BlueCross BlueShield Minnesota

2021

SUMMARY OF BENEFITS

Platinum Blue℠ (Cost) and
Platinum Blue℠ with Rx (Cost)
Core, Choice and Complete Plans

H2461

January 1, 2021 – December 31, 2021

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INTRODUCTION

This guide is a summary of the medical and prescription drug benefits covered by Platinum Blue℠ (Cost) and Platinum Blue℠ with Rx (Cost) plans. In this booklet, you will find an overview of our plan and pharmacy network, an easy-to-read chart of plan coverage options, and contact information for customer service representatives who can assist you and answer questions.

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CONTACT US

We are available for phone calls 8 a.m. to 8 p.m., Central Time. We are available seven days a week October 1 through March 31, and available Monday through Friday the rest of the year.

Members

Call toll-free **1-866-340-8654**

TTY users call **711**

Non-Members

Call **1-855-579-7658**

Visit **bluecrossmnonline.com**

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative toll free at **1-877-662-2583** (TTY **711**).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **bluecrossmn.com** or call toll free at **1-877-662-2583** (TTY **711**) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

FREQUENTLY ASKED QUESTIONS

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*.

WHO CAN ENROLL?

You can enroll in Platinum Blue with Rx if you are enrolled in Medicare Part B (or have both Medicare Part A and Medicare Part B) and live in the plan availability area.

Plan availability area:

You may enroll in a Platinum Blue plan if you live in one of the following counties: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse, Yellow Medicine. Some exceptions may apply. Counties are subject to change. Please contact your agent or Blue Cross for more information.

WHAT DOES THE PLAN COVER?

Platinum Blue members get all the benefits covered in Original Medicare. Platinum Blue plans help pay the deductible, copayments and coinsurance Original Medicare doesn't cover.

Platinum Blue with Rx covers Part D drugs. Both Platinum Blue and Platinum Blue with Rx cover Part B drugs, including chemotherapy and some drugs administered by your provider.

What is the difference between a:

- ➜ Annual physical exam — A yearly preventive visit with your primary care doctor that includes a discussion about your health, a review of your medical history, screenings, immunizations, and some lab work.
- ➜ Welcome to Medicare visit — A one-time preventive visit within the first 12 months of your new Medicare Part B plan. This visit includes a review of your medical history, screenings, vaccinations and a discussion of preventive services available to you that you may need.
- ➜ Medicare annual wellness visit — An annual visit with your doctor after you've been enrolled in Medicare Part B for at least 12 months. This visit includes a review of your medical history, screenings and personalized health advice, and a checklist of appropriate preventive services.

Medicare will pay for a Medicare annual wellness visit and a Welcome to Medicare visit. Your Blue Cross Platinum Blue plan will pay for an annual physical exam.

To see a complete list of your services and benefits, please review your *Evidence of Coverage* (EOC). You can find this document at **bluecrossmnonline.com** by clicking Medicare > Search Medicare Forms. You also may order a copy by calling member services.

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

The Platinum Blue and Platinum Blue with Rx network offers a large list of providers and pharmacies covered under the Platinum Blue plan. You may pay less when you use doctors, hospitals, pharmacies and other providers in this network. You can see the plan's provider and pharmacy directories at **bluecrossmnonline.com**. Or, call us and we will send you a copy of the directories.

When using in-network pharmacies you can typically see lower prices than using out-of-network pharmacies for covered Part D drugs. If you choose to go out of network for services, or outside of your service area, these services will be paid by Original Medicare and your responsibility for cost sharing may be higher.

ARE MY DRUGS COVERED?

If you enroll in Platinum Blue with Rx, you will have Part D prescription drug coverage. You can see the complete *Formulary* (list of Part D prescription drugs) and any restrictions at **myprime.com**. Or, call us and we will send you a copy of the *Formulary*.

The pharmacy benefits information is provided by Prime Therapeutics LLC, an independent company providing pharmacy benefit management services.

HOW MUCH WILL I NEED TO PAY FOR PRESCRIPTION DRUGS?

The amount you pay depends on what tier the drug is in and what benefit stage you have reached. Your costs for each drug tier and benefit stage are shown in the benefit chart later in this summary.

We also offer "preferred" pharmacies within our pharmacy network. These pharmacies have deeper discounted copays and coinsurance on prescription drugs.

