BlueCross BlueShield Minnesota

2024

SUMMARY OF BENEFITS

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

H2461

January 1, 2024 – December 31, 2024

Y0138_082223_G01_M

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

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **bluecrossmn.com/medicare-documents** to view or call toll free at **1-877-662-2583** (TTY **711**) to request 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.
- [ ] Review the formulary to make sure your drugs are covered.

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, 2025.
- [ ] 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).
- [ ] Effect on Current Coverage: If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

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 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 which includes 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 and Yellow Medicine. Some exceptions may apply. Counties are subject to change annually. Please contact your agent or Blue Cross for more information.

WHAT IS A PLATINUM BLUE COST PLAN?

Platinum Blue Cost 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. Some Platinum Blue Cost plans offer combined medical and prescription drug coverage.

To see a complete list of your services and benefits, please review the *Evidence of Coverage* (EOC). You can find this document at **bluecrossmn.com/medicare-documents**. You also may order a copy online or by calling Customer Service.

HOW DO I FIND AN IN-NETWORK DOCTOR OR HOSPITAL?

The Platinum Blue network offers a large list of providers covered under the Platinum Blue plan. You may pay less when you use doctors, hospitals and other providers in this network. You can see or order the plan's provider directory at **bluecrossmn.com/medicare-documents**. Or call us and we will send you a copy of the directory.

Services received out of network, or outside of your service area, will be paid by Original Medicare and your responsibility for cost sharing may be higher.

HOW CAN I FIND A LIST OF COVERED DRUGS?

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 **bluecrossmn.com/pb-core-rx** or **bluecrossmn.com/pb-choice-complete-rx.** You can order a copy of the *Formulary* at **bluecrossmn.com/members/shop-plans/medicare-plans/medicare-materials** or call us and we will send you a copy of the *Formulary*.

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.

When using in-network pharmacies you will typically see lower prices than using out-of-network pharmacies for covered Part D 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 **bluecrossmn.com/pb-core-pharm** or **bluecrossmn.com/pb-choice-complete-pharm**. You also may order a copy online at **bluecrossmn.com/medicare-documents** or call us and we will send you a copy of the pharmacy directory.

WHAT ARE THE DRUG 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 the amount spent by you and your plan on your covered drugs reaches the initial coverage limit set by Medicare for that year.

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

Stage 4: Catastrophic coverage Once you enter the catastrophic coverage stage, you will not have any cost share for the rest of the year.

Health care terms

Allowed amount – The contracted rate, or Blue Cross discount, set by your plan and providers when you use 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.

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.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost sharing amount. As a member of Platinum Blue, you only have to pay our plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to balance bill or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Copayment or Copay – The set dollar amount you pay each time you receive a service or prescription.

Coinsurance – A set percentage you pay toward health care after your deductible has been met.

Deductible – Amount you will pay in one plan year before coverage begins.

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

Maximum out-of-pocket amount – The most you could pay in one plan year for covered medical services and supplies.

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.

Out-of-pocket costs – The amount you must pay for eligible 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, using out-of-network providers results in higher member costs.

Premium – Your monthly payment for a plan.

Prior authorization – Approval in advance to get services or certain drugs.

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

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.

Platinum Blue without Rx Benefits	Core Plan	Choice Plan	Complete Plan
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
Monthly Plan Premium	$34 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$119 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$199 per month. In addition, you must keep paying your monthly Medicare Part B premium.
Annual Medical Deductible	$0	$0	$0
Out-of-Network cost sharing (May have benefits under Original Medicare.)	Not covered (unless otherwise specified)	Not covered (unless otherwise specified)	Not covered (unless otherwise specified)

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			
Monthly Plan Premium	$58.50 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$166 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$265.90 per month. In addition, you must keep paying your monthly Medicare Part B premium.
Annual Medical Deductible	$0	$0	$0
Out-of-Network cost sharing (May have benefits under Original Medicare.)	Not covered (unless otherwise specified)	Not covered (unless otherwise specified)	Not covered (unless otherwise specified)

