BlueCross BlueShield of Illinois

HCSC

# 2025 Summary of Benefits

## Blue Cross Group Medicare Advantage Open Access (PPO)[SM]

January 1, 2025 – December 31, 2025

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."

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**Pre-Enrollment Checklist**

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service representative at 1-877-397-7129 (TTY: 711). We are open October 1 – March 31, daily, 8 a.m. to 8 p.m., local time, Monday through Friday. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

**Understanding the Benefits**

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.bcbsil.com/retiree-medicare-tools or call 1-877-397-7129 (TTY: 711) to request a copy of the EOC.
- ☐ Check with your current providers to confirm that they accept Medicare. Review the *Provider Finder* for a list of doctors in our network.
- ☐ Review the *Pharmacy Directory* to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

**Understanding Important Rules**

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ☐ Blue Cross Group Medicare Advantage Open Access (PPO) has a network of doctors, hospitals, pharmacies, and other providers. 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 Provider Directory and/or Pharmacy Directory at www.bcbsil.com/retiree-medicare-tools.

# 1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not 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." You can also see the Evidence of Coverage on our website, www.bcbsil.com/retiree-medicare-tools.

## You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Group Medicare Advantage Open Access (PPO)**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Blue Cross Group Medicare Advantage Open Access (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the 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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Sections in this booklet

- Things to Know About **Blue Cross Group Medicare Advantage Open Access (PPO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

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

This document may be available in a non-English language. For additional information, call us at 1-877-397-7129 (TTY: 711).

## Things to Know About Blue Cross Group Medicare Advantage Open Access (PPO)

## Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m., Local Time, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Local Time, Monday through Friday. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
- If you are a member of this plan, call us at 1-877-397-7129, (TTY: 711).
- If you are not a member of this plan, call us at 1-877-397-7129, (TTY: 711).
- Our website: www.bcbsil.com/retiree-medicare-tools.

## Who can join?

To join **Blue Cross Group Medicare Advantage Open Access (PPO)**, you must have both Medicare Part A and Medicare Part B, meet your employer's eligibility requirements, and be retired. Our service area includes anywhere in the United States.

## Which doctors, hospitals, and pharmacies can I use?

**Blue Cross Group Medicare Advantage Open Access (PPO)** has a network of doctors, hospitals, pharmacies, and other providers. 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 *Provider Directory* and/or *Pharmacy Directory* at our website (www.bcbsil.com/retiree-medicare-tools).

Or, call us at 1-877-397-7129 (TTY: 711) and we will send you a copy of the *Provider Directory* and *Pharmacy Directory*.

## What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan *Formulary* (list of Part D prescription drugs) and any restrictions on our website, www.bcbsil.com/retiree-medicare-tools.
- Or, call us at 1-877-397-7129 (TTY: 711) and we will send you a copy of the *Formulary*.

## How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage and Catastrophic Coverage.

**If you have any questions about this plan's benefits or costs, please contact Blue Cross and Blue Shield of Illinois**

# 2 SECTION II - SUMMARY OF BENEFITS

## Blue Cross Group Medicare Advantage Open Access (PPO)SM

| MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES | |
|---|---|
| **Monthly Plan 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. |
| **Deductible** | $350 |
| **Maximum Out-of-Pocket Responsibility** | If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.<br>Your yearly limit(s) in this plan:<br>• $1,500 for services you receive from in- and out-of-network providers combined. |
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | |
| **Inpatient Hospital** | Our plan covers unlimited number of days for an inpatient hospital stay.<br>**In-Network:**<br>5% of the total cost per stay.<br>**Out-of-Network:**<br>5% of the total cost per stay.<br>May require prior authorization. |

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|---|---|
| **Outpatient Hospital** | **In-Network:**<br>5% of the total cost.<br>**Out-of-Network:**<br>5% of the total cost.<br>May require prior authorization. |
| **Ambulatory Surgical Center** | **In-Network:**<br>5% of the total cost.<br>**Out-of-Network:**<br>5% of the total cost.<br>May require prior authorization. |
| **Doctor's Office Visits** | **In-Network:**<br>Primary care physician visit: 5% of the total cost.<br>Specialist visit: 5% of the total cost.<br>**Out-of-Network:**<br>Primary care physician visit: 5% of the total cost.<br>Specialist visit: 5% of the total cost.<br>May require prior authorization. |
| **Preventive Care *(e.g., flu vaccine, diabetic screenings)*** | **In-Network:**<br>$0 copay for all preventive services covered under Original Medicare at zero cost sharing.<br>**Out-of-Network:**<br>$0 copay for all preventive services covered under Original Medicare at zero cost sharing.<br>**Important Message About What You Pay for Vaccines**<br>Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information. |
| **Emergency Care** | 5% of the total cost per visit.<br>Worldwide Emergency Coverage: 5% of the total cost.<br>Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital" section of this booklet for other costs. |

