Prescription Blue℠ Group PDP

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

PDP Benefits Chart

Your prescription costs as a member of Trust VEBA Groups- High PDP – Option 4 Prescription Blue Group PDP plan

This *PDP Benefits Chart* is a part of the 2025 *Evidence of Coverage* (EOC), Chapter 4. It contains information about drug payment stages and your prescription drug costs. This is an important legal document. Please keep it in a safe place.

Note: Please read Chapter 4, *What you pay for your Part D prescription drugs*, in its entirety in the EOC. The contents below are only selected sections from that chapter.

This plan is effective January 1, 2025 - December 31, 2025.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for Prescription Blue Group PDP members?

There are three **drug payment stages** for your prescription drug coverage under Prescription Blue Group PDP. How much you pay depends on what stage you are in at the time you get a prescription filled or refilled. If your plan has a deductible, your deductible amount for prescription drugs can be found in the chart below. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage. Details of each stage are in sections 4 through 6 of this chapter.

The stages are:

Stage 1: Yearly Deductible Stage (if applicable)

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

Stage 1 Yearly Deductible Stage	Stage 2 Initial Coverage Stage	Stage 3 Catastrophic Coverage Stage
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach $2,000. (Details are in Section 5 below.)	During this stage, **the plan pays the full cost** of your drugs for the rest of the calendar year (through December 31, 2025). (Details are in Section 6 below.) 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 (if applicable).

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the *Part D EOB*)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1**. This is called *year-to-date* information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions**. This will include information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled**. This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
    - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of the *Evidence of Coverage*.
- **Send us information about the payments others have made for you**. Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count

toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you**. When you receive a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. Be sure to keep these reports.

SECTION 4 There is no deductible for Prescription Blue Group PDP

There is no deductible for Prescription Blue Group PDP. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has five cost-sharing tiers
Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost-share for the drug:

- Tier 1 - Preferred Generic: These are generic drugs in the lowest cost-sharing tier.
- Tier 2 - Generic: These are still generic drugs but not the lowest cost-sharing tier.
- Tier 3 - Preferred Brand: This tier contains mostly brand-name drugs and also includes some high-cost generics. You pay no more than $35 per month supply of each covered insulin product on this tier.
- Tier 4 - Non-Preferred Drug: These are brand-name and generic drugs not in a preferred tier. You pay no more than $35 per month supply of each covered insulin product on this tier.
- Tier 5 - Specialty Tier: This contains high-cost generic and brand-name drugs (the highest tier). You pay no more than $35 per month supply of each covered insulin product on this tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices
How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost sharing.
- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 of the *Evidence of Coverage* to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 of the *Evidence of Coverage* and the plan's *Pharmacy Directory* (or *Pharmacy Locator* for members outside Michigan). www.bcbsm.com/pharmaciesmedicare

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

Your formulary (drug list) is Medicare Plus Blue℠ Group PPO, Prescription Blue℠ Group PDP Enhanced Comprehensive Formulary.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail and standard mail-order cost sharing (in-network) (up to a 31-day supply)	Preferred retail and preferred mail-order cost sharing (in-network) (up to a 31-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$10	$2	$10	$10
Cost-Sharing Tier 2 (Generic)	$10	$2	$10	$10
Cost-Sharing Tier 3 (Preferred Brand)	$50	$40	$50	$50
Cost-Sharing Tier 4 (Non-Preferred Drug)	$100	$75	$100	$100
Cost-Sharing Tier 5 (Specialty Tier)	30%	30%	30%	30%

Note: Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please see your *List of Covered Drugs* (Formulary) to determine if your drugs are subject to any limitations.

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 any applicable deductible (if applicable).

Please see Chapter 4, Section 7 of the *Evidence of Coverage* for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to

prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the *daily cost-sharing rate*) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an *extended supply*). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

Sometimes the cost of the drug is lower than your cost share. In these cases, you pay the lower price for the drug instead of the cost-share amount, *whichever is lower*.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing (in-network) (32- to 90-day supply)	Preferred retail cost sharing (in-network) (32- to 90-day supply)	Standard mail-order cost sharing (in-network) (32- to 90-day supply)	Preferred mail-order cost sharing (in-network) (32- to 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$20	$4	$20	$4
Cost-Sharing Tier 2 (Generic)	$20	$4	$20	$4
Cost-Sharing Tier 3 (Preferred Brand)	$100	$80	$100	$80

Tier	Standard retail cost sharing (in-network) (32- to 90-day supply)	Preferred retail cost sharing (in-network) (32- to 90-day supply)	Standard mail-order cost sharing (in-network) (32- to 90-day supply)	Preferred mail-order cost sharing (in-network) (32- to 90-day supply)
Cost-Sharing Tier 4 (Non-Preferred Drug)	$200	$150	$200	$150
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5.			

Note: Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please see your *List of Covered Drugs* (Formulary) to determine if your drugs are subject to any limitations.

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible (if applicable).

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,000

You stay in the Initial Coverage Stage until your out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage. For plans with enhanced formularies, we offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count toward your total out-of-pocket costs.

The *Part D EOB* that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Chapter 4, Section 1.3 of the *Evidence of Coverage* on how Medicare calculates your out-of-pocket costs.

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.
- You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

This information is not a complete description of benefits. Call Prescription Blue Group PDP at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time for more information. From October 1 through March 31, hours are from 8 a.m. to 9 p.m., Eastern time, seven days a week. (TTY users should call 711.)