BlueRx℠
A Medicare Approved Part D Plan

2024
SUMMARY OF BENEFITS

- Essential
- Enhanced
- Enhanced Plus

January 1, 2024 - December 31, 2024

S1030_SB24_M 09/20/2023

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2024 Summary of Benefits

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. If you would like an Evidence of Coverage, you may call **1-800-327-3998 (AL)/1-888-311-7508 (TN) (TTY: 711)**, email **bcbsalmedicare@bcbsal.org** or view the information at **www.bluerxalatenn.com**.

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)(TTY: 711)**.

How to Contact BlueRx (PDP)

Hours of Operation

- Monday - Friday, 8 a.m. - 8 p.m. CST. From October 1 to March 31, the hours of operation are Monday - Sunday, 8 a.m. - 8 p.m. CST. You may be required to leave a message for calls made after hours, weekends and holidays. 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 should 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 **BCBSALMedicare.com/FindMyPharmacy.**

- This information is not a complete description of benefits. Call **1-800-327-3998 (AL)/ 1-888-311-7508 (TN).** TTY users should call **711**.
- Limitations, copayments, and restrictions may apply.
- Benefits, premiums, deductibles and copayments/coinsurance 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.

PREMIUM & BENEFITS | **BlueRx Essential** (PDP)

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Prescriptions

Monthly Plan Premium	$**72** per month
Deductible	Your yearly deductible for Part D prescription drugs is $**545**.

PRESCRIPTION DRUG BENEFITS

Initial Coverage
After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $**5,030**. 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 our home delivery pharmacy.

Retail & Home Delivery Pharmacy Cost-Sharing

	1–Month Supply*	3–Month Supply	Home Delivery 3-Month Supply
Tier 1 Preferred Generic	$**0** copay	$**0** copay	$**0** copay
Tier 2 Generic	$**14** copay	$**42** copay	$**28** copay
Tier 3 Preferred Brand	$**47** copay	$**141** copay	$**94** copay
Tier 4 Non-Preferred Drug	**46%** coinsurance	**46%** coinsurance	**46%** coinsurance
Tier 5 Specialty	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance
Insulins**	$**35** copay	$**105** copay	$**70** copay

Retail Cost-Sharing and Home Delivery for 1-month supply will have the same copays and coinsurance.

** You won't pay more than $**35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

BlueRx Essential: Over 1000 pharmacies, including **CVS, Walgreens, Walmart, Publix and many local independent pharmacies.** The network pharmacies listed may change at any time. BlueRx members will receive notice when necessary. **BlueRx Essential 90-day savings can only be obtained through the Home Delivery Pharmacy Service by mail.**

For additional information about other pharmacies in our network, please contact Member Services at **1-800-327-3998 (AL) /1-888-311-7508 (TN) (TTY: 711)**. For more information about our **Home Delivery Pharmacy Services**, please call AllianceRx Walgreens Pharmacy at **1-800-731-3588**, Amazon Pharmacy at **1-855-793-5326**, Express Scripts® Pharmacy at **1-833-715-0967** or Kroger PPS at **1-800-552-6694**.

PREMIUM & BENEFITS **BlueRx Enhanced** (PDP)

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Prescriptions

Monthly Plan Premium	$**119.50** per month
Deductible	Your yearly deductible for Part D prescription drugs is $**545**.

PRESCRIPTION DRUG BENEFITS

Initial Coverage
After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $**5,030**. 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 our home delivery pharmacy.

Preferred Retail & Preferred Home Delivery Pharmacy Cost-Sharing

	1–Month Supply	3–Month Supply
Tier 1 Preferred Generic	$**2** copay	$**4** copay
Tier 2 Generic	$**8** copay	$**16** copay
Tier 3 Preferred Brand	$**40** copay	$**80** copay
Tier 4 Non-Preferred Drug	**29%** coinsurance	**29%** coinsurance
Tier 5 Specialty	**25%** coinsurance	**25%** coinsurance
Insulins**	$**35** copay	$**70** copay

PREMIUM & BENEFITS **BlueRx Enhanced Plus** (PDP)

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Prescriptions

Monthly Plan Premium	$**153.70** per month
Deductible	Your yearly deductible for Part D prescription drugs is $**0**.

PRESCRIPTION DRUG BENEFITS

Initial Coverage
You pay the following until your total yearly drug costs reach $**5,030**. 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 our home delivery pharmacy.

Preferred Retail & Preferred Home Delivery Pharmacy Cost-Sharing

	1–Month Supply	3–Month Supply
Tier 1 Preferred Generic	$**2** copay	$**4** copay
Tier 2 Generic	$**10** copay	$**20** copay
Tier 3 Preferred Brand	$**40** copay	$**80** copay
Tier 4 Non-Preferred Drug	**29%** coinsurance	**29%** coinsurance
Tier 5 Specialty	**33%** coinsurance	**33%** coinsurance
Insulins**	$**35** copay	$**70** copay

BlueRx Enhanced and Enhanced Plus: Over 1,200 pharmacies including our preferred pharmacies: **Walgreens, Walmart, Publix, Winn Dixie, Kroger, Costco, Sam's Club and many local independent pharmacies.**
The network pharmacies listed may change at any time. BlueRx members will receive notice when necessary. (Higher cost-sharing may apply at our standard network pharmacies.)

