HIGHMARK

PENNSYLVANIA & WEST VIRGINIA

Blue Rx PDP

Summary of Benefits

January 1, 2024 to December 31, 2024

To enroll in the following plan(s), you need to be entitled to Medicare Part A and Medicare Part B and live in one of these counties:

All Pennsylvania and West Virginia counties

This summary of benefits doesn't list every service, limitation, or special circumstance.
Visit us at **medicare.highmark.com** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-800-290-3914** (TTY 711). We're available 8 a.m. to 8 p.m., 7 days a week.

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 **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

S5593_23_9524_M

	Blue Rx PDP Plus			Blue Rx PDP Complete		
Premium	$108.80			$195.10		
Deductible	$545			$0		
Formulary	Venture			Venture		
Initial Coverage	After you pay your yearly deductible (excludes insulins), 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 your Part D plan.			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 your Part D plan.		
Preferred Retail Cost-Sharing	Tier	31 Day Supply	90 Day Supply	Tier	31 Day Supply	90 Day Supply
	Tier 1 (Preferred Generic)	$0 Copay	$0 Copay*	Tier 1 (Preferred Generic)	$0 Copay	$0 Copay*
	Tier 2 (Generic)	$7 Copay	$21 Copay*	Tier 2 (Generic)	$5 Copay	$15 Copay*
	Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay	Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
	Tier 3 (Preferred Brand)	20% of the cost	20% of the cost	Tier 3 (Preferred Brand)	$40 Copay	$120 Copay
	Tier 4 (Insulin)	$35 Copay	$105 Copay	Tier 4 (Insulin)	$35 Copay	$105 Copay
	Tier 4 (Non-Preferred Drug)	40% of the cost	40% of the cost	Tier 4 (Non-Preferred Drug)	35% of the cost	35% of the cost
	Tier 5 (Specialty Tier)	25% of the cost	Not Applicable	Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Standard Retail Cost-Sharing	Tier	31 Day Supply	90 Day Supply	Tier	31 Day Supply	90 Day Supply
	Tier 1 (Preferred Generic)	$5 Copay	$15 Copay*	Tier 1 (Preferred Generic)	$4 Copay	$12 Copay*
	Tier 2 (Generic)	$12 Copay	$36 Copay*	Tier 2 (Generic)	$10 Copay	$30 Copay*
	Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay	Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
	Tier 3 (Preferred Brand)	25% of the cost	25% of the cost	Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
	Tier 4 (Insulin)	$35 Copay	$105 Copay	Tier 4 (Insulin)	$35 Copay	$105 Copay
	Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost
	Tier 5 (Specialty Tier)	25% of the cost	Not Applicable	Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Preferred Mail Cost-Sharing	Tier	31 Day Supply	90 Day Supply	Tier	31 Day Supply	90 Day Supply
	Tier 1 (Preferred Generic)	Not Applicable	$0 Copay*	Tier 1 (Preferred Generic)	Not Applicable	$0 Copay*
	Tier 2 (Generic)	Not Applicable	$17.50 Copay*	Tier 2 (Generic)	Not Applicable	$12.50 Copay*
	Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay	Tier 3 (Preferred Insulin)	Not Applicable	$100 Copay
	Tier 3 (Preferred Brand)	Not Applicable	20% Copay	Tier 3 (Preferred Brand)	Not Applicable	$100 Copay
	Tier 3 (Insulin)	Not Applicable	$105 Copay	Tier 3 (Insulin)	Not Applicable	$105 Copay
	Tier 4 (Non-Preferred Drug)	Not Applicable	40% Copay	Tier 4 (Non-Preferred Drug)	Not Applicable	35% Copay
	Tier 5 (Specialty Tier)	25% of the cost	Not Applicable	Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Standard Mail Cost-Sharing	Tier	31 Day Supply	90 Day Supply	Tier	31 Day Supply	90 Day Supply
	Tier 1 (Preferred Generic)	Not Applicable	$10 Copay*	Tier 1 (Preferred Generic)	Not Applicable	$10 Copay*
	Tier 2 (Generic)	Not Applicable	$30 Copay*	Tier 2 (Generic)	Not Applicable	$25 Copay*
	Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay	Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
	Tier 3 (Preferred Brand)	Not Applicable	25% of the cost	Tier 3 (Preferred Brand)	Not Applicable	$112.50 Copay
	Tier 4 (Insulin)	Not Applicable	$105 Copay	Tier 4 (Insulin)	Not Applicable	$105 Copay
	Tier 4 (Non-Preferred Drug)	Not Applicable	50% of the cost	Tier 4 (Non-Preferred Drug)	Not Applicable	50% of the cost
	Tier 5 (Specialty Tier)	25% of the cost	Not Applicable	Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

*Indicates a 100 day supply.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

	Blue Rx PDP Plus	Blue Rx PDP Complete
Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.
	Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)	**See Table on Next Page**
Catastrophic Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000, the plan pays the full cost for your covered drugs. You pay nothing.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000, the plan pays the full cost for your covered drugs. You pay nothing.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Blue Rx PDP Complete			
Coverage Gap	Preferred Network	Tier	
		Tier 1 (Preferred Generic)	10% of the cost
		Tier 2 (Generic)	10% of the cost
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount
	Standard Network	Tier	
		Tier 1 (Preferred Generic)	15% of the cost
		Tier 2 (Generic)	15% of the cost
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: (PA) Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. (WV) Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. The Blue Shield© and Shield Symbol are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

This information is not a complete description of benefits. Call 1-866-435-1047 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.