BlueCross BlueShield Minnesota

2022

SUMMARY OF BENEFITS

Blue Cross Medicare Advantage (PPO)
Core, Choice and Complete Plans

Metro Region

H5959

January 1, 2022 – December 31, 2022

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Introduction

This guide is a summary of the medical and prescription drug benefits covered by Blue Cross Medicare Advantage 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.

What's included

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 **1-800-711-9865**

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 **1-855-579-7658** (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 **1-855-579-7658** (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, 2022.
- [ ] Our plan allows you to see out-of-network providers (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

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 Medicare Advantage (PPO) if you are enrolled in Medicare Part A and Medicare Part B and live in the plan availability area, which includes the following counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott and Washington.

WHAT IS MEDICARE ADVANTAGE?

Medicare Advantage plans are private Medicare health plans. They have a yearly limit on your out-of-pocket costs, and once you reach this limit, you'll pay nothing for covered services. Medicare Advantage plans are combined medical and prescription drug coverage.

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 Medicare Advantage 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 Medicare Advantage provider network and the Medicare Advantage pharmacy network offers a selective list of providers and pharmacies covered under the Medicare Advantage plan. You may pay less when you use doctors, hospitals, pharmacies and other providers in these networks. You can see the plan's provider and pharmacy directories at **bluecrossmnonline.com** by clicking Medicare > Search Medicare Forms> Select Medicare Advantage (PPO)-Metro Region. Or, call us and we will send you a copy of the directories.

When using in-network pharmacies you will typically see lower prices than using out-of-network pharmacies for covered Part D drugs.

ARE MY DRUGS COVERED?

Medicare Advantage is a combined medical and prescription drug plan. You can see the complete *Formulary* (list of Part D prescription drugs) and any restrictions at **bluecrossmn.com/drugs**. 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.

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 **bluecrossmn.com/pharmacy.**

WHAT ARE THE DRUG TIERS?

Our plan places a drug into one of five tiers. Check the 2022 *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 $4,430 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 $7,050 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 plan like Blue Cross Medicare Advantage.

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 2022 *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 and multiple copays may apply. In most cases, your copay is due at the time you receive the service or prescription.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. The cost is a percentage of the allowed amount that is set by your plan. The amount you pay for coinsurance will vary if the provider is in-network or out-of-network.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

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 – Approval in advance to get services or certain drugs that may or may not be on our formulary.

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

Medicare Advantage 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?	$0 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$78.70 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$161.90 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 medical deductible.	This plan does not have a medical deductible.	This plan does not have a medical deductible.
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	$5,500	$3,000	$2,900
Combined in-network and out-of-network providers	$7,900	$5,150	$5,100
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.			
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.

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Covered Hospital and Medical Benefits – Hospital Care			
Inpatient hospital care*	$300 copay per day for days 1 through 5 $0 for days 6 through 90	$150 copay per admittance	$150 copay per admittance
Meals following inpatient stay 2 meals per day for 28 days	$0	$0	$0
Outpatient hospital care*			
Outpatient hospital surgery	$350 copay surgery	$150 copay surgery	$100 copay surgery
Ambulatory surgery center services	$350 copay	$100 copay	$75 copay
Observation stay	$225 copay	$125 copay	$75 copay
Blood services	$0	$0	$0
Outpatient hospital all other services	$20 copay	$10 copay	$0
Doctor's office visits*			
Primary Care Physician	$0	$0	$0
Specialist	$40 copay	$30 copay	$20 copay
Non-Medicare-covered acupuncture	$20 copay (max. 20 visits per year)	$20 copay (max. 20 visits per year)	$20 copay (max. 20 visits per year)

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

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
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 rectum 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.		