Standard Retail Cost-Sharing

BlueRx Enhanced (PDP)

	1–Month Supply	3–Month Supply
Tier 1 Preferred Generic	$9 copay	$27 copay
Tier 2 Generic	$15 copay	$45 copay
Tier 3 Preferred Brand	$47 copay	$141 copay
Tier 4 Non-Preferred Drug	**34%** coinsurance	**34%** coinsurance
Tier 5 Specialty	**25%** coinsurance	**25%** coinsurance
Insulins**	$35 copay	$105 copay

BlueRx Enhanced Plus (PDP)

	1–Month Supply	3–Month Supply
Tier 1 Preferred Generic	$9 copay	$27 copay
Tier 2 Generic	$17 copay	$51 copay
Tier 3 Preferred Brand	$47 copay	$141 copay
Tier 4 Non-Preferred Drug	**34%** coinsurance	**34%** coinsurance
Tier 5 Specialty	**33%** coinsurance	**33%** coinsurance
Insulins**	$35 copay	$105 copay

** You won't pay more than $**35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

NOTE: Save money on prescriptions with a 90-day supply for the cost of a 60-day supply from any Preferred Pharmacy and our Preferred Home Delivery Pharmacy Service for drugs on Tiers 1, 2 & 3 with BlueRx Enhanced and BlueRx Enhanced Plus plans.

For additional information about other pharmacies in our network, please contact Member Services at **1-800-327-3998 (AL) /1-888-311-7508 (TN) (TTY:711)**. For more information about our **Preferred Home Delivery Pharmacy Services**, please call AllianceRx Walgreens Pharmacy at **1-800-731-3588**, Amazon Pharmacy at **1-855-793-5326**, Express Scripts® Pharmacy at **1-833-715-0967** or Kroger PPS at **1-800-552-6694**.

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, home delivery pharmacy service, 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 $**5,030**. During this stage, you pay **25%** of the price for brand name drugs (plus a portion of the dispensing fee) and **25%** of the price for generic drugs.

You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $**8,000**. This amount and rules for counting costs toward this amount have been set by Medicare.

Insulins will continue to have a $**35** copay (for 1-month supply) during the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your out-of-pocket drug costs (including drugs purchased through your retail pharmacy and/or through home delivery pharmacy service) reach $**8,000**, you pay $**0** for the rest of the calendar year.

Important Words to Know

Brand Name Drug
A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredients as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage
The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $**8,000** for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Coinsurance
An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles. Coinsurance is a percentage (for example, 20%).

Copayment (or "copay")
An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage (for example, $10).

Cost-Sharing
Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier
Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Covered Drugs
The term we use to mean all of the prescription drugs covered by our plan.

Coverage Gap ("donut hole")
During this stage, you pay **25%** of the price for brand name drugs (plus a portion of the dispensing fee) and **25%** of the price for generic drugs. You stay in this stage until your year-to-date "**out-of-pocket costs**" (your payments) reach a total of $**8,000**. This amount and rules for counting costs toward this amount have been set by Medicare.

Deductible
The amount you must spend on drugs before your plan pays insurance benefits (this may vary based upon the type of plan).

Important Words to Know

Generic Drug
A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Initial Coverage Stage
This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached **$5,030**.

List of Covered Drugs (Formulary or "Drug List")
A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Network Pharmacy
A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare)
Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy
A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in the Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Preferred Cost-sharing
Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs when filled at a preferred network pharmacy. For BlueRx Essential, preferred cost-sharing can only be obtained through the Home Delivery Pharmacy Service by mail.

Premium
The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Standard Cost-sharing
Standard cost-sharing is offered for certain covered Part D drugs when filled at a standard network pharmacy. A member's copay or coinsurance may be higher at a standard pharmacy compared to purchasing the same drug from a preferred pharmacy.

Form Approved
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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, 1-855-630-6823 (TTY: 711), 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.

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 1-855-216-3144 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Form CMS-10802
(Expires 12/31/25)

MKT225-2308

Form Approved
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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 quí vị cần thông dịch viên xin gọi 1-855-216-3144 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-216-3144 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 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 1-855-216-3144 (TTY: 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、1-855-216-3144 (TTY: 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。

BlueRx[SM]
A Medicare Approved Part D Plan

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to Member Services at **1-800-327-3998 (AL) / 1-888-311-7508 (TN) or, for TTY users, 711, Monday - Friday, 8 a.m. - 8 p.m. Central Time. From October 1 to March 31, the hours of operation are Monday - Sunday, 8 a.m. - 8 p.m. Central Time.** You may be required to leave a message for calls made after hours, weekends and holidays. Calls will be returned the next business day.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **www.bluerxalatenn.com** or call **1-800-327-3998 (AL) / 1-888-311-7508 (TN) or, for TTY users, 711,** for a copy of the EOC.

- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions. Visit **www.bluerxalatenn.com**, or call **1-800-327-3998 (AL) / 1-888-311-7508 (TN) or, for TTY users, 711**, for a copy of our Pharmacy Directory.

- ☐ Review the formulary to make sure your drugs are covered. Visit **www.bluerxalatenn.com**, or call **1-800-327-3998 (AL) / 1-888-311-7508 (TN) or, for TTY users, 711**, for a copy of our Drug Formulary.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2025.

- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

BlueRx is a PDP with a Medicare contract. Enrollment in **BlueRx (PDP)** depends on contract renewal.

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.

S1030_PRECL24_C

Notes

Notes

BlueRx is a PDP with a Medicare contract. Enrollment in BlueRx (PDP) depends on contract renewal.

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.

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