BlueCross BlueShield of Illinois

DePaul University

Summary of Benefits

Blue Cross Group Medicare Advantage Open Access (PPO)[SM]

January 1 – December 31, 2024

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 Benefits Insert."

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Blue Cross Group Medicare Advantage Open Access (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-877-299-1008 (TTY 711) and request the "Evidence of Coverage" or access it online at www.bcbsil.com/retiree-medicare-tools.

To join Blue Cross Group Medicare Advantage Open Access (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and be a retiree, or Medicare-eligible dependent of a retiree, of DePaul University.

Our service area includes anywhere in the United States.

For 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), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-877-299-1008 (TTY users should call 711), 7 days a week, 8 a.m. to 8 p.m. or visit us at www.bcbsil.com/retiree-medicare-tools.

Understanding the Benefits

NOTE: Services with a * may require prior authorization or a referral from your doctor.

	Blue Cross Group Medicare Advantage Open Access (PPO)[SM]
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium? ***(includes both medical and drugs)***	For information concerning the actual premiums you will pay, please contact your employer or your employer group benefits plan administrator. In addition, you must keep paying your Medicare Part B premium.
Deductible	Your deductible is $200 for in-network and out-of-network medical services with a coinsurance.
Maximum Out-of-Pocket Responsibility ***(does not include Part D prescription drugs)***	Your yearly limit(s) in this plan: • $1,000 combined for services you receive from in-network and out of network providers.
Inpatient Hospital Care*	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network:** 4% of the total cost per stay **Out-of-network:** 4% of the total cost per stay
Outpatient Hospital*	**In-network:** 4% of the total cost **Out-of-network:** 4% of the total cost
Ambulatory Surgical Center (ASC)*	**In-network:** 4% of the total cost **Out-of-network:** 4% of the total cost
Doctor Visits* • **Primary care provider** • **Specialists**	• **In-network:** $20 copay • **Out-of-network:** $20 copay • **In-network:** $40 copay • **Out-of-network:** $40 copay

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Preventive Care* **(e.g., flu vaccine, diabetic screenings)**	**In-network:** $0 copay **Out-of-network:** $0 copay **Important Message About What You Pay for Vaccines** Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information. *Other preventive services are available. There are some covered services that may have a cost.
Emergency Care	**In-network:** $65 copay **Out-of-network:** $65 copay Cost share waived if admitted within 3 days for the same condition.
Urgently Needed Services	**In-network:** $40 copay **Out-of-network:** $40 copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays*	
• **Diagnostic tests and procedures**	• **In-network:** 4% of the total cost **Out-of-network:** 4% of the total cost
• **Lab services**	• **In-network:** 4% of the total cost **Out-of-network:** 4% of the total cost
• **MRI, CAT Scan**	• **In-network:** 4% of the total cost **Out-of-network:** 4% of the total cost
• **X-Rays**	• **In-network:** 4% of the total cost **Out-of-network:** 4% of the total cost
Hearing Services*	
• **Medicare covered hearing exam**	• **In-network:** $0 copay • **Out-of-network:** $0 copay

	Blue Cross Group Medicare Advantage Open Access (PPO)[SM]
• **Routine hearing exam** • **Hearing aid**	• **In-network:** $15 copay for 1 routine hearing exam each year • **Out-of-network:** $15 copay for 1 routine hearing exam each year • **In-network and Out-of-network**: $1,000 allowance for both ears in-network and out-of-network on hearing aids every 3 years
Dental Services*	
• **Medicare covered dental**	• **In-network:** 4% of the total cost • **Out-of-network:** 4% of the total cost
• **Preventive Dental**	• Not Covered
• **Supplemental Dental Services**	• Not Covered
Vision Services*	
• **Medicare covered vision exam**	• **In-network:** $0 copay • **Out-of-network:** $0 copay
• **Medicare covered eyewear**	• **In-network:** $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery • **Out-of-network:** $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery
• **Routine vision exam**	• Not Covered
• **Routine eyewear**	• Not Covered

