



BlueCross BlueShield  
of Illinois

# City of Chicago

## Summary of Benefits

Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup>

**January 1, 2023 – December 31, 2023**

# Blue Cross Group Medicare Advantage Open Access (PPO)

**Blue Cross Group Medicare Advantage Open Access (PPO), Blue Cross Group Medicare Advantage Open Access (PPO), and Blue Cross Group Medicare Advantage Open Access (PPO)** are a Medicare Advantage PPO plan 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 1-866-390-4276 (TTY 711) and request the “Evidence of Coverage” or access it online at [www.bcbsil.com/retiree-medicare-tools](http://www.bcbsil.com/retiree-medicare-tools).

To join Blue Cross Group Medicare Advantage Open Access (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and be a retiree, or Medicare-eligible dependent of a retiree, of City of Chicago.

Our service area includes anywhere in the United States.

For coverage and costs of Original Medicare, look in your current **“Medicare & You”** handbook. View it online at [www.medicare.gov](http://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 1-866-390-4276 (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](http://www.bcbsil.com/retiree-medicare-tools).

## Understanding the Benefits

**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](http://www.bcbsil.com/retiree-medicare-tools).

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

Premiums and Benefits	Blue Cross Group Medicare Advantage Open Access (PPO) <sup>SM</sup> Premium Plan	Blue Cross Group Medicare Advantage Open Access (PPO) <sup>SM</sup> Value Plus Plan	Blue Cross Group Medicare Advantage Open Access (PPO) <sup>SM</sup> Value Plan
Monthly Plan Premium <i>(includes both medical and drugs)</i>	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	This plan does not have a deductible for medical services.	Your deductible is \$250 for in-network and out-of-network medical services with a coinsurance.	Your deductible is \$625 for in-network and out-of-network medical services with a coinsurance.
Maximum Out-of-Pocket Responsibility <i>(does not include Part D prescription drugs)</i>	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> <li>• \$1,000 for services you receive from in-network providers.</li> <li>• \$1,000 for services you receive from out-of-network providers.</li> </ul>	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> <li>• \$2,000 for services you receive from in-network providers.</li> <li>• \$2,000 for services you receive from out-of-network providers.</li> </ul>	Your yearly limit(s) in this plan: <ul style="list-style-type: none"> <li>• \$5,000 for services you receive from in-network providers.</li> <li>• \$5,000 for services you receive from out-of-network providers.</li> </ul>
Inpatient Hospital Care*	Our plan covers an unlimited number of days for an inpatient hospital stay. <b>In-network:</b> \$0 copay per stay <b>Out-of-network:</b> \$0 copay per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. <b>In-network:</b> \$0 copay per stay <b>Out-of-network:</b> \$0 copay per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. <b>In-network:</b> \$250 copay per day for days 1-7 <b>Out-of-network:</b> \$250 copay per day for days 1-7

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Outpatient Hospital*	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p>	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p>	<p><b><u>In-network:</u></b> 20% of the total cost</p> <p><b><u>Out-of-network:</u></b> 20% of the total cost</p>
Ambulatory Surgical Center (ASC)*	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p>	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p>	<p><b><u>In-network:</u></b> 20% of the total cost</p> <p><b><u>Out-of-network:</u></b> 20% of the total cost</p>
<p>Doctor Visits*</p> <ul style="list-style-type: none"> <li>• Primary care provider</li> <li>• Specialists</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$20 copay</li> <li>• <b><u>Out-of-network:</u></b> \$20 copay</li> <li>• <b><u>In-network:</u></b> \$30 copay</li> <li>• <b><u>Out-of-network:</u></b> \$30 copay</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$25 copay</li> <li>• <b><u>Out-of-network:</u></b> \$25 copay</li> <li>• <b><u>In-network:</u></b> \$30 copay</li> <li>• <b><u>Out-of-network:</u></b> \$30 copay</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$25 copay</li> <li>• <b><u>Out-of-network:</u></b> \$25 copay</li> <li>• <b><u>In-network:</u></b> \$50 copay</li> <li>• <b><u>Out-of-network:</u></b> \$50 copay</li> </ul>