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			
Maximum Out-of-Pocket Amount Your yearly out-of-pocket limit in this plan is 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

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			
Inpatient hospital care (Medicare-covered)	$600 copay per stay (coverage up to 90 days)	$200 copay per stay (coverage for unlimited days)	$100 copay per stay (coverage for unlimited days)
Skilled nursing facility (SNF) care (Medicare-covered) This plan pays up to 100 days in a SNF	$0 per day for days 1 through 20 $203 copay per day for days 21 through 100	$0 per day for days 1 through 20 $0 per day for days 21 through 100	$0 per day for days 1 through 20 $0 per day for days 21 through 100
Outpatient hospital care			
Medicare-covered outpatient hospital surgery	20% coinsurance	$50 copay	$0
Medicare-covered ambulatory surgical center services	20% coinsurance	$50 copay	$0
Medicare-covered outpatient hospital all other services	20% coinsurance	$0	$0
Doctor's office visits			
Medicare-covered primary care physician	$20 copay	$0	$0
Medicare-covered specialist*	20% coinsurance	$15 copay	$0

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

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
Preventive care (Medicare-covered) **See *Evidence of Coverage* for complete list of covered services.**	$0 This plan covers many preventive services, including but not limited to: • Annual wellness visit • Colorectal cancer screenings • Mammograms (breast cancer screening) • One-time "Welcome to Medicare" preventive visit • Ovarian cancer screenings • Routine annual physical exam Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency care in the United States and Worldwide (Medicare-covered) In- and Out-of-Network	$95 copay	$95 copay	$0
Urgently needed services (Medicare-covered) • United States In- and Out-of-Network	$60 copay	$15 copay	$0
• Worldwide In- and Out-of-Network	Not covered	Not covered	Not covered

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

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
Outpatient diagnostic tests and therapeutic services			
Medicare-covered diagnostic mammograms or colonoscopy	20% coinsurance	$0	$0
Medicare-covered laboratory tests (e.g., A1C, Cholesterol tests) In-and Out-of-Network	$0	$0	$0
Medicare-covered x-rays	$60 copay	$0	$0
Medicare-covered diagnostic tests & procedures (excludes x-ray and advanced imaging) (e.g., EKG's, INR tests, pulmonary function tests, psychological/ neuro-psychological testing, home or lab-based sleep studies)	20% coinsurance	$0	$0
Medicare-covered diagnostic advanced imaging (e.g., specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds, angiograms)	20% coinsurance	$0	$0
Medicare-covered radiation (e.g., treatment of cancer)	20% coinsurance	$0	$0

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

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
Hearing services			
Medicare-covered exams to diagnose and treat hearing and balance issues	$0	$0	$0
Non-Medicare-covered routine hearing exam (limit 2)	$0	$0	$0
Non-Medicare-covered hearing aid screening (limit 1) Through TruHearing	$0	$0	$0
Non-Medicare-covered hearing aid (limit 2 aids per year, 1 per ear) through TruHearing			
• Advanced Hearing Aid	$699 per aid	$599 per aid	$499 per aid
• Premium Hearing Aid	$999 per aid	$899 per aid	$799 per aid
• Rechargeable battery option is available on select styles at no additional cost	$0	$0	$0
Dental services*			
Medicare-covered dental services	20% coinsurance	$15 copay	$0
Non-Medicare-covered routine dental services*			
Cleaning (limit 2 per year) Oral exam (limit 2 per year) Fluoride (limit 2 per year) Periodontal cleaning (limit 2 per year) Dental x-rays (limit 1 per year)	Not covered	$0	$0
Maximum plan benefit amount per year (combined in-and out-of-network)	Not covered	$2,000	$2,000