You can also save costs when you choose 90-day supplies from certain pharmacies and mail-order pharmacies.

You can find the most updated list of pharmacies in your area at **myprime.com**.

WHAT ARE THE DRUG TIERS?

Our plan places a drug into one of five tiers. Check the 2021 *Formulary* to find out which tier your drug is in.

WHAT ARE THE BENEFIT STAGES?

As you spend up to certain dollar amounts on your covered prescription drugs, you will move into different benefit stages.

Stage 1: Meet your deductible This is the amount you must pay each year for prescriptions before the plan will begin to pay its share of your covered drugs.

Stage 2: Initial coverage Once you've met your deductible, you'll pay a copay or coinsurance until you and your plan have spent $4,130 on covered drugs.

Stage 3: Coverage gap Sometimes known as a "donut hole," it offers a temporary limit on what your plan will cover for drugs.

Stage 4: Catastrophic coverage Once you've spent $6,550 out-of-pocket on prescription drugs in a plan year, you will pay a small copay or coinsurance for the rest of the year.

ABOUT ORIGINAL MEDICARE AND HOW TO GET BENEFITS

You have choices about how to get your Medicare benefits through Original Medicare, a program run directly by the federal government.

You can also choose to get Medicare benefits by joining a Cost plan like Platinum Blue or Platinum Blue with Rx.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits. Or, use the Medicare Plan Finder on **medicare.gov**.

If you want to know more about the coverage and costs of Original Medicare, look in your 2021 *Medicare & You* handbook or view it online at **medicare.gov**. Or, request 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**.

HEALTH CARE TERMS AND WHAT THEY MEAN

Allowed amount — The contracted rate, or "Blue Cross discount," set by your plan and providers when you see in-network hospital, clinics or pharmacies. Providers are required to accept the allowed amount as payment in full, and cannot charge above it when you see an in-network provider.

Copay — A set fee you pay for some services and prescriptions. Copays vary by type of service and prescription. In most cases, your copay is due at the time you receive the service or prescription.

Coinsurance — The amount you may pay for some services once you reach your deductible. The cost is a percent of the allowed amount and is set by your plan. The amount you pay for coinsurance will vary if the provider is in-network or out-of-network.

Deductible — A set amount of money you must pay before your plan begins to pay. Usually, you will have a separate deductible for Medicare Part A , Part B and Part D.

In-network — The hospitals, clinics and pharmacies that are included in your plan. Typically, in-network providers result in lower member costs.

Out-of-pocket costs — The amount you must pay for health care. It includes copays, coinsurance and deductibles, plus any costs for care that is not covered.

Out-of-network — The hospitals, clinics and pharmacies that are not included in your plan. Typically, out-of-network providers result in higher member costs.

Out-of-pocket maximum — The most you could pay for covered care in a plan year. Once you reach this amount, your plan will pay 100 percent for in-network covered care.

Premium — The amount you pay each month to be a member of your plan.

Prior authorization — The purpose of prior authorizations is to determine medical necessity and appropriateness of services. Prior authorizations are submitted by your physician and/or provider.

Total charge — The amount the provider or pharmacy charges for services before a Blue Cross discount (allowed amount) is applied.

Platinum Blue without Rx Benefits	Core Plan	Choice Plan	Complete Plan
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
How much is the monthly premium?	$29 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$94 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$164 per month. In addition, you must keep paying your monthly Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.

Platinum Blue with Rx Benefits	Core Plan with Rx	Choice Plan with Rx	Complete Plan with Rx
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
How much is the monthly premium?	$54.80 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$134.50 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$230.30 per month. In addition, you must keep paying your monthly Medicare Part B premium.
How much is the deductible?	$445 all Tiers	$445 per year for Part D prescription drugs Tiers 3 – 5. Tiers 1 – 2 are excluded from the deductible.	$445 per year for Part D prescription drugs Tiers 3 – 5. Tiers 1 – 2 are excluded from the deductible.

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
Is there any limit on how much I will pay for my covered service? Your yearly out-of-pocket limit(s) in this plan are for services you receive from in-network providers If you reach the limit on out-of-pocket costs, you will continue to be covered for hospital and medical services and your plan will pay the full cost for the rest of the year. You will still need to pay your monthly premiums.	$6,000	$3,500	$2,700
Is there a limit on how much the plan will pay?	Our plan has a yearly limit for certain in-network benefits. Contact us for the services that apply.	Our plan has a yearly limit for certain in-network benefits. Contact us for the services that apply.	Our plan has a yearly limit for certain in-network benefits. Contact us for the services that apply.