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Mental Health Care* • **Inpatient mental health** • **Outpatient group therapy/ individual therapy visit**	• **In-Network:** 4% of the total cost • **Out-of-network:** 4% of the total cost **Individual** • **In-network:** $20 copay • **Out-of-network:** $20 copay **Group** • **In-network:** $20 copay • **Out-of-network:** $20 copay
Skilled Nursing Facility (SNF)*	**In-network:** 4% of the total cost per day for days 1-20. 4% of the total cost per day for days 21-100. **Out-of-network:** 4% of the total cost per day for days 1-20 4% of the total cost per day for days 21-100.
Outpatient Rehabilitation* • **Occupational Therapy** • **Physical therapy and speech and language therapy visit**	**In-network:**$40 copay **Out-of-network:**$40 copay **In-network:** $40 copay **Out-of-network:** $40 copay

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Ambulance*	
• **Ground services**	• **In-network:** 4% of the total cost for each one-way trip • **Out-of-network:** 4% of the total cost for each one-way trip
• **Air services**	• **In-network:** 4% of the total cost for each one-way trip • **Out-of-network:** 4% of the total cost for each one-way trip
Transportation*	• Not Covered
Medicare Part B Drugs*	
• **Chemotherapy drugs**	• **In-network:** 4% of the total cost • **Out-of-network:** 4% of the total cost
• **Other Part B drugs**	• **In-network:** 4% of the total cost • **Out-of-network:** 4% of the total cost

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PRESCRIPTION DRUG BENEFITS	
Stage 1: Part D Deductible	Because there is no prescription drug deductible for the plan, this payment stage does not apply to you. **Important Message About What You Pay for Insulin** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.
Stage 2: Initial Coverage	You stay in the Intial Coverage Stage until your yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Cost Shares During the Initial Coverage Stage

Initial Coverage Stage: Standard Retail Pharmacy	
Standard Retail	**Blue Cross Group Medicare Advantage Open Access (PPO)[SM]**
Tier 1: Preferred Generic	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max
Tier 2: Generic	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max
Tier 3: Preferred Brand	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max
Tier 4: Non-Preferred Drug	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max
Tier 5: Specialty Tier	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max

Initial Coverage Stage: Standard Mail Order Pharmacy	
Standard Mail Order	**Blue Cross Group Medicare Advantage Open Access (PPO)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $10
	Three-month supply: $25
Tier 2: Generic	**One-month supply:** $10
	Three-month supply: $25
Tier 3: Preferred Brand	**One-month supply:** $30
	Three-month supply: $60
Tier 4: Non-Preferred Drug	**One-month supply:** $50
	Three-month supply: $100
Tier 5: Specialty Tier	**One-month supply:** 20%
	Three-month supply: 20%

Initial Coverage Stage: Long-term Care and Out-of-network Pharmacies (one-month supply)	
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Long-term Care Tiers 1-5	If you reside in a long-term facility, you pay the same as at a standard retail pharmacy.
Out-of-network Tiers 1-5	You may get drugs from an out-of-network pharmacy in specific situations. You generally must use a network pharmacy to fill your prescription.

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Stage 3: Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. See the table(s) below for your costs during this stage. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $1,000.

Coverage Gap Stage: Standard Retail Pharmacy	
Standard Retail	**Blue Cross Group Medicare Advantage Open Access (PPO)[SM]**
Tier 1: Preferred Generic	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max
Tier 2: Generic	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max
Tier 3: Preferred Brand	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max
Tier 4: Non-Preferred Drug	**One-month supply:** 20% $10 min; $100 max
	Three-month supply: 20% $30 min; $300 max
Tier 5: Specialty Tier	**One-month supply:** 15% $10 min; $100 max **Three-month supply:** 15% $30 min; $300 max

Coverage Gap Stage: Standard Mail Order Pharmacy	
Standard Mail Order	**Blue Cross Group Medicare Advantage Open Access (PPO)[SM]**
Tier 1: Preferred Generic	**One-month supply:** $10
	Three-month supply: $25
Tier 2: Generic	**One-month supply:** $10
	Three-month supply: $25
Tier 3: Preferred Brand	**One-month supply:** $30
	Three-month supply: $60
Tier 4: Non-Preferred Drug	**One-month supply:** $50
	Three-month supply: $100
Tier 5: Specialty Tier	**One-month supply:** 15% **Three-month supply:** 15%

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Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs reach your out-of-pocket limit (refer to the Evidence of Coverage Benefit Insert for your yearly limit), you pay nothing for covered Part D drugs.