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

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
Vision care			
Medicare-covered: annual glaucoma screening, diabetic retinopathy, and exams to diagnose and treat eye diseases and conditions.	$0	$0	$0
Medicare-covered eyewear after cataract surgery	20% coinsurance	20% coinsurance	20% coinsurance
Non-Medicare-covered routine eye exam (limit 1 per year)	Not covered	$0	$0
Non-Medicare-covered eyewear allowance for frames, lenses or contacts			
In- and Out-of-Network	Not covered	$125 allowance per year	$150 allowance per year
Mental health care (including inpatient)	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.		
Medicare-covered inpatient visit	$600 copay per stay	$200 copay per stay	$100 copay per stay
Medicare-covered outpatient individual or group therapy visit	$40 copay	$15 copay	$0
Medicare-covered partial hospitalization	$60 copay per day	$15 copay per day	$0
Mental health office visit			
Medicare-covered psychiatrist or psychologist	$40 copay	$15 copay	$0

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

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
Physical therapy services Medicare-covered physical, occupational and speech therapy visits	$40 copay	$15 copay	$0
Ambulance services (ground and air) (Medicare-covered) In- and Out-of-Network	20% coinsurance	$20 copay	$0
• Worldwide Transportation (Non-Medicare-covered) In- and Out-of-Network	20% coinsurance	$15 copay	$0
Ambulance services without transportation to a medical facility and other non-Medicare-covered transport services	Not covered	Not covered	Not covered
Medicare Part B prescription drugs Medicare-covered Part B oral chemotherapy and prescription drugs*	0%–20% coinsurance	0%–20% coinsurance	0%–20% coinsurance
Other Medicare-covered Part B drugs including but not limited to: Medicare-covered Part B drugs and biologicals that are not usually self-administered and are injected during an office visit but are administered by a healthcare professional, Medicare-covered medications packaged for use in a nebulizer, and self-administered Erythropoietin (EPO) when provided to you in accordance with Medicare guidelines. (Cost sharing for certain Part B rebatable drugs authorized by the plan may be subject to a lower coinsurance than shown.)*	0%–20% coinsurance	0%–20% coinsurance	0%–20% coinsurance
Medicare-covered Part B Insulin for use in an insulin pump	Up to $35 copay for a one-month supply	Up to $35 copay for a one-month supply	Up to $35 copay for a one-month supply

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

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			
Acupuncture*			
Medicare-covered acupuncture for chronic lower back pain (max. 20 visits every 12 months)	$20 copay	$15 copay	$0
Non-Medicare-covered routine acupuncture for pain diagnosis (max. 12 visits per year)	$20 copay	$15 copay	$0
Chiropractic services*			
Medicare-covered chiropractic services for manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	$20 copay	$15 copay	$0
Diabetes self-management training, diabetic services and supplies			
Medicare-covered diabetes monitoring supplies (coverage for test strips and monitors is limited to Ascensia brands)	$0	$0	$0
Medicare-covered diabetes self-management training	$0	$0	$0
Medicare-covered therapeutic shoes and inserts	20% coinsurance	20% coinsurance	$0
Durable medical equipment, prosthetic devices and medical supplies* (Medicare-covered) (wheelchairs, oxygen, continuous glucose monitor, braces, artificial limbs, etc.)	20% coinsurance	20% coinsurance	$0
Fitness program Gym membership at a participating SilverSneakers® facility, online fitness classes, or choose a home exercise kit	$0	$0	$0

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

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
Home health agency care (Medicare-covered)	$0	$0	$0
Outpatient substance abuse services (Medicare-covered) Individual and group therapy visits	20% coinsurance	$15 copay	$0
Over-The-Counter (OTC) items Quarterly allowance for the purchase of covered OTC medications and supplies through CVS OTC Health Solutions. This is not a reimbursement.	$25	$50	$50
Podiatry services (Medicare-covered foot care) Foot exams and treatment for diabetes-related nerve damage or certain medical conditions.	$50 copay	$15 copay	$0
Services to treat kidney disease Medicare-covered renal dialysis services Medicare-covered equipment and supplies Medicare-covered kidney disease education services	 20% coinsurance 20% coinsurance 20% coinsurance	 $15 copay 20% coinsurance $0	 $0 $0 $0
Smoking and Tobacco use cessation (Medicare-covered) Counselling to stop smoking or tobacco use.	$0	$0	$0

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

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. To view what drugs are covered by Platinum Blue with Rx, visit **bluecrossmn.com/core-rx** or **bluecrossmn.com/choice-complete-rx** and search by drug name. Or, go to **bluecrossmn.com/medicare-documents** to view a comprehensive formulary drug list.

