HIGHMARK

PENNSYLVANIA & WEST VIRGINIA

Blue Rx PDP

Summary of Benefits

January 1, 2023 to December 31, 2023

The service area for these plans includes the following counties:

All Pennsylvania and West Virginia counties

To enroll in the following plans, you need to be entitled to Medicare Part A and Medicare Part B, and live in our service area.

To contact us about Blue Rx PDP, call 1-866-435-1047 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

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PENNSYLVANIA & WEST VIRGINIA

This section is a summary of benefits. It doesn't list every service, limitation, or special circumstance. If you want the whole kit and caboodle — the full Evidence of Coverage — call the number on the plan page you're looking for.

How to Find a Pharmacy

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com**. Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

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.

	Blue Rx PDP Plus			Blue Rx PDP Complete		
Premium	$121.10			$192.60		
Deductible	$505			$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 $4,660. 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 $4,660. 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)	$6 Copay	$18 Copay	Tier 1 (Preferred Generic)	$4 Copay	$12 Copay
	Tier 2 (Generic)	$14 Copay	$42 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	$105 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	$18 Copay	Tier 1 (Preferred Generic)	Not Applicable	$12 Copay
	Tier 2 (Generic)	Not Applicable	$42 Copay	Tier 2 (Generic)	Not Applicable	$30 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	$135 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

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 $4,660. 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 $7,400, 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs.
	Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 for all others	Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 for all others

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 Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Highmark Health Insurance Company depends on contract renewal.

Health benefits or health benefit administration may be provided by or through Highmark Health Insurance Company. Highmark Blue Shield provides certain administrative communications for this company. Highmark Blue Shield and Highmark Health Insurance Company are independent licensees of the Blue Cross Blue Shield Association. 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.

This information is not a complete description of benefits. Call 1-866-435-1047 (TTY users may call 711) for more information.