reduced your household income, you can ask Social Security to lower the additional amount you will pay.

Q. What happens if I do not pay my Part B premiums?

A. Non-payment of any required Part A or Part B premiums and/or IRMAA surcharges will result in termination of coverage.

Q. What is a Medicare Advantage Plan? How does it work with Original Medicare?

A. Medicare Advantage plans bundle your Part A, Part B and usually Part D coverage into one plan. Medicare Advantage, also known as 'Medicare Part C', must cover all emergency and urgent care and almost all medically necessary services Original Medicare covers. Your rights and protections are the same.

Medicare Advantage plans like this one may offer some extra benefits such as a fitness membership, 24-hour nurse advice line or discount program. Plans also coordinate care and offer disease prevention and management resources. The plan takes care of all claims and coordinates Original Medicare benefits for you. You will not need your Medicare card to receive services or prescription drugs, just your BCBSIL member ID card. Costs for monthly premiums and the services you receive vary depending on your group retiree plan. You must continue to pay your Part B premium.

For more information about Medicare Advantage plans, visit **www.medicare.gov**.

Q. Can my spouse or partner be on a different plan?

A. All Medicare-based plans are individual plans. A retiree and their eligible spouse/partner each enroll as individuals, even if they choose the same plan.

Q. Will I be able to see my current providers?

A. Under this Medicare Advantage Open Access plan, which is a 'non-differentiated' or 'passive' PPO, you can go to any providers who: 1) accept Medicare; 2) agree to see you as a patient; and 3) will send claims to the plan. Providers do not need to be part of any Blue Cross and Blue Shield network.

Members' coverage levels are the same inside and outside their plan service area nationwide for covered benefits. Referrals are not required for office visits. Prior authorization may be required for certain services from providers who are Medicare Advantage-contracted with BCBSIL.

Please note: Even providers who accept Medicare can decide which patients they want to see, except in an emergency. We recommend that you confirm that yours will accept and submit claims to this Open Access plan. Share the enclosed 'Your Providers, Your Personal Network' flyer with your providers. It explains your plan and how to submit claims.

Q. Will my provider be able to submit claims easily to the plan?

A. We make the claims process simple. Instead of submitting claims to Medicare, your providers will send them directly to the plan. Providers across the United States can file claims with their local BCBS plan. They are familiar with how to do this. We take care of any interactions with Medicare. The customer service number listed on the back of your member ID card is for you or your provider to call with any questions.

Q. What happens if I have a pre-existing condition?

A. If you have a pre-existing condition, you cannot be refused coverage, your coverage cannot be canceled and your claims for covered services cannot be denied.

Q. I am already on a care plan. Will it continue?

A. We offer help from a team of experts who will handle your care as you move to the new plan. This help is known as continuity of care or coordination of care.

Q. Does my plan cover any prescription drugs?

A. This group retiree Medicare Advantage Prescription Drug plan covers drugs or services that are normally covered by Medicare Part B and Part D.

Q. Which medical services need prior authorization?

A. Prior Authorization is when a contracted provider needs to get approval from the health plan to deliver a service. The goal is to make sure the treatment or service is covered by Medicare, the best for the member, medically necessary and safe. A PA is needed for the following procedures (not a complete list):

- Advanced Imaging (MRI, MRA, CT scans and PET scans).
- Lab Management Solutions – molecular and genomic lab testing.
- Musculoskeletal – pain/joint/spine services – excludes exams, physical therapy and occupational therapy.
- Inpatient stay that is not the result of an emergency.
- Outpatient medical oncology, radiation therapy, sleep study and specialty drugs.
- Select Durable Medical Equipment.
- Some procedures that are performed as part of an inpatient stay.

Twenty-three hour observation and emergency room visits do not need PA. Your provider will work with the plan to get any PA you may need and may talk with you about other options if necessary.

Q. What happens if a PA is not completed?

A. Your provider is responsible for getting a PA for you. If they fail to get a PA before providing a service, the plan may not pay the claim and the provider would have to absorb the cost of the service. You are not required to pay for the service if the provider fails to get a required PA. Providers can request a PA by calling the customer service number listed on your member ID card or via fax. They may also use our provider service through Availity® Essentials.*

Q. Can I continue to use manufacturer coupons and/or discount cards with this plan?

A. Federal law forbids people who have Medicare from using coupons or other discounts with their Part D plan. These may only be used outside of your Part D benefit.

Q. Are there resources to help with the high cost of drugs?

A. Financial assistance to help with the costs of prescription drugs, like deductibles and copays, may be available through the government's Low Income Subsidy program, also called Extra Help. You can apply for it any time. Visit the Social Security website at **www.ssa.gov** and click 'Medicare,' then 'Apply for Part D Extra Help.'

* Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Q. Will I be covered if I travel internationally?

A. Blue Cross Blue Shield Global® Core program gives members traveling outside of the United States and its territories access to urgent and emergency medical assistance services, doctors and hospitals in more than 200 countries around the world.

Q. Will I receive a periodic Medicare statement based on the plan I select?

A. You will receive your Explanation of Benefits from Blue Cross and Blue Shield of Illinois. How often you receive one depends on how often you see a provider or fill a prescription. The EOB is a statement, not a bill. It simply details what you have paid and indicates the level of benefits you have used.

Blue Cross and Blue Shield of Illinois is honored to be entrusted with your care.

We are committed to providing you with outstanding service, medical expertise and convenience.

Questions about your HCSC group retiree Medicare plan?

Visit **www.bcbsil.com/retiree-medicare-hcsc** or call the Medicare Help Center at **1-877-842-7564** TTY 711

We are open October 1 – March 31: Daily, 8:00 a.m. to 8:00 p.m., Local Time
April 1 – September 30: Monday through Friday, 8:00 a.m. to 8:00 p.m., Local Time.
Alternate technologies (for example, voicemail) will be used on weekends and holidays.

This information is not a complete description of benefits. Providers are under no obligation to treat BCBSIL members, except in emergency situations. The formulary and pharmacy network may change at any time. You will receive notice when necessary.

The Healthy Activity Portal is a website owned and operated by HealthMine, Inc., an independent company that has contracted with Blue Cross and Blue Shield of Illinois to provide digital health and personal clinical engagement tools and services for members with coverage through BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company.

PPO plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.