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Preventive Care* (e.g., flu vaccine, diabetic screenings)	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p> <p><b>Important Message About What You Pay for Vaccines</b> Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.</p> <p>*Other preventive services are available. There are some covered services that may have a cost.</p>	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p> <p><b>Important Message About What You Pay for Vaccines</b> Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.</p> <p>*Other preventive services are available. There are some covered services that may have a cost.</p>	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p> <p><b>Important Message About What You Pay for Vaccines</b> Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.</p> <p>*Other preventive services are available. There are some covered services that may have a cost.</p>
Emergency Care	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p> <p>Cost share waived if admitted within 3 days for the same condition.</p>	<p><b><u>In-network:</u></b> \$50 copay</p> <p><b><u>Out-of-network:</u></b> \$50 copay</p> <p>Cost share waived if admitted within 3 days for the same condition.</p>	<p><b><u>In-network:</u></b> 20% of the total cost (Max of \$90)</p> <p><b><u>Out-of-network:</u></b> 20% of the total cost (Max of \$90)</p> <p>Cost share waived if admitted within 3 days for the same condition.</p>
Urgently Needed Services	<p><b><u>In-network:</u></b> \$0 copay</p> <p><b><u>Out-of-network:</u></b> \$0 copay</p>	<p><b><u>In-network:</u></b> 20% of the total cost (Max of \$65)</p> <p><b><u>Out-of-network:</u></b> 20% of the total cost (Max of \$65)</p>	<p><b><u>In-network:</u></b> 20% of the total cost (Max of \$65)</p> <p><b><u>Out-of-network:</u></b> 20% of the total cost (Max of \$65)</p>

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Diagnostic Tests, Lab and Radiology Services, and X-Rays* <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Lab services</li> <li>• MRI, CAT Scan</li> <li>• X-Rays</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay <b><u>Out-of-network:</u></b> \$0 copay</li> <li>• <b><u>In-network:</u></b> \$0 copay <b><u>Out-of-network:</u></b> \$0 copay</li> <li>• <b><u>In-network:</u></b> \$0 copay <b><u>Out-of-network:</u></b> \$0 copay</li> <li>• <b><u>In-network:</u></b> \$0 copay <b><u>Out-of-network:</u></b> \$0 copay</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay <b><u>Out-of-network:</u></b> \$0 copay</li> <li>• <b><u>In-network:</u></b> \$0 copay <b><u>Out-of-network:</u></b> \$0 copay</li> <li>• <b><u>In-network:</u></b> 20% of the total cost <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• <b><u>In-network:</u></b> 20% of the total cost <b><u>Out-of-network:</u></b> 20% of the total cost</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• <b><u>In-network:</u></b> 20% of the total cost <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• <b><u>In-network:</u></b> 20% of the total cost <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• <b><u>In-network:</u></b> 20% of the total cost <b><u>Out-of-network:</u></b> 20% of the total cost</li> </ul>

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Hearing Services* <ul style="list-style-type: none"> <li>• Medicare covered hearing exam</li> <li>• Hearing aid</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay</li> <li>• <b><u>Out-of-network:</u></b> \$0 copay</li> <li>• Not Covered</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• Not Covered</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• Not Covered</li> </ul>
Dental Services* <ul style="list-style-type: none"> <li>• Medicare covered dental</li> <li>• Preventive Dental</li> <li>• Supplemental Dental Services</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay</li> <li>• <b><u>Out-of-network:</u></b> \$0 copay</li> <li>• Not Covered</li> <li>• Not Covered</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• Not Covered</li> <li>• Not Covered</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• Not Covered</li> <li>• Not Covered</li> </ul>
Vision Services* <ul style="list-style-type: none"> <li>• Medicare covered vision exam</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay</li> <li>• <b><u>Out-of-network:</u></b> \$0 copay</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> </ul>

