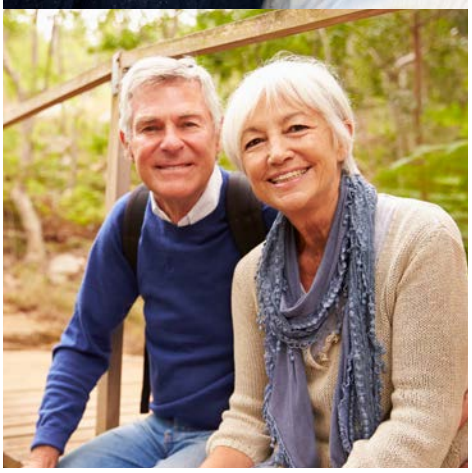
2019



Summary of Benefits

BlueRx℠

A Medicare Approved Part D Plan

ESSENTIAL

ENHANCED

ENHANCED PLUS

January 1, 2019 - December 31, 2019

S1030_SB19_M Accepted

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and 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 and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have 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 in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance 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, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-630-6823 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-630-6823 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果┌使用繁體中文，┌可以免費獲得語言援助服務。請致電1-855-630-6823（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-630-6823 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-630-6823 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-630-6823 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-630-6823 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-630-6823 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-630-6823 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-630-6823 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-630-6823 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-630-6823 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-630-6823 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-630-6823 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-630-6823 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-630-6823 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-630-6823 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-630-6823（TTY: 711）まで、お電話にてご連絡ください。

2019 Summary of Benefits

BlueRx℠
A Medicare Approved Part D Plan

BlueRx (PDP)

This is a summary of drug services covered by **BlueRx (PDP)**.

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."

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.

This document is available in other formats such as Braille, large print or audio. This document may be available in a non-English language. For additional information, call us at **1-800-327-3998 (AL)/ 1-888-311-7508 (TN).**

How to Contact BlueRx (PDP)

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Central Time.
- From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Central Time. From April 1 to September 30, on weekends and holidays you may be required to leave a message. Calls will be returned the next business day.

BlueRx (PDP) Phone Numbers and Website

- If you are a member of this plan, call toll-free **1-800-327-3998 (AL)/1-888-311-7508 (TN).** TTY users should call **711.**
- If you are not a member of this plan, call toll free **1-877-233-3555 (AL)/1-855-617-6760 (TN)** TTY users call **711**.
- Our website: **www.bluerxalatenn.com**

Who can join?

To join **BlueRx (PDP)**, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area. Our service area includes the following states: Alabama, Tennessee.

Which drugs are covered?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website **(www.bluerxalatenn.com)**.

Which pharmacies can I use?

You can see our plan's pharmacy directory at our website **(www.bluerxalatenn.com)**.

- **BlueRx (PDP)** is a Medicare-approved Part D plan. Enrollment in **BlueRx (PDP)** depends on CMS contract renewal.
- This information is not a complete description of benefits. Call **1-800-327-3998 (AL) / 1-888-311-7508 (TN) / TTY: 711** for more information.
- Limitations, co-payments, and restrictions may apply.
- Benefits, premiums, deductibles and co-payments/co-insurance may change on January 1 of each year.
- You must continue to pay your Medicare Part B premium.
- The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

	BlueRx Essential (PDP)	BlueRx Enhanced (PDP)	BlueRx Enhanched Plus (PDP)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
Monthly Plan Premium	$34.40 per month.	$71.50 per month.	$119.90 per month.
	In addition, you must continue to pay your Medicare Part B premium.		
Deductible	$415 per year for Part D prescription drugs.	$350 per year for Part D prescription drugs.	This plan does not have a deductible.
Prescription Drug Benefits			
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach $3,820. 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		

Standard Retail Cost-Sharing

	BlueRx Essential (PDP)		BlueRx Enhanced (PDP)		BlueRx Enhanced Plus (PDP)	
Tier	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$1 copay	$3 copay	$8 copay	$24 copay	$9 copay	$27 copay
Tier 2 (Generic)	$4 copay	$12 copay	$11 copay	$33 copay	$15 copay	$45 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay	$47 copay	$141 copay	$47 copay	$141 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	50% of the cost	(Tier 4 Non-Preferred Brand for Enhanced Plus) 50% of the cost	50% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	25% of the cost	33% of the cost	33% of the cost

Mail Order and Preferred Retail Cost-Sharing

Tier	BlueRx Essential (PDP)*		BlueRx Enhanced (PDP)		BlueRx Enhanced Plus (PDP)	
	One-month supply	**Three-month supply**	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$1 copay	$2 copay	$1 copay	$2 copay	$2 copay	$4 copay
Tier 2 (Generic)	$4 copay	$8 copay	$4 copay	$8 copay	$8 copay	$16 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$40 copay	$80 copay	$40 copay	$80 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	45% of the cost	45% of the cost	(Tier 4 Non-Preferred Brand for Enhanced Plus) 45% of the cost	45% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	25% of the cost	33% of the cost	33% of the cost
	***Note:** BlueRx Essential does not have Preferred Retail Cost-Sharing.					

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. Cost-sharing may differ relative to the pharmacy's status as preferred or non-preferred, mail-order, Long Term Care (LTC) or home infusion, and 30-day or 90-day supply. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of:

- 5% of the cost, or
- $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.

BlueRx (PDP) is a Medicare-approved Part D plan.
Enrollment in BlueRx (PDP) depends on CMS contract renewal.

BlueRx℠

A Medicare Approved Part D Plan

BlueRx (PDP) is provided by Blue Cross and Blue Shield of Alabama and
UTIC Insurance Company, independent licensees of the Blue Cross and Blue Shield Association.