	Platinum Blue with Rx Benefits	Core Plan with Rx
	Deductible	$545 all Tiers
	Initial Coverage Begins after you meet your deductible	**Standard Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay
	Tier 2: Generic Drugs	$11 copay
	Tier 3: Preferred Brand Drugs	22% coinsurance
	Tier 4: Non-Preferred Drugs	44% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance
	Insulin Coverage	Up to a $35 copay, even if you haven't paid your deductible.
60-90 Day Supply from a Network or Preferred Mail Order Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay
	Tier 2: Generic Drugs	$22 copay
	Tier 3: Preferred Brand Drugs	22% coinsurance
	Tier 4: Non-Preferred Drugs	44% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance
	Insulin Coverage	Up to a $70 copay Even if you haven't paid your deductible.
	Coverage Gap Begins once your total drug costs for the year reach $5,030[1]	• Generic Drugs: 25% of the plan cost • Brand-name Drugs: 25% of the plan cost • Insulin Coverage: Up to a $35 copay per month
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $8,000[2]	$0

[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.

	Platinum Blue with Rx Benefits	Choice Plan with Rx
	Deductible	$0 Tiers 1-2; $545 Tiers 3-5
	Initial Coverage Begins after you meet your deductible	**Standard Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay
	Tier 2: Generic Drugs	$15 copay
	Tier 3: Preferred Brand Drugs	21% coinsurance
	Tier 4: Non-Preferred Drugs	42% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance
	Insulin Coverage	Up to a $35 copay, even if you haven't paid your deductible.
60-90 Day Supply from a Network or Preferred Mail Order Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay
	Tier 2: Generic Drugs	$30 copay
	Tier 3: Preferred Brand Drugs	21% coinsurance
	Tier 4: Non-Preferred Drugs	42% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance
	Insulin Coverage	Up to a $70 copay Even if you haven't paid your deductible.
	Coverage Gap Begins once your total drug costs for the year reach $5,030[1]	• Generic Drugs: 25% of the plan cost • Brand-name Drugs: 25% of the plan cost • Insulin Coverage: Up to a $35 copay per month
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $8,000[2]	$0

[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.

	Platinum Blue with Rx Benefits	Complete Plan with Rx
	Deductible	$0 Tiers 1-2; $545 Tiers 3-5
	Initial Coverage Begins after you meet your deductible	**Standard Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay
	Tier 2: Generic Drugs	$9 copay
	Tier 3: Preferred Brand Drugs	20% coinsurance
	Tier 4: Non-Preferred Drugs	40% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance
	Insulin Coverage	Up to a $35 copay, even if you haven't paid your deductible.
60-90 Day Supply from a Network or Preferred Mail Order Pharmacy	Tier 1: Preferred Generic Drugs	$0 copay
	Tier 2: Generic Drugs	$18 copay
	Tier 3: Preferred Brand Drugs	20% coinsurance
	Tier 4: Non-Preferred Drugs	40% coinsurance
	Tier 5: Specialty Drugs	25% coinsurance
	Insulin Coverage	Up to a $70 copay Even if you haven't paid your deductible.
	Coverage Gap Begins once your total drug costs for the year reach $5,030[1]	• Generic Drugs: 25% of the plan cost • Brand-name Drugs: 25% of the plan cost • Insulin Coverage: Up to a $35 copay per month
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $8,000[2]	$0

[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.

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: Blue Cross and Blue Shield of Minnesota and Blue Plus
  Attn: Civil Rights Coordinator P3-2
  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.

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.

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 toll-free **1-877-662-2583**
TTY users call **711**

Visit **bluecrossmn.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 Customer Service or see the *Evidence of Coverage* for more information.

If you want to know more about the coverage and costs of Original Medicare, look in your 2024 *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**.

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