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Emergency care You do not pay this amount if you are admitted to the hospital on an inpatient basis within 24 hours for the same condition. See the "Inpatient Hospital Care" section of this booklet for other costs.	$90 copay	$90 copay	$90 copay
Urgently needed care	$45 copay	$35 copay	$25 copay
Worldwide emergency care	$90 copay	$90 copay	$90 copay
Transportation	20% coinsurance	20% coinsurance	20% coinsurance
Urgent care	$90 copay	$90 copay	$90 copay
Outpatient diagnostic tests and therapeutic services and supplies*			
X-rays	$10 copay for Medicare-covered x-rays	$0 for Medicare-covered x-rays	$0 for Medicare-covered x-rays
Radiation (radium and isotope) therapy including technician materials and supplies	20% coinsurance for Medicare-covered radiation therapy services. Examples include, but are not limited to, treatment of cancer.	15% coinsurance for Medicare-covered radiation therapy services. Examples include, but are not limited to, treatment of cancer.	10% coinsurance for Medicare-covered radiation therapy services. Examples include, but are not limited to, treatment of cancer.
Surgical supplies, such as dressings Splints, casts and other devices used to reduce fractures and dislocations	20% coinsurance for Medicare-covered surgical supplies, splints and casts.	20% coinsurance for Medicare-covered surgical supplies, splints and casts.	15% coinsurance for Medicare-covered surgical supplies, splints and casts.
Laboratory tests	$0 for Medicare-covered laboratory tests.	$0 for Medicare-covered laboratory tests.	$0 for Medicare-covered laboratory tests.
Blood	$0 for Medicare-covered blood.	$0 for Medicare-covered blood.	$0 for Medicare-covered blood.

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Diagnostic advanced imaging	$95 copay for Medicare-covered diagnostic advanced imaging. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds and angiograms.	$70 copay for Medicare-covered diagnostic advanced imaging. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds and angiograms.	$0 for Medicare-covered diagnostic advanced imaging. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds and angiograms.
Diagnostic tests & procedures (excludes x-ray and advanced imaging)	$25 copay for Medicare-covered diagnostic tests & procedures. Examples include, but are not limited to, EKG's, pulmonary function tests, psychological/ neuropsychological testing, home or lab-based sleep studies.	$20 copay for Medicare-covered diagnostic tests & procedures. Examples include, but are not limited to, EKG's, pulmonary function tests, psychological/ neuropsychological testing, home or lab-based sleep studies.	$0 for Medicare-covered diagnostic tests & procedures. Examples include, but are not limited to, EKG's, pulmonary function tests, psychological/ neuropsychological testing, home or lab-based sleep studies.
Diagnostic mammograms or colonoscopy	$0 for each Medicare-covered diagnostic mammogram or colonoscopy.	$0 for each Medicare-covered diagnostic mammogram or colonoscopy.	$0 for each Medicare-covered diagnostic mammogram or colonoscopy.

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

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Hearing services*			
Medicare-covered exams to diagnose and treat hearing and balance issues	$0	$0	$0
Non-Medicare covered hearing exam (1 per year)	$0	$0	$0
Non-Medicare covered hearing aid screening (1 per year) Through TruHearing	$0	$0	$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. $0 per aid for optional hearing aid rechargeability on premium aids.	$599 copay per aid for Advanced Aid or $899 copay per aid for Premium Aid from TruHearing. $0 per aid for optional hearing aid rechargeability on premium aids.	$499 copay per aid for Advanced Aid or $799 copay per aid for Premium Aid from TruHearing. $0 per aid for optional hearing aid rechargeability on premium aids.
Dental services*			
Medicare-covered dental services	$50 copay	$30 copay	$20 copay

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Non-Medicare covered dental services**			
Cleaning (Up to 2 per year)	$0	$0	$0
Dental x-rays (Up to 1 per year)	$0	$0	$0
Oral exam (Up to 2 per year)	$0	$0	$0
Periodontal cleaning (Up to 1 per year)	$0	$0	$0
Fluoride (Up to 2 per year)	$0	$0	$0
Restorations (e.g., fillings)	Not Covered	30% coinsurance	30% coinsurance
Extractions (e.g., pulling teeth)	Not Covered	50% coinsurance	50% coinsurance
Endodontics (e.g., root canal)	Not Covered	50% coinsurance	50% coinsurance
Other periodontal services (Note: no additional periodontal cleaning coverage beyond the one (1) $0 copay periodontal cleaning per year)	Not Covered	50% coinsurance	50% coinsurance
Prosthetics	Not Covered	50% coinsurance	50% coinsurance
Crowns	Not Covered	50% coinsurance	50% coinsurance
Oral surgery	Not Covered	50% coinsurance	50% coinsurance

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

**Maximum plan benefit amount is $2,000 per year for in-network and out-of-network covered dental services, $0 annual deductible.