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Covered Hospital and Medical Benefits – Hospital Care			
Inpatient hospital care	Our plan covers 90 days for an inpatient hospital stay. $600 copay per admission	Our plan covers an unlimited number of days for an inpatient hospital stay. $200 copay per admission	Our plan covers an unlimited number of days for an inpatient hospital stay. $100 copay per admission
Outpatient hospital care			
Outpatient hospital visit	20% coinsurance	$0	$0
Ambulatory surgery center visit	20% coinsurance	$50 copay	$0
Observation stay	20% coinsurance	$50 copay	$0
Blood services	$0	$0	$0
Doctor's office visits			
Primary Care Physician	$20 copay	$5 copay	$0
Specialist	20% coinsurance	$15 copay	$0

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Covered Hospital and Medical Benefits – Outpatient Care and Services			

Preventive care	\$0
	
	Our plan covers many preventive services, including:
	
	• Abdominal aortic aneurysm screening
	• Alcohol misuse screenings and counseling
	• Annual physical exam
	• Barium enema
	• Bone mass measurements (bone density screening)
	• Cardiovascular disease screenings
	• Cardiovascular disease (behavioral therapy)
	• Cervical & vaginal cancer screening
	• Colorectal cancer screenings
	• Depression screenings
	• Diabetes screenings
	• Diabetes self-management training
	• Digital rectal exam
	• EKG (Following a "Welcome Visit")
	• Glaucoma tests
	• Hepatitis C screening
	• HIV screening
	• Lung cancer screening
	• Mammograms (breast cancer screening)
	• Nutrition therapy services
	• Obesity screenings and counseling
	• One-time "Welcome to Medicare" preventive visit
	• Prostate cancer screenings
	• Routine annual physical exam
	• Sexually transmitted infections screening & counseling
	• Shots (vaccines): (If administered in a doctor's office or hospital setting, vaccines will be filed as a Part B claim. If administered at a pharmacy, vaccines will be filed as a Part D claim.)
	  • Flu shots
	  • Hepatitis B shots
	  • Pneumococcal shots
	• Tobacco cessation counseling
	
	Any additional preventive services approved by Medicare during the contract year will be covered.		

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Emergency care (In the United States and worldwide) Copayment is waived if you are admitted to the hospital within 24 hours for the same condition. See the "Inpatient Hospital Care" section of this booklet for other costs.	$90 copay	$90 copay	$0
Worldwide emergency transportation	20% coinsurance	$20 copay	$0 copay
Urgently needed care	$25 copay	$25 copay	$0
Diagnostic services, labs and imaging			
Diagnostic radiology services (such as MRIs, CT scans)	20% coinsurance	$0	$0
Diagnostic tests and procedures	20% coinsurance	$0	$0
Lab services	$0	$0	$0
Outpatient x-rays	20% coinsurance	$0	$0
Therapeutic radiology services (such as treatment for cancer)	20% coinsurance	$0	$0

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Hearing services			
Medicare-covered exams to diagnose and treat hearing and balance issues	$20 copay	$15 copay	$0
Non-Medicare covered hearing exam (1 per year)	$20 copay	$15 copay	$0
Non-Medicare covered hearing aid screening (1 per year)	$20 copay	$15 copay	$0
Hearing aid (up to 2 aids per year)	$699 copay per aid for Advanced Aid or $999 copay per aid for Premium Aid from TruHearing	$599 copay per aid for Advanced Aid or $899 copay per aid for Premium Aid from TruHearing	$499 copay per aid for Advanced Aid or $799 copay per aid for Premium Aid from TruHearing
Dental services			
Medicare-covered dental services	20% coinsurance	$15 copay	$0
Non-Medicare covered dental services*			
Cleaning (Up to 2 per year)	Not covered	$0	$0
Dental x-rays (Up to 1 per year)	Not covered	$0	$0
Oral exam (Up to 2 per year)	Not covered	$0	$0
Periodontal cleaning (Up to 1 per year)	Not covered	$0	$0

*Maximum plan benefit amount is $2,250 per year.

TruHearing® is a registered trademark of TruHearing, Inc., an independent company who works with health plans to offer low out-of-pocket costs on hearing aids.

