BlueCross BlueShield of Illinois

Illinois Municipal Retirement Fund

Effective 1/1/2024 – 12/31/2024	Blue Cross Group MedicareRx (PDP)[SM]	
Annual Deductible Amount member pays before plan begins to pay	$0	
Initial Coverage Period Copays (30-day supply) Annual drug costs up to $5,030	**Preferred Pharmacy / Standard Pharmacy**	
	Tier 1 – Preferred Generic Drugs	**$0 / $5**
	Tier 2 – Generic Drugs	**$6 / $11**
	Tier 3 – Preferred Brand Drugs	**$39 / $44**
	Tier 4 – Non-Preferred Brand Drugs	**$85 / $95**
	Tier 5 – Specialty Drugs	**33% / 33% coinsurance**
Gap Coverage Copays Annual drug costs exceeding $5,030 (up to a total of $8,000 out-of-pocket costs)	**Preferred Pharmacy / Standard Pharmacy**	
	Tier 1 – Preferred Generic Drugs	**$0 / $5**
	Tier 2 – Generic Drugs	**$6 / $11**
	Tier 3 – Preferred Brand Drugs	**$39 / $44**
	Tier 4 – Non-Preferred Brand Drugs	**$85 / $95**
	Tier 5 – Specialty Drugs	**15% / 15% coinsurance**
After the Gap Copays After your total out-of-pocket costs exceed $8,000	Beneficiary cost sharing is reduced to $0 for those who reach the catastrophic spending level.	
Preferred Pharmacy Networks	Albertsons (Jewel-Osco), Arete, Kroger (Mariano's), Walgreens, Walmart	

Contact your benefit administrator for more information.

This information is not a complete description of benefits.

Prescription drug plans provided by Blue Cross and Blue Shield of Illinois, which refers to 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.

Y0096_GRPRXPOV_M

246581.1123

Blue Cross Group MedicareRx (PDP)℠

Maximize your Part D coverage.

Look inside for:

- Information about your retiree group prescription drug plan (PDP)
- Getting started
- What to expect

live your Blue life℠

Y0096_GRPPDPBREK24_M

237874.0723

Get to know Blue Cross Group MedicareRx℠.

Let's talk about your retiree group Medicare Part D prescription drug benefit, including how it works, how to enroll, and what to expect once your coverage begins.

Blue Cross Group MedicareRx helps you stay healthy and protects you against high pharmacy costs.

Medicare Part D covers common outpatient medications, like those used to treat high blood pressure, high cholesterol, depression, and osteoporosis. These types of prescription drugs are not covered under Original Medicare Part A or Part B.

It offers:

- A comprehensive drug list (formulary).
- Convenient home delivery and online ordering.
- A nationwide network of pharmacies.
- The confidence of knowing you are covered by a leading, member-focused health insurer.

Part D coverage generally has four stages.

Review the Summary of Benefits for details about the retiree group plan available to you.

1. Annual Deductible

You pay this amount for your prescriptions before the plan starts to pay.