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| **Urgently Needed Services** | 5% of the total cost per visit.<br>Worldwide Urgent Coverage: 5% of the total cost. |
| **Diagnostic Services / Labs/ Imaging** | **In-Network:**<br>Diagnostic tests and procedures: 5% of the total cost.<br>Lab services: 5% of the total cost.<br>MRIs, CT Scans: 5% of the total cost.<br>X-rays: 5% of the total cost.<br>Therapeutic radiology services (such as radiation treatment for cancer): 5% of the total cost.<br>**Out-of-Network:**<br>Diagnostic tests and procedures: 5% of the total cost.<br>Lab services: 5% of the total cost.<br>MRIs, CT Scans: 5% of the total cost.<br>X-rays: 5% of the total cost.<br>Therapeutic radiology services (such as radiation treatment for cancer): 5% of the total cost.<br>May require prior authorization. |
| **Hearing Services** | **In-Network:**<br>**Medicare-covered:**<br>Exam to diagnose and treat hearing and balance issues: 5% of the total cost.<br>**Routine Hearing:**<br>Routine hearing exam (1 each year): $35 copay.<br>**Out-of-Network:**<br>**Medicare-covered:**<br>Exam to diagnose and treat hearing and balance issues: 5% of the total cost.<br>**Routine Hearing:**<br>Routine hearing exam (1 each year): $35 copay.<br>**In-Network and Out-of-Network:**<br>**Hearing Aid:** $5,000 Allowance for both ears combined in-network and out-of-network on hearing aids every three years.<br>May require prior authorization. |

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| **Dental Services** | **In-Network:**<br>Medicare-covered: 5% of the total cost.<br>**Out-of-Network:**<br>Medicare-covered: 5% of the total cost.<br>May require prior authorization. |
| **Vision Services** | **In-Network:**<br>**Medicare-covered:**<br>• Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 5% of the total cost for an eye exam.<br>• Eyeglasses or contact lenses after cataract surgery: 5% of the total cost<br>**Routine Vision:**<br>• Routine eye exam (1 every year): $35 copay<br>**Out-of-Network:**<br>**Medicare-covered:**<br>• Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 5% of the total cost for an eye exam.<br>• Eyeglasses or contact lenses after cataract surgery: 5% of the total cost<br>**Routine Vision:**<br>• $40 Annual allowance maximum for 1 routine eye exam.<br>May require prior authorization. |
| **Mental Health Services** | Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.<br>**In-Network:**<br>Inpatient Mental Health Care:<br>5% of the total cost per stay. |

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| | Outpatient group therapy visit: 5% of the total cost.<br>Outpatient Individual therapy visit: 5% of the total cost.<br>**Out-of-Network:**<br>Inpatient Mental Health Care:<br>5% of the total cost per stay.<br>Outpatient group therapy visit: 5% of the total cost.<br>Outpatient Individual therapy visit: 5% of the total cost.<br>May require prior authorization. |
| **Skilled Nursing Facility (SNF)** | **In-Network:**<br>Days 1-20: 5% of the total cost per day.<br>Days 21-100: 5% of the total cost per day.<br>**Out-of-Network:**<br>Days 1-20: 5% of the total cost per day.<br>Days 21-100: 5% of the total cost per day.<br>May require prior authorization. |
| **Physical Therapy** | **In-Network:**<br>5% of the total cost.<br>**Out-of-Network:**<br>5% of the total cost.<br>May require prior authorization. |
| **Outpatient Rehabilitation** | **In-Network:**<br>Cardiac rehab services (Maximum of 2 one-hour sessions per day up to 36 sessions in 36 weeks. Limit to 36 per year): 5% of the total cost.<br>Occupational therapy visit: 5% of the total cost.<br>**Out-of-Network:**<br>Cardiac rehab services (Maximum of 2 one-hour sessions per day up to 36 sessions in 36 weeks. Limit to 36 per year): 5% of the total cost.<br>Occupational therapy visit: 5% of the total cost.<br>May require prior authorization. |

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| **Ambulance** | Ground Ambulance: 5% of the total cost for each one-way trip.<br>Air Ambulance: 5% of the total cost for each one-way trip.<br>May require prior authorization. |
| **Transportation** | Not covered |
| **Medicare Part B Drugs** | **<u>In-Network:</u>**<br>For Part B drugs such as chemotherapy drugs: 5% of the total cost.<br>Other Part B drugs: 5% of the total cost.<br>For Part B Insulin Drugs: 5% of the total cost with a maximum copay amount per month of $35.<br>**<u>Out-of-Network:</u>**<br>For Part B drugs such as chemotherapy drugs: 5% of the total cost.<br>Other Part B drugs: 5% of the total cost.<br>For Part B Insulin Drugs: 5% of the total cost with a maximum copay amount per month of $35.<br>May require prior authorization. |