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Vision services			
Annual glaucoma screening	$0	$0	$0
Medicare-covered exams to diagnose and treat eye diseases and conditions	20% coinsurance	$15 copay	$0
Medicare-covered eyewear after cataract surgery	20% coinsurance	20% coinsurance	20% coinsurance
Non-Medicare covered exam (2 per year)	Not covered	$0	$0
Non-Medicare covered eyewear allowance	Not covered	$125 (frames, lenses or contacts)	$150 (frames, lenses or contacts)
Diabetic retinopathy exam	$0	$0	$0
Mental health care (including inpatient)	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a specialty psychiatric hospital. This limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.		
Inpatient visit	$600 copay per admission	$200 copay per admission	$100 copay per admission
Outpatient group therapy visit	20% coinsurance	$15 copay	$0
Outpatient individual therapy visit	20% coinsurance	$15 copay	$0
Partial hospitalization	20% coinsurance	$15 copay	$0
Mental health office visit			
Psychiatrist or psychologist	20% coinsurance	$15 copay	$0

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Skilled nursing facility (SNF) Our plan pays up to 100 days in a SNF	$0 per day for days 1 through 20 $184 copay per day for days 21 through 100	$0	$0
Rehabilitation services Cardiac and pulmonary rehabilitation services Physical, occupational and speech therapy visits Pulmonary rehab services	 20% coinsurance 20% coinsurance 20% coinsurance	 $15 copay $15 copay $15 copay	 $0 $0 $0
Ambulance (ground and air)	20% coinsurance	$20 copay	$0
Non-Medicare covered transportation	Not covered	Not covered	Not covered
Prescription drug benefits			
How much do I pay? Part B chemotherapy drugs Other Medicare-covered Part B drugs including but not limited to oxygen	 20% coinsurance 20% coinsurance	 20% coinsurance 20% coinsurance	 20% coinsurance 0-20% coinsurance

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Additional benefits and services			
Medicare-covered acupuncture Covered for chronic lower back pain	20% coinsurance (max. 20 visits every 12 months)	$15 copay (max. 20 visits every 12 months)	$0 (max. 20 visits every 12 months)
Non-Medicare covered acupuncture Covered for pain diagnosis, except chronic lower back pain	20% coinsurance (max. 20 visits per year)	$15 copay (max. 20 visits per year)	$0 (max. 20 visits per year)
Chiropractic care Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	20% coinsurance	$15 copay	$0
Diabetes supplies and services Diabetes monitoring supplies through Ascensia	$0	$0	$0
Diabetes self-management training	20% coinsurance	$0	$0
Therapeutic shoes and inserts	20% coinsurance	20% coinsurance	$0
Durable medical equipment* (wheelchairs, oxygen, etc.)	20% coinsurance	20% coinsurance	$0
Fitness program Sign up at a participating SilverSneakers® facility or choose a home exercise kit	$0	$0	$0
Home health care	$0	$0	$0
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.		
Outpatient substance abuse Individual and group therapy visits	20% coinsurance	$15 copay	$0

*Benefits under this category may require prior authorization by the health plan.

Ascensia Diabetes Care US, Inc. is an independent company providing diabetic supplies.

SilverSneakers® is a registered trademark of Tivity Health, Inc., an independent company that provides health and fitness programs.

Platinum Blue with and without Rx Benefits	Core Plan with and without Rx	Choice Plan with and without Rx	Complete Plan with and without Rx
Additional benefits and services			
Over-The-Counter (OTC)	$25 per quarter for the purchase of covered over-the-counter (OTC) items through CVS Over The Counter Health Solutions (OTCHS).		
Podiatry services (Foot care) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain medical conditions	20% coinsurance	$15 copay	$0
Prosthetic devices (braces, artificial limbs, etc.) Prosthetic devices Related medical supplies	 20% coinsurance 20% coinsurance	 20% coinsurance 20% coinsurance	 $0 $0
Renal dialysis Kidney Disease Education	20% coinsurance 20% coinsurance	$15 copay $0	$0 $0
Tobacco cessation A wellness coach helps members develop and maintain a plan to quit	$0	$0	$0

CVS Health Corporation is an independent company providing pharmacy benefit management services.