2. Initial Coverage Limit

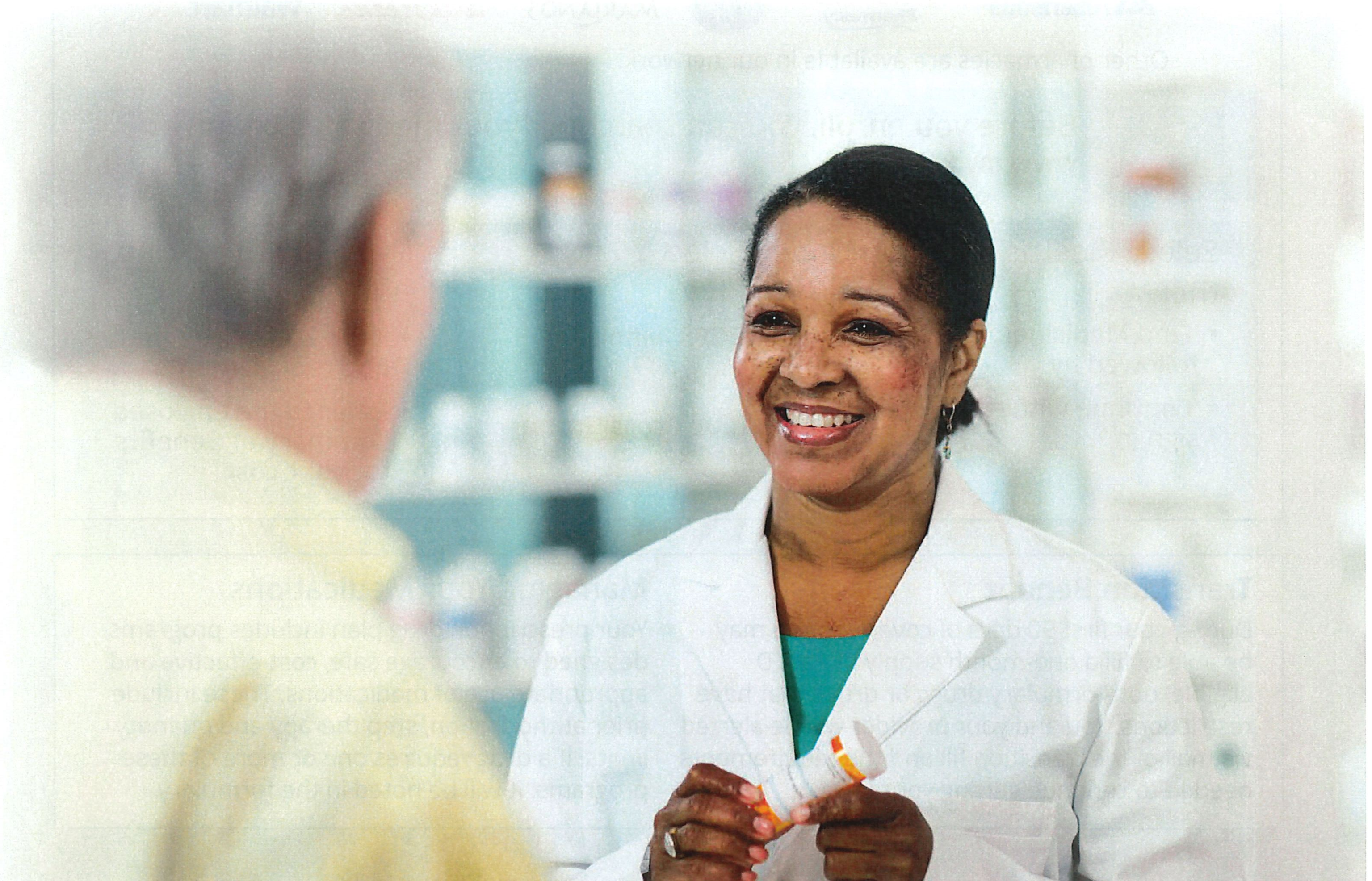
You may pay a copay or coinsurance for each eligible prescription. The plan pays the rest until total costs reach the Initial Coverage Limit. This is an amount determined by the Centers for Medicare and Medicaid Services (CMS). It may change each year. Only the retail cost of a prescription drug goes toward the Initial Coverage Limit. So if the retail cost is $100, and your copay is $10, the amount that counts toward your Initial Coverage Limit will be the full $100 retail cost.

3. Coverage Gap

Also called the 'donut hole,' this stage starts after you and the plan have spent up to the Initial Coverage Limit. While you are in the Coverage Gap, what you pay for drugs may change, based on your plan. Review the Summary of Benefits for details about your retiree group Part D plan.

4. Catastrophic Coverage

When your out-of-pocket costs for covered drugs reach an amount that is set by CMS each year, you will enter Catastrophic Coverage. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.



How does Medicare Part D work?

Copay and Deductible

You may have a copay or coinsurance for your prescriptions. You may need to meet a deductible before benefits start. Review the Summary of Benefits to understand the details of your retiree group Part D plan.

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 generally different. Tier 1 includes the drugs prescribed for common conditions.

Important Message About What You Pay for Insulin and Vaccines

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, even if you haven't paid your deductible.

Vaccines: Your plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. The following vaccines are now covered under Medicare Part D: Shingles, Tetanus/diphtheria (Td), Tetanus, diphtheria, and pertussis (whooping cough) (Tdap), Hepatitis A and Hepatitis B.

