Prescription Blue℠ Group PDP



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PDP Benefits Chart

Your prescription costs as a member of City of Detroit General Retiree Health Care Trust Prescription Blue Group PDP plan

This *PDP Benefits Chart* is a part of the 2027 *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 Part D drugs,* in its entirety in the EOC. The contents below are only selected sections from that chapter.

This plan is effective January 1, 2027 - December 31, 2027.

SECTION 2 Drug payment stages for Prescription Blue Group PDP members

There are **3 drug payment stages** for your drug coverage under Prescription Blue Group PDP. How much you pay for each prescription depends on what stage you're in when 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 our plan's monthly premium regardless of the drug payment stage. Details of each stage are explained in 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 $2,400. (Details are in Section 5 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).	During this stage, **the plan pays the full cost** of your drugs for the rest of the calendar year (through December 31, 2027). You pay nothing. (Details are in Section 6 below.)

SECTION 3 Your Part D Explanation of Benefits (EOB) explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. 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, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

- **Total Drug Costs**: this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

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

Section 3.1 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's 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 make sure we know about the prescriptions you fill and what you pay.
- **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 won't 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. **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 use a discount card that's not part of our plan's benefit.
    - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
    - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
    - If you're 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.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by 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 get 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 questions, call Customer Service at 1-866-684-8216 (TTY users call 711). 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 for the year. Go to Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

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

During the Initial Coverage Stage, our plan pays its share of the cost of your covered 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.

Our plan has five cost-sharing tiers
Every drug on our 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 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 our 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 preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A network retail pharmacy that offers standard cost sharing.
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 3, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy

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

Section 5.2 Your costs for a *one-month* supply of a covered drug

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

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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

Your costs for a *one-month* supply (or less) of a covered Part D 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; go to Chapter 5 for details.) (up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$20	$10	$20	$20
Cost-Sharing Tier 2 (Generic)	$20	$10	$20	$20
Cost-Sharing Tier 3 (Preferred Brand)	$60	$45	$60	$60
Cost-Sharing Tier 4 (Non-Preferred Drug)	50% Minimum: $60 Maximum: $120	50% Minimum: $60 Maximum: $120	50% Minimum: $60 Maximum: $120	50% Minimum: $60 Maximum: $120
Cost-Sharing Tier 5 (Specialty Tier)	50% Minimum: $300 Maximum: $600	50% Minimum: $300 Maximum: $600	50% Minimum: $300 Maximum: $600	50% Minimum: $300 Maximum: $600

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 your deductible (if applicable).

Go to Chapter 4, Section 8 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 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're 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 if this will help you plan refill dates better.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're 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're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We 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 get.

Section 5.4 Your costs for a *long-term* (up to a 32- to 90-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up a 32- to 90-day supply.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the costs when you get a *long-term 32- to 90-day* supply of a covered Part D 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)	$40	$20	$40	$20
Cost-Sharing Tier 2 (Generic)	$40	$20	$40	$20
Cost-Sharing Tier 3 (Preferred Brand)	$120	$90	$120	$90
Cost-Sharing Tier 4 (Non-Preferred Drug)	50% Minimum: $120 Maximum: $240	50% Minimum: $120 Maximum: $240	50% Minimum: $120 Maximum: $240	50% Minimum: $120 Maximum: $240
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.

***Tier 1 drugs allow for a 100-day supply at the same cost share as a 90-day supply. If you are taking a Tier 1 drug, talk with your doctor about whether a new prescription for a 100-day supply is appropriate.**

You won't pay more than $105 for up to a 3-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 $2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move to the Catastrophic Coverage Stage. For plans with enhanced formularies, we offer additional coverage on some prescription drugs that aren't normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won't count toward your total out-of-pocket costs.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,400 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Chapter 4 Section 1.3 in the *Evidence of Coverage* for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,400 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll 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.
- For excluded drugs covered under our enhanced benefit, you may have cost sharing.

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.)