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $50 for Tiers 1, 2, 3, 4 and 5.<br>Once you have paid $50 for your Tiers 1, 2, 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.<br>Important Message About What You Pay for Insulin<br>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, even if you haven’t paid your deductible.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your yearly out-of-pocket drug costs reach $2,000.
<table>
<tr><th colspan="3">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$10 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$30 copay</td><td>$90 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$45 copay</td><td>$135 copay</td></tr>
<tr><td>Tier 5 (Specialty)</td><td>$45 copay</td><td>$135 copay</td></tr>
<tr><th colspan="3">Preferred Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$5 copay</td><td>$15 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$5 copay</td><td>$15 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$25 copay</td><td>$75 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$40 copay</td><td>$120 copay</td></tr>
<tr><td>Tier 5 (Specialty)</td><td>$40 copay</td><td>$120 copay</td></tr>
<tr><th colspan="3">Standard Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$10 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$30 copay</td><td>$90 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$45 copay</td><td>$135 copay</td></tr>
<tr><td>Tier 5 (Specialty)</td><td>$45 copay</td><td>$135 copay</td></tr>
</table></td></tr>
</table>

| PRESCRIPTION DRUG BENEFITS | |
|---|---|
| | **Preferred Mail Order** |

| Tier | One-month supply | Three-month supply |
|---|---|---|
| Tier 1 (Preferred Generic) | $5 copay | $15 copay |
| Tier 2 (Generic) | $5 copay | $15 copay |
| Tier 3 (Preferred Brand) | $25 copay | $75 copay |
| Tier 4 (Non-Preferred Drug) | $40 copay | $120 copay |
| Tier 5 (Specialty) | $40 copay | $120 copay |

| | |
|---|---|
| **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. |
| **Catastrophic Coverage** | After your yearly out-of-pocket drug costs reach $2,000, you pay nothing for covered Part D drugs. |

Please note: Federal law prohibits individuals enrolled in Medicare from using manufacturer coupons or other drug discounts with their drug plan. Financial assistance to help with the costs of prescription drugs may be available through the government's Extra Help/Low Income Subsidy program. You can apply for Extra Help any time before or after you enroll in Part D. For more information or to apply, visit the Social Security website at www.ssa.gov and click "Medicare," then "Apply for Part D Extra Help."

| Additional Member Benefits | Blue Cross Group Medicare Advantage Open Access (PPO)[SM] |
|---|---|
| **Acupuncture for Chronic Low Back Pain** | **In-Network:**<br>**Medicare-covered:**<br>• $0 copay<br>**Routine Acupuncture:**<br>• Routine acupuncture: Not Covered.<br>**Out-of-Network:**<br>**Medicare-covered:**<br>• $0 copay<br>**Routine Acupuncture:**<br>• Routine acupuncture: Not Covered.<br>May require prior authorization. |
| **Chiropractic Care** | **Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)**<br>**In-Network:**<br>**Medicare-covered:**<br>• 5% of the total cost<br>**Routine Chiropractic Care:**<br>• Routine chiropractic: Not Covered.<br>**Out-of-Network:**<br>**Medicare-covered:**<br>• 5% of the total cost<br>**Routine Chiropractic Care:**<br>• Routine chiropractic: Not Covered.<br>May require prior authorization. |
| **Diabetes Supplies and Services** | **In-Network:**<br>**Diabetes monitoring supplies** |

| Additional Member Benefits | Blue Cross Group Medicare Advantage Open Access (PPO)[SM] |
|---|---|
| | • 5% cost sharing for all diabetic testing supplies (meters, strips and lancets) obtained through the pharmacy.<br><br>**Diabetes self-management training**<br><br>• $0 copay<br><br>**Therapeutic shoes or inserts**<br><br>• 5% of the total cost<br><br>**<u>Out-of-Network:</u>**<br><br>**Diabetes monitoring supplies**<br><br>• 5% cost sharing for all diabetic testing supplies (meters, strips and lancets) obtained through the pharmacy.<br><br>**Diabetes self-management training**<br><br>• $0 copay<br><br>**Therapeutic shoes or inserts**<br><br>• 5% of the total cost<br><br>May require prior authorization. |
| **Durable Medical Equipment *(wheelchairs, oxygen, etc.)*** | **<u>In-Network:</u>**<br><br>• 5% of the total cost<br><br>**<u>Out-of-Network:</u>**<br><br>• 5% of the total cost<br><br>May require prior authorization. |
| **Wellness Programs** | $0 copay for SilverSneakers®† Fitness Program<br><br>SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations.[1]<br><br>[1]You have access to a nationwide network of participating locations where you can take classes.<br><br>†SilverSneakers is a registered trademark of Tivity Health, Inc.© 2023 Tivity Health, Inc. All rights reserved. |