Pharmacies in the Neighborhood and across the Nation

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

Other pharmacies are available in our network.

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 MedicareRx.

Type your medicine and dosage

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

Transition Benefit

During your 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 getting your drug.

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.

What happens after you enroll?

1. Medicare Approval

You must be a retiree enrolled in Medicare Part A and/or Part B to be eligible for this plan. Medicare must approve your enrollment in this plan before you are officially a member.

2. Acknowledgment and Confirmation Letters

We'll let you know the status of your enrollment. Within 10–14 days of receiving your enrollment, we'll send you an acknowledgment letter. It explains that we've received your information and are waiting for Medicare to approve your eligibility. After Medicare approves, we'll send you a confirmation letter followed by your member ID card.

3. Member ID Card

Always show your Blue Cross and Blue Shield of Illinois (BCBSIL) ID card when you visit the pharmacy. Information on the ID card helps the pharmacy file your claim with us.

Your card will have this information:

- **Your name**
- **The name of your retiree group Medicare plan**
- **Member ID number**
  This number is unique to you.
- **Plan number**
  This number is used by the plan only.
- **Customer service phone number**
- **Our website**

If your ID card hasn't come in the mail by your effective date, you can still use your benefits. Just show your confirmation letter as proof of insurance.

4. Welcome Kit

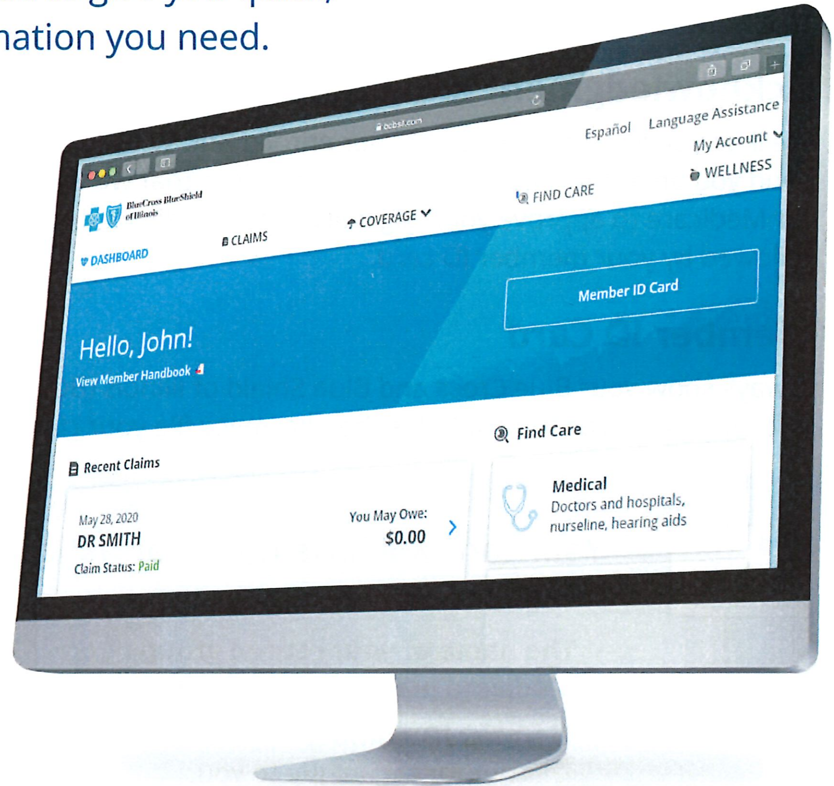
You will receive your Welcome Kit in the mail. It includes information to help you get the most from your plan and includes your:

- Welcome Guide.
- Evidence of Coverage Benefit Insert.
- Formulary.

Blue Access for Members℠

Register for Blue Access for Members (BAM℠) at www.bluememberil.com.

BAM is a secure website designed to give you quick, easy access to the health information you need. Bookmark it on your computer or download the easy-to-use mobile app.



You can:

- Search for pharmacies.
- See your prescription history.
- View claims status and up to 18 months of activity.
- Request an ID card or print a temporary ID.
- And more!

It's Easy to Get Started!

