Blue Cross Group MedicareRx (PDP)[SM]

HCSC

Summary of Benefits

Blue Cross Group MedicareRx (PDP)[SM]

January 1, 2022 – December 31, 2022

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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INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

	Blue Cross Group MedicareRx (PDP)[SM]
You have choices about how to get your Medicare prescription drug benefits	• One choice is to get prescription drug coverage through a Medicare Prescription Drug Plan, like **Blue Cross Group MedicareRx (PDP)**. • Another choice is to get your prescription drug coverage through a Medicare Advantage Plan (like an HMO or PPO) or another Medicare health plan that offers Medicare prescription drug coverage. You get all your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans.
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **Blue Cross Group MedicareRx (PDP)** covers and what you pay. • If you want to compare our plans with other Prescription Drug 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 MedicareRx (PDP)** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Prescription Drug Benefits
Hours of Operation	• From September 1 to January 31, you can call us 7 days a week from 8:00 a.m. – 9:00 p.m. local time. • From February 1 to August 30, you can call us Monday through Friday from 8:00 a.m. – 8:00 p.m. local time.
Phone Numbers	• Call toll-free 1-866-486-9636. (TTY users should call 711).

	Blue Cross Group MedicareRx (PDP)[SM]
Who can join?	To join **Blue Cross Group MedicareRx (PDP)**, you must be entitled to Medicare Part A and/or enrolled in Medicare Part B, and be a retiree, or Medicare-eligible dependent of a retiree, of HCSC. Our service area includes anywhere in the United States.
What drugs are covered?	You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions. You can see the plan formulary (list of Part D prescription drugs) and any restrictions at www.bcbsil.com/retiree-medicare-tools. Call us 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, Coverage Gap, and Catastrophic Coverage.
Which pharmacies can I use?	We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's *Pharmacy Directory* at www.bcbsil.com/retiree-medicare-tools. Call us and we will send you a copy of the *Pharmacy Directory*.

SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

	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.
Stage 2: Initial Coverage	You pay the following (see table(s) below) until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

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
Tier 5: Specialty Tier	**One-month supply:** $45
	Three-month supply: $135

Initial Coverage Stage: Preferred Mail Order Pharmacy	
Preferred Mail Order	**Blue Cross Group MedicareRx (PDP)[SM]**
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: 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 retail pharmacy.
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You generally must use a network pharmacy to fill your prescription. Please see the *Evidence of Coverage* Booklet Chapter 3, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

	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 $4,430. 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 $7,050.

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
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

Coverage Gap 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

Coverage Gap Stage: Standard Mail Order Pharmacy	
Standard Mail Order	**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
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Tier 5: Specialty Tier	**One-month supply:** $45
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Coverage Gap Stage: Preferred Mail Order Pharmacy	
Preferred Mail Order	**Blue Cross Group MedicareRx (PDP)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $0
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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

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Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,050, you pay the greater of: • 5% of the total cost, or • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other 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.