

## Mail Service Prescription Drug Program

---

### 2024 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option

#### Section 5. Benefits

#### Section 5(f). Prescription Drug Benefits

#### Covered Medications and Supplies

---

**Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.**

#### Benefits Description

#### Covered Medications and Supplies

#### Mail Service Prescription Drug Program

For Standard Option and Basic Option members when Medicare Part B is Primary, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills.

Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program.

Note: You must obtain prior approval for certain drugs before Mail Service will fill your prescription. See Section 3.

Note: Not all drugs are available through the Mail Service Prescription Drug Program. There are no specialty drugs available through the Mail Service Program.

Note: Please keep reading for information about the Specialty Drug Pharmacy Program.

Note: We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative.

**Contact Us:** If you have any questions about this program, or need assistance with your Mail Service drug orders, please call 800-262-7890, TTY: 711.

Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.

### **Standard Option - You Pay**

Tier 1 (generic drug): \$15 copayment (no deductible)

Note: You pay a \$10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary.

Note: You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement, as previously stated.

Tier 2 (preferred brand-name drug): \$90 copayment (no deductible)

Tier 3 (non-preferred brand-name drug): \$125 copayment (no deductible)

### **Basic Option - You Pay**

#### **When Medicare Part B is primary, you pay the following:**

Tier 1 (generic drug): \$20 copayment

Tier 2 (preferred brand-name drug): \$100 copayment

Tier 3 (non-preferred brand-name drug): \$125 copayment

#### **When Medicare Part B is not primary: No benefits**

Note: Although you do not have access to the Mail Service Prescription Drug Program, you may request home delivery of prescription drugs you purchase from Preferred retail pharmacies offering options for online ordering.