Go to **www.bluememberil.com** or grab your smartphone and your member ID card and text† BCBSILAPP to 33633 so you can use BAM while you're on the go.

† Message and data rates may apply.

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

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

Let's get started.

1. You must be a retiree enrolled in Medicare Part A and/or Medicare Part B. You must continue to pay your required Part A and/or Part B premiums. These are usually deducted from your Social Security benefit. If you haven't signed up yet, contact your local Social Security office or go to **www.ssa.gov** to enroll online.

2. Review the enclosed Summary of Benefits and search for your medicines at **www.myprime.com**.

3. **It's time to enroll!** Follow the enrollment instructions provided by your benefit administrator.

4. Watch the mailbox for your enrollment acknowledgment and confirmation letters, followed by your new member ID card and Welcome Kit.

Questions about your retiree group Part D plan?

Talk to your benefit administrator or refer to the plan documents for details.

This information is not a complete description of benefits. The formulary and pharmacy network may change at any time. You will receive notice when necessary.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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

Prescription drug plans provided by Blue Cross and Blue Shield of Illinois, which refers to 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.

Health Care Program Premium Deduction Authorization for IMRF-endorsed Plans

IMRF Form 7.10E (Rev. 08/2013)

- Please indicate which program you are **NEWLY** applying for by checking the appropriate box(es) below.
- Fill out the front page of this form only; the back page will be filled out by the plan administrator.
- **Please note**: All programs except for Sav-Rx **require additional applications**.
- **Return completed form to**: Doyle Rowe Ltd.,1301 W. 22nd Street, Suite 101, Oak Brook, IL 60523.
- **If you have any questions contact Doyle Rowe at 1-800-564-7227 or www.doylerowe.com**.

PLEASE PRINT OR TYPE

MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	IMRF MEMBER ID OR LAST 4 DIGITS OF SSN

(If applicable) SPOUSE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
	______ - ______ - ______

HOME STREET (MAILING) ADDRESS

CITY, STATE, AND ZIP	DAYTIME TELEPHONE NUMBER (with Area Code)
	( )

To be completed by applicant. Please note that all programs except Sav-Rx require a separate application form. CHECK ONLY THE PLAN YOU ARE NEWLY ENROLLING IN.

Plan			Plan			
Seniors Choice	☐ **Individual**	☐ **Spouse**	**Humana Local PPO**	☐ **Individual**	☐ **Spouse**	
United Health Care Medicare Complete	☐ **Individual**	☐ **Spouse**	**Humana Regional PPO**	☐ **Individual**	☐ **Spouse**	
Health Care Alliance HMO	☐ **Individual**	☐ **Spouse**	**Humana Group PDP Plan**	☐ **Individual**	☐ **Spouse**	
Health Care Alliance PPO	☐ **Individual**	☐ **Spouse**	**Sav-Rx Advantage Card**	☐ **Individual**	☐ **Spouse**	
Blue Cross Blue Shield of Illinois	☐ **Individual**	☐ **Spouse**	**Delta Dental of Illinois**	☐ **Individual**	☐ **Spouse**	☐ **Family**
Blue Cross Blue Shield of Texas	☐ **Individual**	☐ **Spouse**	**United Health Care Vision Plan**	☐ **Individual**	☐ **Spouse**	☐ **Family**

Member Authorization

I authorize and request the Illinois Municipal Retirement Fund (IMRF) to deduct premiums for the selected program(s) from my IMRF benefit payment and to remit the amount deducted to the health care program. I authorize IMRF to release information to the health care program in order to ensure proper handling of premiums. I understand IMRF will adjust deductions in response to changes in the premiums. I further understand that IMRF will cease making any deduction if the premiums exceed my IMRF benefit amount. This authorization is not an assignment of my right to receive payment. This authorization will remain in effect with IMRF until cancelled by written notice from me or until IMRF is notified that a premium deduction is no longer required.