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ADDITIONAL MEMBER BENEFITS	
NOTE: Services with a * may require prior authorization or a referral from your doctor.	
Acupuncture	**Acupuncture for chronic low back pain (Medicare-covered)** • In-network: $0 copay • Out-of-network: $0 copay **Routine Acupuncture (non-Medicare-covered)** • Not Covered
Chiropractic Care*	**Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)** • In-network: $20 copay • Out-of-network: $20 copay **Routine Chiropractic Services (non-Medicare-covered)** • Not Covered
Diabetes Supplies and Services*	**Diabetes monitoring supplies** • In-network: 4% of the total cost • Out-of-network: 4% of the total cost **Diabetes self-management training** • In-network: $0 copay • Out-of-network: $0 copay
Durable Medical Equipment *(wheelchairs, oxygen, etc.)**	• In-network: 4% of the total cost • Out-of-network: 4% of the total cost

	Blue Cross Group Medicare Advantage Open Access (PPO)℠
Wellness Programs	$0 copay for SilverSneakers® † Fitness Program This benefit includes SilverSneakers instructor-led group fitness classes. At participating locations, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms. SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and a mobile app, SilverSneakers GO™. †SilverSneakers, SilverSneakers FLEX, SilverSneakers On-Demand, and SilverSneakers GO are registered trademarks or trademarks of Tivity Health, Inc.
Foot Care *(podiatry services)**	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions** • In-network: 4% of the total cost • Out-of-network: 4% of the total cost
Home Health Care*	• In-network: 4% of the total cost • Out-of-network: 4% of the total cost
Opioid Treatment Program Services*	• In-network: $0 copay • Out-of-network: $0 copay
Outpatient Substance Abuse Services*	**Group therapy visit** • In-network: 4% of the total cost • Out-of-network: 4% of the total cost **Individual therapy visit** • In-network: 4% of the total cost • Out-of-network: 4% of the total cost
Over-the-Counter Items	• In-network: $30 allowance every month for specific over-the-counter drugs and other health-related products. Unused monthly allowance will rollover to the next month but does not rollover to the next year. • Out-of-network: Not Covered

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Prosthetic Devices *(braces, artificial limbs, etc.)**	**<u>Prosthetic devices</u>** • In-network: 4% of the total cost • Out-of-network: 4% of the total cost **<u>Related medical supplies</u>** • In-network: 4% of the total cost • Out-of-network: 4% of the total cost
Meals	• Not Covered
Renal Dialysis*	• In-network: 4% of the total cost • Out-of-network: 4% of the total cost
Supplemental Telehealth Services	• In-network: $35 copay for urgent care; $20 copay for Outpatient Mental Health; $0 copay for Outpatient Mental Health Psychiatric visit through MDLive. • Out-of-network: Not Covered
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

BlueCross BlueShield of Illinois

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

Blue Cross and Blue Shield of Illinois:

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

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has 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 with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights 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, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-299-1008** (TTY/TDD: **711**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-299-1008** (TTY/TDD: **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-299-1008** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-299-1008**（TTY/TDD：**711**）。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-299-1008** (TTY/TDD: **711**) 번으로 전화해 주십시오

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-299-1008** (TTY/TDD: **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-299-1008** (رقم هاتف الصم والبكم: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-299-1008** (телетайп: **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-299-1008** (TTY: **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-877-299-1008** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-299-1008** (TTY/TDD: **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-299-1008** (TTY/TDD: **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-299-1008** (TTY/TDD: **711**) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-299-1008** (ATS : **711**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-299-1008** (TTY: **711**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-299-1008** (TTY/TDD: **711**).

BlueCross BlueShield of Illinois

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-877-299-1008 (TTY: 711) for more information.

PPO plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.