PRESCRIPTION DRUG MEDICARE PART D COVERAGE

You can add prescription drug coverage to your Platinum Blue plan. Bundling medical and Part D coverage into one plan gives you the convenience of a single member ID card, customer service center and bill for both your medical and prescription costs. The monthly premium and deductible costs below reflect both your medical and prescription drug coverage. To view what drugs are covered by Platinum Blue with Rx, visit **myprime.com**, register your account and click on the Medicines tab at the top of the page.

	Platinum Blue with Rx Benefits	**Core Plan with Rx**	
	Monthly Plan Premium	$54.80	
	Deductible	$445 all Tiers	
	Initial Coverage	**Preferred Cost-Sharing**	**Standard Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay	$15 copay
	Tier 2: Generic Drugs	$12 copay	$20 copay
	Tier 3: Preferred Brand Drugs	21% coinsurance	25% coinsurance
	Tier 4: Non-Preferred Drugs	45% coinsurance	50% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance	25% coinsurance
60-90 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay	$30 copay
	Tier 2: Generic Drugs	$24 copay	$40 copay
	Tier 3: Preferred Brand Drugs	21% coinsurance	25% coinsurance
	Tier 4: Non-Preferred Drugs	45% coinsurance	50% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance	25% coinsurance
	Coverage Gap Begins once your total drug costs for the year reach $4,130[1]	• Generic Drugs: 25% of the plan cost • Brand-name Drugs: 25% of the plan cost	
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $6,550[2]	You pay the greater of: • 5% of the cost, or • $3.70 copay for generic drugs	

[1]Total yearly drug costs include the amount you have paid for covered drugs plus what the plan has paid for the calendar year. This does not include plan premiums you pay. The brand-name drug coverage in the coverage gap is subject to agreements between the Centers for Medicare & Medicaid Services (CMS) and drug manufacturers. Not all brand drugs may be discounted. Call Blue Cross customer service if you have questions.

[2]Your out-of-pocket costs includes the amount you have paid for covered drugs for the calendar year. This does not include the amount the plan has paid or the plan premiums you pay.

Choice Plan with Rx		**Complete Plan with Rx**	
$134.50		$230.30	
$0 Tiers 1-2; $445 Tiers 3-5		$0 Tiers 1-2; $445 Tiers 3-5	
Preferred Cost-Sharing	**Standard Cost-Sharing**	**Preferred Cost-Sharing**	**Standard Cost-Sharing**
$0 copay	$15 copay	$0 copay	$13 copay
$10 copay	$20 copay	$9 copay	$19 copay
20% coinsurance	25% coinsurance	20% coinsurance	25% coinsurance
45% coinsurance	50% coinsurance	45% coinsurance	50% coinsurance
25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
$0 copay	$30 copay	$0 copay	$26 copay
$20 copay	$40 copay	$18 copay	$38 copay
20% coinsurance	25% coinsurance	20% coinsurance	25% coinsurance
45% coinsurance	50% coinsurance	45% coinsurance	50% coinsurance
25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance

(including brand drugs treated as generic) and an $9.20 copay for all other drugs

Mail Order

The below mail order supply chart shows your cost-sharing amounts during your initial coverage stage. When you enter the coverage gap or catastrophic coverage stages, you will pay those cost-sharing amounts regardless of whether you choose to use mail order.

	Platinum Blue	Core with Rx	Choice with Rx	Complete with Rx
60 or 90 day supply via Mail Order	Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$0 copay
	Tier 2: Generic Drugs	$24 copay	$20 copay	$18 copay
	Tier 3: Preferred Brand Drugs	21% coinsurance	20% coinsurance	20% coinsurance
	Tier 4: Non-Preferred Drugs	45% coinsurance	45% coinsurance	45% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance	25% coinsurance	25% coinsurance

CONTACT US

We are available for phone calls 8 a.m. to 8 p.m., Central Time. We are available seven days a week October 1 through March 31, and available Monday through Friday the rest of the year.

Members

Call toll-free **1-866-340-8654**

TTY users call **711**

Non-Members

Call **1-855-579-7658**

Visit **bluecrossmnonline.com**

This document may be available in a non-English language. For additional information call us at a number above.

This document is available in other formats such as braille and large print.

Out-of-network/non-contracted providers are under no obligation to treat Platinum Blue (Cost) or Platinum Blue with Rx (Cost) plan 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.

Platinum Blue is a Cost plan with a Medicare contract. Enrollment in Platinum Blue depends on contract renewal.

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

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

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

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
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

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

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Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta’e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.

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