MEMBER SIGNATURE* ______ DATE (MM/DD/YYYY) ______ SPOUSE'S SIGNATURE ______ DATE (MM/DD/YYYY) ______

***Member signs if member is receiving benefit payment; Spouse signs if spouse is receiving surviving spouse benefit or if spouse is enrolling in the Sav-Rx Advantage Card program.**

FOR IMRF USE ONLY	Date Entered	Date Effective

THIS PAGE TO BE COMPLETED BY PLAN ADMINISTRATOR

Plan Name	Plan Code	Member	Plan Code	Spouse	Coverage Effective
Seniors Choice					
Blue Cross Blue Shield of Illinois					
Blue Cross Blue Shield of Texas					
Health Care Alliance HMO					
Health Care Alliance PPO					
Humana Local PPO					
Humana Regional PPO					
Humana Group PDP Plan					
Sav-Rx Advantage Card					

Delta Dental of Illinois

PLAN CODE____________ Member_______________ Coverage Effective Date ____________________

PLAN CODE____________ Spouse_______________ Coverage Effective Date ____________________

PLAN CODE____________ Family_______________ Coverage Effective Date ____________________

Delta Dental of Illinois (P)

PLAN CODE____________ Member_______________ Coverage Effective Date ____________________

PLAN CODE____________ Spouse_______________ Coverage Effective Date ____________________

PLAN CODE____________ Family_______________ Coverage Effective Date ____________________

United Health Care Vision Plan

PLAN CODE____________ Member_______________ Coverage Effective Date ____________________

PLAN CODE____________ Spouse_______________ Coverage Effective Date ____________________

PLAN CODE____________ Family_______________ Coverage Effective Date ____________________

Illinois Municipal Retirement Fund
2211 York Road Suite 500 Oak Brook, IL 60523-2337
Member Services Representatives 1-800-ASK IMRF (1-800-275-4673) Fax: (630) 706-4289
www.imrf.org

Blue Cross Group MedicareRx (PDP)℠

Proposed Effective Date:
____/ 0 1 / 2 0 ____
(Must be after enrollee signature date)

Blue Cross Group MedicareRx℠ Medicare Prescription Drug Plan Employee Enrollment Form

To enroll in Blue Cross Group MedicareRx, please provide the following information:

Please check the plan you want to enroll in:

☐ **Blue Cross Group Medicare Rx (PDP)**

Employer: Illinois Municipal Retirement Fund			Group #: BILP0005
Legal LAST Name:	Legal FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ____/____/________	Sex: ☐ M ☐ F	Employee ID: ____________	
Home Phone Number: (____)____-______		Alternate Phone Number: (____)____-______	
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	County:	State:	ZIP Code: ______
Mailing Address (only if different from your Permanent Residence Street Address):			
Street Address:	City:	State:	ZIP Code: ______
Emergency Contact Name:			
Phone Number: (____)____-______		Relationship to You:	
Member Email Address:			

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. **– OR –** • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.	Name (as it appears on your Medicare Card): ____________ Medicare Number: ____________ Some boxes may be blank. is Entitled to: Effective Date: **HOSPITAL (Part A)** ____________ **MEDICAL (Part B)** ____________

Applicant LAST name:	FIRST name:

Paying Your Plan Premium

For Employer Group Plans with Direct Bill Premiums:

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay your monthly plan premium including any late enrollment penalty that you currently have, or may owe, by mail or by Electronic Funds Transfer (EFT) each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay Blue Cross and Blue Shield of Texas (BCBSTX) the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option: (Select one payment option)

☐ **Get a bill**

☐ **Electronic funds transfer (EFT) from your bank account each month.**
Please enclose a VOIDED check or provide the following:

Account holder name:

Bank routing number: ____ ____ ____ ____ ____ ____ ____ ____ ____

Bank account number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Account type: ☐ **Checking** ☐ **Savings**

All fields for the next two questions are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin.
☐ **I choose not to answer**.

Applicant LAST name: FIRST name:

All fields for the next two questions are optional. (continued)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Please read and answer these important questions:

1. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have other **prescription** drug coverage in addition to Blue Cross Group MedicareRx? ☐ Yes ☐ No

If **yes**, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ______________ ID # for this coverage: ______________ Group # for this coverage: ______________

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If **yes**, please provide the following information:

Name of Institution: ______________________________

Address & Phone Number of Institution (number and street):

____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Braille/Large Print

Please contact Blue Cross Group MedicareRx at 1-877-838-3833 if you need information in an accessible format or language than what is listed above. TTY users should call 711. Our office hours are 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Applicant LAST name: FIRST name:

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Blue Cross Group MedicareRx is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue Cross Group MedicareRx of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time — if I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Cross Group MedicareRx will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan at any time or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Blue Cross Group MedicareRx has a service area that includes the United States and its territories. If I move out of the area that Blue Cross Group MedicareRx serves, I need to notify my Employer Group Benefits Office so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue Cross Group MedicareRx network pharmacies. Once I am a member of Blue Cross Group MedicareRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue Cross Group MedicareRx when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber's Employer Group and Blue Cross and Blue Shield of Illinois (BCBSIL), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSIL to use the Blue Cross and/or Blue Shield Service Marks in the State of Illinois, and that BCBSIL is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than BCBSIL and that no person, entity, or organization other than BCBSIL shall be held accountable or liable to Subscriber for any of BCBSIL's obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSIL other than those obligations created under other provisions of this agreement.

Release of Information:

By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Cross Group MedicareRx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross Group MedicareRx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described below), this signature certifies that: **1)** this person is authorized under State law to complete this enrollment and **2)** documentation of this authority is available upon request by Medicare.

Applicant LAST name:	FIRST name:

Please Read and Sign Below (continued)	
Signature:	**Today's Date:** ______/______/__________

If you are the authorized representative, you must sign above and provide the following information: Name:
Address:
Phone Number: (_________)_________-___________
Relationship to Enrollee:

Office Use Only:			
Plan ID #:			
☐ ICEP / IEP	☐ AEP	☐ SEP (type):	☐ Not Eligible
Name of staff member/agent/broker (if assisted in enrollment):			
LC:		Referral ID:	
Subgroup ID #:		Subgroup Description:	
Class ID #:		Plan ID #:	
Plan Description:			

MAIL APPLICATIONS TO:
Blue Medicare RX℠
C/O Prescription Drug Plan (PDP) Forms
PO Box 3897
Scranton, PA 18505
FAX APPLICATIONS TO: (855) 297-4245

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.

Applicant LAST name:	FIRST name:

Illinois Municipal Retirement Fund (IMRF)

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."

Y0096_5715IMRFSB24_M

230743.0723

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 1-877-838-3833 (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 Illinois Municipal Retirement Fund (IMRF).

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 1-877-838-3833 (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)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $5
	Three-month supply: $15
Tier 2: Generic	**One-month supply:** $11
	Three-month supply: $33
Tier 3: Preferred Brand	**One-month supply:** $44
	Three-month supply: $132
Tier 4: Non-Preferred Drug	**One-month supply:** $95
	Three-month supply: $285
Tier 5: Specialty Tier	**One-month supply:** 33%
	Three-month supply: 33%

Initial Coverage Stage: Preferred Retail Pharmacy	
Preferred Retail	**Blue Cross Group MedicareRx (PDP)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $0
	Three-month supply: $0
Tier 2: Generic	**One-month supply:** $6
	Three-month supply: $18
Tier 3: Preferred Brand	**One-month supply:** $39
	Three-month supply: $117
Tier 4: Non-Preferred Drug	**One-month supply:** $85
	Three-month supply: $255
Tier 5: Specialty Tier	**One-month supply:** 33%
	Three-month supply: 33%

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:** $11
	Three-month supply: $33
Tier 3: Preferred Brand	**One-month supply:** $44
	Three-month supply: $132
Tier 4: Non-Preferred Drug	**One-month supply:** $95
	Three-month supply: $285
Tier 5: Specialty Tier	**One-month supply:** 33%
	Three-month supply: 33%

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:** $6
	Three-month supply: $18
Tier 3: Preferred Brand	**One-month supply:** $39
	Three-month supply: $117
Tier 4: Non-Preferred Drug	**One-month supply:** $85
	Three-month supply: $255
Tier 5: Specialty Tier	**One-month supply:** 33%
	Three-month supply: 33%

Initial Coverage Stage: Long-term Care and Out-of-network Pharmacies (one-month supply)	
	Blue Cross Group MedicareRx (PDP)℠
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)℠
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:** $11
	Three-month supply: $33
Tier 3: Preferred Brand	**One-month supply:** $44
	Three-month supply: $132
Tier 4: Non-Preferred Drug	**One-month supply:** $95
	Three-month supply: $285
Tier 5: Specialty Tier	**One-month supply:** 15%
	Three-month supply: 15%