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<ul style="list-style-type: none"> <li>• Medicare covered eyewear</li> <li>• Routine vision exam</li> <li>• Routine eyewear</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery</li> <li>• <b><u>Out-of-network:</u></b> \$0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery</li> <li>• Not Covered</li> <li>• Not Covered</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery</li> <li>• Not Covered</li> <li>• Not Covered</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery</li> <li>• Not Covered</li> <li>• Not Covered</li> </ul>
<p>Mental Health Care*</p> <ul style="list-style-type: none"> <li>• Inpatient mental health</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay per stay</li> <li>• <b><u>Out-of-network:</u></b> \$0 copay per stay</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay per stay</li> <li>• <b><u>Out-of-network:</u></b> \$0 copay per stay</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$250 copay per day for days 1-6 and \$0 copay per day for days 7+</li> <li>• <b><u>Out-of-network:</u></b> \$250 copay per day for days 1-6 and \$0 copay per day for days 7+</li> </ul>



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<ul style="list-style-type: none"> <li>Outpatient group therapy/ individual therapy visit</li> </ul>	<p><b>Individual</b></p> <ul style="list-style-type: none"> <li><b>In-network:</b> \$0 copay</li> <li><b>Out-of-network:</b> \$0 copay</li> </ul> <p><b>Group</b></p> <ul style="list-style-type: none"> <li><b>In-network:</b> \$0 copay</li> <li><b>Out-of-network:</b> \$0 copay</li> </ul>	<p><b>Individual</b></p> <ul style="list-style-type: none"> <li><b>In-network:</b> 20% of the total cost</li> <li><b>Out-of-network:</b> 20% of the total cost</li> </ul> <p><b>Group</b></p> <ul style="list-style-type: none"> <li><b>In-network:</b> 20% of the total cost</li> <li><b>Out-of-network:</b> 20% of the total cost</li> </ul>	<p><b>Individual</b></p> <ul style="list-style-type: none"> <li><b>In-network:</b> 20% of the total cost</li> <li><b>Out-of-network:</b> 20% of the total cost</li> </ul> <p><b>Group</b></p> <ul style="list-style-type: none"> <li><b>In-network:</b> 20% of the total cost</li> <li><b>Out-of-network:</b> 20% of the total cost</li> </ul>
Skilled Nursing Facility (SNF)*	<p><b>In-network:</b> \$0 copay per day for days 1-20. \$0 copay per day for days 21-100.</p> <p><b>Out-of-network:</b> \$0 copay per day for days 1-20. \$0 copay per day for days 21-100.</p>	<p><b>In-network:</b> \$0 copay per day for days 1-20. \$178 copay per day for days 21-100.</p> <p><b>Out-of-network:</b> \$0 copay per day for days 1-20. \$178 copay per day for days 21-100.</p>	<p><b>In-network:</b> \$0 copay per day for days 1-20. \$164.50 copay per day for days 21-100.</p> <p><b>Out-of-network:</b> \$0 copay per day for days 1-20. \$164.50 copay per day for days 21-100.</p>
<p>Outpatient Rehabilitation*</p> <ul style="list-style-type: none"> <li>Physical therapy and speech and language therapy visit</li> </ul>	<p><b>In-network:</b> \$0 copay</p> <p><b>Out-of-network:</b> \$0 copay</p>	<p><b>In-network:</b> 20% of the total cost</p> <p><b>Out-of-network:</b> 20% of the total cost</p>	<p><b>In-network:</b> 20% of the total cost</p> <p><b>Out-of-network:</b> 20% of the total cost</p>