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.

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Vision services*			
Medicare-covered annual glaucoma screening	$0	$0	$0
Medicare-covered exams to diagnose and treat eye diseases and conditions	$0	$0	$0
Medicare-covered eyewear after cataract surgery	$0	$0	$0
Non-Medicare covered eye exam (2 per year)	$0	$0	$0
Non-Medicare covered eyewear allowance	$100 (frames, lenses or contacts)	$150 (frames, lenses or contacts)	$150 (frames, lenses or contacts)
Medicare-covered 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	$300 copay per day for days 1 through 5	$150 copay per admittance	$150 copay per admittance
Outpatient group therapy visit	$40 copay	$30 copay	$20 copay
Outpatient individual therapy visit	$40 copay	$30 copay	$20 copay
Partial Hospitalization	$55 copay per day	$55 copay per day	$55 copay per day
Mental health office visit*			
Psychiatrist	$40 copay	$30 copay	$20 copay
Psychologist	$40 copay	$30 copay	$20 copay

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

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Skilled nursing facility (SNF)*	$0 per day for days 1 through 20	$0 per day for days 1 through 20	$0 per day for days 1 through 20
Our plan pays up to 100 days in a SNF	$188 copay per day for days 21 through 100	$188 copay per day for days 21 through 100	$188 copay per day for days 21 through 100
Meals following SNF stay 2 meals per day for 28 days	$0	$0	$0
Rehabilitation services*			
Cardiac and intensive cardiac rehab services	$40 copay	$30 copay	$20 copay
Physical, occupational and speech therapy visits	$40 copay	$30 copay	$20 copay
Pulmonary rehab services	$30 copay	$30 copay	$20 copay
Ambulance (ground and air)	$265 copay	$200 copay	$50 copay
Non-Medicare covered transportation	Not covered	Not covered	Not covered
Prescription drug benefits			
How much do I pay?*			
Part B chemotherapy drugs	20% coinsurance	20% coinsurance	20% coinsurance
Other Part B drugs including but not limited to oxygen or Erythropeitin (EPO)	20% coinsurance	20% coinsurance	20% coinsurance

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

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Additional benefits and services			
Medicare-covered acupuncture Covered for chronic lower back pain	$20 copay (max. 20 visits every 12 months)	$20 copay (max. 20 visits every 12 months)	$20 copay (max. 20 visits every 12 months)
Non-Medicare covered acupuncture Covered for pain diagnosis, except chronic lower back pain	$20 copay (max. 20 visits per year)	$20 copay (max. 20 visits per year)	$20 copay (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 copay	$20 copay	$20 copay
Non-Medicare-covered acupuncture	$20 copay (max. 20 visits per year)	$20 copay (max. 20 visits per year)	$20 copay (max. 20 visits per year)
Diabetes supplies and services			
Diabetes monitoring supplies through Ascensia	$0	$0	$0
Diabetes self-management training	$0	$0	$0
Therapeutic shoes and inserts	20% coinsurance	15% coinsurance	15% coinsurance
Durable medical equipment* (wheelchairs, oxygen, etc.)	20% coinsurance	20% coinsurance	15% coinsurance
Fitness program Gym membership at a participating SilverSneakers® facility, online fitness classes, or choose a home exercise kit	$0	$0	$0
Home health care*	$0	$0	$0
Outpatient substance abuse*			
Individual and group therapy visits	$40 copay	$30 copay	$20 copay

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

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

Doctor On Demand is an independent company providing telehealth services.