Coverage Gap Stage: Preferred Retail Pharmacy	
Preferred Retail	**Blue Cross Group MedicareRx (PDP)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $0
	Three-month supply: $0
Tier 2: Generic	**One-month supply:** $6
	Three-month supply: $18
Tier 3: Preferred Brand	**One-month supply:** $39
	Three-month supply: $117
Tier 4: Non-Preferred Drug	**One-month supply:** $85
	Three-month supply: $255
Tier 5: Specialty Tier	**One-month supply:** 15%
	Three-month supply: 15%

Coverage Gap 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:** $11
	Three-month supply: $33
Tier 3: Preferred Brand	**One-month supply:** $44
	Three-month supply: $132
Tier 4: Non-Preferred Drug	**One-month supply:** $95
	Three-month supply: $285
Tier 5: Specialty Tier	**One-month supply:** 15% **Three-month supply:** 15%

Coverage Gap 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:** $6
	Three-month supply: $18
Tier 3: Preferred Brand	**One-month supply:** $39
	Three-month supply: $117
Tier 4: Non-Preferred Drug	**One-month supply:** $85
	Three-month supply: $255
Tier 5: Specialty Tier	**One-month supply:** 15%
	Three-month supply: 15%

	Blue Cross Group MedicareRx (PDP)℠
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.

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.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-299-1008** (TTY/TDD: **711**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-299-1008** (TTY/TDD: **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-299-1008** (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 **1-877-299-1008**（TTY/TDD：**711**）。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-299-1008** (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 **1-877-299-1008** (TTY/TDD: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-299-1008** (رقم هاتف الصم والبكم: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-299-1008** (телетайп: **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-299-1008** (TTY: **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-877-299-1008** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-299-1008** (TTY/TDD: **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-299-1008** (TTY/TDD: **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-299-1008** (TTY/TDD: **711**) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-299-1008** (ATS : **711**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-299-1008** (TTY: **711**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-299-1008** (TTY/TDD: **711**).

This information is not a complete description of benefits. Call 1-877-838-3833 (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.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2024 Medicare Star Ratings

Blue Cross Group MedicareRX (PDP) - S5715

For 2024, Blue Cross Group MedicareRX (PDP) - S5715 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	Service not offered
Drug Services Rating:	★★★½☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online
Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?
You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 877-583-8129 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. local time and alternate technologies (for example, voicemail) will be used on weekends and holidays. Current members please call 877-838-3833 (toll-free) or 711 (TTY).

Y0096_Group5715CentralPLANRTG24_M 105290.1023

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.

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/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.

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 **1-877-838-3833** (TTY/TDD: **711**). Someone who speaks English/Language 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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (TTY/TDD: **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: سيقوم شخص ما يتحدث العربية إإننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول **1-877-838-3833** (TTY/TDD: **711**). بمساعدتك. هذه خدمة مجانية على مترجم فوري، ليس عليك سوى الاتصال بنا على

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-877-838-3833** (TTY/TDD: **711**). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी 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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (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 **1-877-838-3833** (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、**1-877-838-3833** (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。

BlueCross BlueShield of Illinois

What happens after you enroll in Blue Cross Group MedicareRx (PDP)?

Medicare Approval

Medicare must approve your enrollment before you are officially a member. This generally takes about 10 business days.

Watch your mailbox for these items.

- **Acknowledgment Letter:** Within 10 days of getting your enrollment form, we will send an acknowledgment letter.
- **Confirmation Letter:** After your enrollment is approved by Medicare, we will send a confirmation letter. It can be used as proof of insurance if you have **not** received your member ID card by your effective date.
- **Member ID Card:** Your member ID card will be mailed next. Show your new card at the pharmacy so you are giving the right information.
- **Welcome Guide:** This helpful kit includes plan documents and other useful information.

If you have any questions about your plan, please call the customer service number listed on your acknowledgment or confirmation letter or the back of your member ID card.

Prescription drug plans provided by Blue Cross and Blue Shield of Illinois, which refers to 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.

Y0096_GRPPDPIDINSa_C

105376.0422