

This is only a summary of your plan's benefits. See your Evidence of Coverage for more detailed information.



2020 Benefit Summary

**University of Pittsburgh --
01973605**

Blue Rx PDP

You pay the following until your total yearly drug costs reach \$4020 Total yearly drug costs are the total drug costs paid by both you and your Part D Plan.

Initial Coverage	Deductible	\$0		
		Tier	Up to 31 Day Supply	
	Retail Cost Sharing (Preferred Pharmacy)	Tier 1 (Preferred Generic)		\$10 copay
		Tier 2 (Generic)		\$10 copay
		Tier 3 (Preferred Brand)		\$30 copay
		Tier 4 (Non-Preferred Drug)		\$65 copay
		Tier 5 (Specialty)		\$70 copay
		Tier	Up to 31 Day Supply	
	Retail Cost Sharing (Standard Pharmacy)	Tier 1 (Preferred Generic)		\$15 copay
		Tier 2 (Generic)		\$15 copay
		Tier 3 (Preferred Brand)		\$35 copay
		Tier 4 (Non-Preferred Drug)		\$70 copay
		Tier 5 (Specialty)		\$70 copay
		Tier	Up to 90 Day Supply	
	Mail Order Cost Sharing	Tier 1 (Preferred Generic)		\$20 copay
Tier 2 (Generic)			\$20 copay	
Tier 3 (Preferred Brand)			\$60 copay	
Tier 4 (Non-Preferred Drug)			\$130 copay	
Tier 5 (Specialty)			n/a	

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4020.01 until your costs total \$6.350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Coverage Gap	Retail Cost Sharing (Preferred Pharmacy)	Tier	Up to 31 Day Supply
		Tier 1 (Preferred Generic)	\$10 copay
		Tier 2 (Generic)	\$10 copay
		Tier 3 (Preferred Brand)	\$30 copay
		Tier 4 (Non-Preferred Drug)	\$65 copay
	Tier 5 (Specialty)	\$70 copay	
	Retail Cost Sharing (Standard Pharmacy)	Tier	Up to 31 Day Supply
		Tier 1 (Preferred Generic)	\$15 copay
Tier 2 (Generic)		\$15 copay	
	Tier 3 (Preferred Brand)	\$35 copay	

	Pharmacy)	Tier 4 (Non-Preferred Drug)	\$70 copay
		Tier 5 (Specialty)	\$70 copay
	Mail Order Cost Sharing	Tier	Up to 90 Day Supply
		Tier 1 (Preferred Generic)	\$20 copay
		Tier 2 (Generic)	\$20 copay
		Tier 3 (Preferred Brand)	\$60 copay
		Tier 4 (Non-Preferred Drug)	\$130 copay
Tier 5 (Specialty)	n/a		

Catastrophic Coverage Description: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$6,350.01, you pay the greater of: 5% of the cost, or a \$3.60 copay for generics and a \$8.95 copay for all other drugs.

Catastrophic Coverage	Greater of: 5% or \$3.60 Generic/Preferred Multi-Source or \$8.95 for all others.
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HM Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in HM Health Insurance Company depends on contract renewal. Highmark Blue Shield and HM Health Insurance Company are independent licensees of the Blue Cross and Blue Shield Association. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits and/or co-payments/co-insurance may change on January 1 of each year. The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Highmark Blue Shield complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

Questions on BlueRx PDP benefits? Call 1-800-290-3914 seven days a week, from 8 a.m. to 8 p.m. (TTY users call 711).

Reference Code (Please have this number ready when you call): **20BRX197360**

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