| Additional Member Benefits | Blue Cross Group Medicare Advantage Open Access (PPO)[SM] |
|---|---|
| **Foot Care** ***(podiatry services)*** | **Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions**<br>**In-Network:**<br>**Medicare-covered:**<br>• 5% of the total cost<br>**Routine Podiatry:**<br>• Routine podiatry: Not Covered.<br>**Out-of-Network:**<br>**Medicare-covered:**<br>• 5% of the total cost<br>**Routine Podiatry:**<br>• Routine podiatry: Not Covered.<br>May require prior authorization. |
| **Home Health Care** | **In-Network:**<br>• 5% of the total cost<br>**Out-of-Network:**<br>• 5% of the total cost<br>May require prior authorization. |
| **Opioid Treatment Program Services** | **In-Network:**<br>• $0 copay<br>**Out-of-Network:**<br>• $0 copay<br>May require prior authorization. |
| **Outpatient Substance Abuse Services** | **In-Network:**<br>**Group therapy visit**<br>• 5% of the total cost |

| Additional Member Benefits | Blue Cross Group Medicare Advantage Open Access (PPO)[SM] |
|---|---|
| | **Individual therapy visit**<br>• 5% of the total cost<br>**Out-of-Network:**<br>**Group therapy visit**<br>• 5% of the total cost<br>**Individual therapy visit**<br>• 5% of the total cost<br>May require prior authorization. |
| **Over-the-Counter Items** | $20 monthly allowance on the Wellness Benefit Card, a preloaded debit card. The Wellness Benefit Card can be used for approved over-the-counter health and wellness items at participating retail locations or for home delivery through our OTC catalog. Unused monthly allowance amounts roll over to the next month. All funds expire at the end of the plan year, or when you leave the plan.<br>Please see your Evidence of Coverage for details. |
| **Prosthetic Devices** ***(braces, artificial limbs, etc.)*** | **In-Network:**<br>**Prosthetic devices**<br>• 5% of the total cost<br>**Related medical supplies**<br>• 5% of the total cost<br>**Out-of-Network:**<br>**Prosthetic devices**<br>• 5% of the total cost<br>**Related medical supplies**<br>• 5% of the total cost<br>May require prior authorization. |
| **Meals** | Not Covered |
| **Renal Dialysis** | **In-Network:** |

| Additional Member Benefits | Blue Cross Group Medicare Advantage Open Access (PPO)[SM] |
|---|---|
| | • 5% of the total cost<br><br>**<u>Out-of-Network:</u>**<br><br>• 5% of the total cost<br><br>May require prior authorization. |
| **Telehealth Services** | • Virtual Urgent Care - $0 copay (through MDLive only), Virtual Mental Health Specialty Services - $0 copay (through MDLive only), Virtual Psychiatric Services - $0 copay (through MDLive only) |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. |

## DISCLAIMERS

This document is available in other alternate formats.

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-397-7129 (TTY: 711). Someone who speaks English can help you. This is a free service.

Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-397-7129 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Illinois members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

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 a 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. You can file a grievance by phone, mail, or fax. If you need help filing a grievance, a 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/smartscreen/main.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

https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-397-7129 (TTY/TDD: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-397-7129 (TTY/TDD: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-397-7129 (TTY/TDD: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-877-397-7129 (TTY/TDD: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-397-7129 (TTY/TDD: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-397-7129 (TTY/TDD: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-397-7129 (TTY/TDD: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phi.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-397-7129 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-397-7129 (TTY/TDD: 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-397-7129 (TTY/TDD: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic 711): سيقوم شخصما يتحدث العربية إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليسعليك سوى الاتصال بنا على 1-877-397-7129 (TTY/TDD: 711). هذه خدمة مجانية بمساعدتك.

Hindi: हमारेस्वास्थ्य या दवा की योजना केबारेमेंआपकेकिसी भी प्रश्न केजवाब देनेकेलिए हमारेपास मुफ्त दुभाषिया सेवाएँउपलब्ध हैं. एक दुभाषिया प्राप्त करनेकेलिए, बस हमें 1-877-397-7129 (TTY/TDD: 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता हैआपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-397-7129 (TTY/TDD: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-397-7129 (TTY/TDD: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-397-7129 (TTY/TDD: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-397-7129 (TTY/TDD: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用 命になるには、1-877-397-7129 (TTY/TDD: 711). にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。


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

This information is not a complete description of benefits. Call 1-877-397-7129 (TTY: 711) for more information.

Premium, copays, coinsurance, and deductibles may vary based on the level of extra Help you receive. Please contact the plan for further details.

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.

# THANK YOU

## Connect with us

**Contact Information:** 1-877-397-7129, TTY: 711

**Organization Name:** Blue Cross and Blue Shield of Illinois

**Organization website:** www.bcbsil.com