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Ambulance* <ul style="list-style-type: none"> <li>• Ground services</li> <li>• Air services</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> \$0 copay for each one-way trip</li> <li>• <b><u>Out-of-network:</u></b> \$0 copay for each one-way trip</li> <li>• <b><u>In-network:</u></b> \$0 copay for each one-way trip</li> <li>• <b><u>Out-of-network:</u></b> \$0 copay for each one-way trip</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost for each one-way trip</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost for each one-way trip</li> <li>• <b><u>In-network:</u></b> 20% of the total cost for each one-way trip</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost for each one-way trip</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost for each one-way trip</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost for each one-way trip</li> <li>• <b><u>In-network:</u></b> 20% of the total cost for each one-way trip</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost for each one-way trip</li> </ul>
Transportation*	Not Covered	Not Covered	Not Covered
Medicare Part B Drugs* <ul style="list-style-type: none"> <li>• Chemotherapy drugs</li> <li>• Other Part B drugs</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 0% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 0% of the total cost</li> <li>• <b><u>In-network:</u></b> 0% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 0% of the total cost</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> </ul>	<ul style="list-style-type: none"> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> <li>• <b><u>In-network:</u></b> 20% of the total cost</li> <li>• <b><u>Out-of-network:</u></b> 20% of the total cost</li> </ul>

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<b>PRESCRIPTION DRUG BENEFITS</b>			
Stage 1: Part D Deductible	\$100 per year for Part D prescription drugs	\$200 per year for Part D prescription drugs	\$400 per year for Part D prescription drugs
Stage 2: Initial Coverage	<p>You pay the following (see table(s) below) until your total yearly drug costs reach \$4,660.</p> <p>Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>	<p>You pay the following (see table(s) below) until your total yearly drug costs reach \$4,660.</p> <p>Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>	<p>You pay the following (see table(s) below) until your total yearly drug costs reach \$4,660.</p> <p>Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p>

## Cost Shares During the Initial Coverage Stage

Initial Coverage Stage: Standard Retail Pharmacy			
Standard Retail	Blue Cross Group Medicare Advantage Open Access (PPO) <sup>SM</sup> Premium Plan	Blue Cross Group Medicare Advantage Open Access (PPO) <sup>SM</sup> Value Plus Plan	Blue Cross Group Medicare Advantage Open Access (PPO) <sup>SM</sup> Value Plan
Tier 1: Preferred Generic	One-month supply: 20%	One-month supply: 20%	One-month supply: 25%
	Three-month supply: 20%	Three-month supply: 20%	Three-month supply: 25%
Tier 2: Generic	One-month supply: 20%	One-month supply: 20%	One-month supply: 25%
	Three-month supply: 20%	Three-month supply: 20%	Three-month supply: 25%
Tier 3: Preferred Brand	One-month supply: 20%	One-month supply: 20%	One-month supply: 25%
	Three-month supply: 20%	Three-month supply: 20%	Three-month supply: 25%
Tier 4: Non-Preferred Drug	One-month supply: 20%	One-month supply: 20%	One-month supply: 25%
	Three-month supply: 20%	Three-month supply: 20%	Three-month supply: 25%
Tier 5: Specialty Tier	One-month supply: 20%	One-month supply: 20%	One-month supply: 25%
	Three-month supply: 20%	Three-month supply: 20%	Three-month supply: 20%

<b>Initial Coverage Stage: Standard Mail Order Pharmacy</b>			
<b>Standard Mail Order</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Premium Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plus Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plan</b>
<b>Tier 1: Preferred Generic</b>	<b>One-month supply: \$10</b>	<b>One-month supply: \$10</b>	<b>One-month supply: \$10</b>
	<b>Three-month supply: \$30</b>	<b>Three-month supply: \$30</b>	<b>Three-month supply: \$30</b>
<b>Tier 2: Generic</b>	<b>One-month supply: \$10</b>	<b>One-month supply: \$10</b>	<b>One-month supply: \$10</b>
	<b>Three-month supply: \$30</b>	<b>Three-month supply: \$30</b>	<b>Three-month supply: \$30</b>
<b>Tier 3: Preferred Brand</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 25%</b>
<b>Tier 4: Non-Preferred Drug</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 25%</b>
<b>Tier 5: Specialty Tier</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>

	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Premium Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plus Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plan</b>
<b>Stage 3: Coverage Gap</b>	<p>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 \$4,660.</p> <p>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 \$7,400.</p>		