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

Medicare Advantage Benefits	Core Plan	Choice Plan	Complete Plan
Additional benefits and services			
Over-The-Counter (OTC) OTC medications and supplies are available to order online or by telephone through CVS OTCHS. Retail purchases are non-reimbursable.	$40 per quarter for the purchase of covered over-the-counter (OTC) items through CVS Over The Counter Health Solutions (OTCHS).	$40 per quarter for the purchase of covered over-the-counter (OTC) items through CVS Over The Counter Health Solutions (OTCHS).	$50 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	$40 copay	$30 copay	$10 copay
Prosthetic devices and medical supplies*	20% coinsurance	20% coinsurance	15% coinsurance
Renal dialysis Kidney Disease Education	20% coinsurance $0	20% coinsurance $0	20% coinsurance $0
Tobacco cessation A wellness coach helps members develop and maintain a plan to quit	$0	$0	$0

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

CVS Pharmacy, Inc. d/b/a OTC Health Solutions is an independent company providing OTC supplemental benefit administrative services.

Prescription drug Medicare Part D coverage

Blue Cross Medicare Advantage plans offer combined medical and prescription drug coverage to give you the convenience of one plan, one card and one bill. To view what drugs are covered by Medicare Advantage, visit **bluecrossmn.com/drugs** and either search by drug name or scroll halfway down to Helpful documents to view the comprehensive formulary.

	Medicare Advantage Benefits	**Core Plan**
	Deductible	$0 Tiers 1-2; $350 Tiers 3-5
	Initial Coverage	**Standard/LTC[3] Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay
	Tier 2: Generic Drugs	$13 copay
	Tier 3: Preferred Brand Drugs	21% coinsurance
	Tier 4: Non-Preferred Drugs	45% coinsurance
	Tier 5: Specialty Drugs	27% coinsurance
	Select Insulins	Regular tier cost share
60-90 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay
	Tier 2: Generic Drugs	$26 copay
	Tier 3: Preferred Brand Drugs	21% coinsurance
	Tier 4: Non-Preferred Drugs	45% coinsurance
	Tier 5: Specialty Drugs	27% coinsurance
	Select Insulins	Regular tier cost share
	Coverage Gap Begins once your total drug costs for the year reach $4,430[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 $7,050[2]	You pay the greater of: • 5% of the cost, or • $3.95 copay for generic drugs (including brand drugs treated as generic) and an $9.85 copay for all other 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.

[3]If in Long-Term Care facility (LTC), 31 day supply only.

Choice Plan	Complete Plan
$0 Tiers 1-3; $250 Tiers 4-5	$0 all Tiers
Standard/LTC[3] Cost-Sharing	**Standard/LTC[3] Cost-Sharing**
$0 copay	$0 copay
$10 copay	$9 copay
$47 copay	$47 copay
40% coinsurance	45% coinsurance
28% coinsurance	33% coinsurance
Regular tier cost share	$0 copay
$0 copay	$0 copay
$20 copay	$18 copay
$94 copay	$94 copay
40% coinsurance	45% coinsurance
28% coinsurance	33% coinsurance
Regular tier cost share	$0 copay
• Generic Drugs: 25% of the plan cost • Brand-name Drugs: 25% of the plan cost	• Generic Drugs: 25% of the plan cost • Brand-name Drugs: 25% of the plan cost • Select Insulins: $0 copay
You pay the greater of: • 5% of the cost, or • $3.95 copay for generic drugs (including brand drugs treated as generic) and an $9.85 copay for all other drugs	You pay the greater of: • 5% of the cost, or • $3.95 copay for generic drugs (including brand drugs treated as generic) and an $9.85 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.

	Medicare Advantage	Core	Choice	Complete
60- or 90-day supply via Mail Order	Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$0 copay
	Tier 2: Generic Drugs	$26 copay	$20 copay	$18 copay
	Tier 3: Preferred Brand Drugs	21% coinsurance	$94 copay	$94 copay
	Tier 4: Non-Preferred Drugs	45% coinsurance	40% coinsurance	45% coinsurance
	Tier 5: Specialty Drugs	27% coinsurance	28% coinsurance	33% coinsurance
	Select Insulins	Regular tier cost share	Regular tier cost share	$0 copay

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 **1-800-711-9865**

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 Blue Cross Medicare Advantage (PPO) 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. Blue Cross Medicare Advantage is a PPO plan with a Medicare contract. Enrollment in Blue Cross Medicare Advantage 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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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.

နမ့်ကတိၤကသီကျိာ်ဒီး, တ၊်ကဟ့ဉ်နၤကျိာ်တ၊်မၤစၢၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိ၊်, ကိး 711 တက့၊်.

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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