<b>Coverage Gap Stage: Standard Retail Pharmacy</b>			
<b>Standard Retail</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Premium Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plus Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plan</b>
<b>Tier 1: Preferred Generic</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 25%</b>
<b>Tier 2: Generic</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 25%</b>
<b>Tier 3: Preferred Brand</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 25%</b>
<b>Tier 4: Non-Preferred Drug</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 25%</b>
<b>Tier 5: Specialty Tier</b>	<b>One-month supply: 15%</b>	<b>One-month supply: 15%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 15%</b>	<b>Three-month supply: 15%</b>	<b>Three-month supply: 15%</b>

<b>Coverage Gap Stage: Standard Mail Order Pharmacy</b>			
<b>Standard Mail Order</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Premium Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plus Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plan</b>
<b>Tier 1: Preferred Generic</b>	<b>One-month supply: \$10</b>	<b>One-month supply: \$10</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: \$30</b>	<b>Three-month supply: \$30</b>	<b>Three-month supply: 25%</b>
<b>Tier 2: Generic</b>	<b>One-month supply: \$10</b>	<b>One-month supply: \$10</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: \$30</b>	<b>Three-month supply: \$30</b>	<b>Three-month supply: 25%</b>
<b>Tier 3: Preferred Brand</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 25%</b>
<b>Tier 4: Non-Preferred Drug</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 20%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 20%</b>	<b>Three-month supply: 20%</b>	<b>Three-month supply: 25%</b>
<b>Tier 5: Specialty Tier</b>	<b>One-month supply: 15%</b>	<b>One-month supply: 15%</b>	<b>One-month supply: 25%</b>
	<b>Three-month supply: 15%</b>	<b>Three-month supply: 15%</b>	<b>Three-month supply: 15%</b>

	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Premium Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plus Plan</b>	<b>Blue Cross Group Medicare Advantage Open Access (PPO)<sup>SM</sup> Value Plan</b>
Stage 4: Catastrophic Coverage	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach \$7,400, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% of the total cost, or</li> <li>• \$4.15 copay for generic (including brand drugs treated as generic) and a \$10.35 copayment for all other drugs</li> </ul>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach \$7,400, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% of the total cost, or</li> <li>• \$4.15 copay for generic (including brand drugs treated as generic) and a \$10.35 copayment for all other drugs</li> </ul>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach \$7,400, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% of the total cost, or</li> <li>• \$4.15 copay for generic (including brand drugs treated as generic) and a \$10.35 copayment for all other drugs</li> </ul>







**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 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., 35<sup>th</sup> 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 1-877-299-1008 (TTY/TDD: 711). Someone who speaks English/Language can help you. This is a free service.

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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 1-877-299-1008 (TTY/TDD: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

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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 1-877-299-1008 (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。

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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 1-877-299-1008 (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。

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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 1-877-299-1008 (TTY/TDD: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

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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 1-877-299-1008 (TTY/TDD: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

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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 quý vị cần thông dịch viên xin gọi 1-877-299-1008 (TTY/TDD: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

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German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-299-1008 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-299-1008 (TTY/TDD: 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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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 1-877-299-1008 (TTY/TDD: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

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Arabic: سيقوم شخص ما يتحدث العربية إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول (TTY/ 1-877-299-1008 TDD: 711). بمساعدتك. هذه خدمة مجانية على مترجم فوري، ليس عليك سوى الاتصال بنا على

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Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषयिणी सेवाएँ उपलब्ध हैं. एक दुभाषयिणी प्राप्त करने के लिए, बस हमें 1-877-299-1008 (TTY/TDD: 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

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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 1-877-299-1008 (TTY/TDD: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

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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 1-877-299-1008 (TTY/TDD: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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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 1-877-299-1008 (TTY/TDD: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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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 1-877-299-1008 (TTY/TDD: 711). Ta usługa jest bezpłatna.

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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。通訳をご利用になるには、1-877-299-1008 (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。

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**BlueCross BlueShield  
of Illinois**

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare 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 1-866-390-4276 (TTY: 711) for more information.

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.