BlueCross BlueShield Minnesota

2025

SUMMARY OF BENEFITS

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

West Region

H5959

January 1, 2025 – December 31, 2025

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Introduction

This booklet includes an overview of our plan benefits, a glossary of health care terms and contact information for Customer Service representatives who are available to answer your questions.

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services				
Monthly Plan Premium	$0 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$59 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$105 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$228 per month. In addition, you must keep paying your monthly Medicare Part B premium.
Part B Premium Reduction	Up to $5.80 per month	Not offered	Not offered	Not offered
Annual Medical Deductible	$0	$0	$0	$0
Out-of-Network cost sharing (unless otherwise specified)	45% coinsurance	40% coinsurance	40% coinsurance	40% coinsurance
Maximum Out-of-Pocket Amount The following out-of-pocket limits apply:				
For services you receive from in-network providers	$4,900	$3,800	$3,100	$2,900
For services you receive from in-network and out-of-network providers	$7,900	$5,750	$5,150	$5,100
Once you reach the maximum out-of-pocket, your plan pays 100% of covered medical services. Your plan premium and all other non-Medicare covered services do not count toward the maximum out-of-pocket.				

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Covered Hospital and Medical Benefits				
Inpatient hospital care* (Medicare-covered)	$350 copay per day for days 1 through 5, per stay	$400 copay per stay	$250 copay per stay	$150 copay per stay
Skilled nursing facility (SNF) care* (Medicare-covered) Your plan covers up to 100 days in a SNF	$0 per day for days 1 through 20 $214 copay per day for days 21 through 100	$0 per day for days 1 through 20 $214 copay per day for days 21 through 100	$0 per day for days 1 through 20 $214 per day for days 21 through 100	$0 per day for days 1 through 20 $214 per day for days 21 through 100
Meals following inpatient stay (Non-Medicare-covered) After an approved inpatient hospital or skilled nursing facility stay, we cover up to 2 meals per day for 14 days delivered to your home.	$0	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Outpatient hospital care*				
Medicare-covered outpatient hospital surgery	$400 copay	$300 copay	$175 copay	$150 copay
Medicare-covered ambulatory surgical center services	$300 copay	$225 copay	$150 copay	$125 copay
Medicare-covered outpatient hospital all other services	$20 copay	$20 copay	$10 copay	$0
Medicare-covered outpatient observation	$400 copay	$300 copay	$175 copay	$150 copay
Doctor's office visits				
Medicare-covered primary care physician	$0	$0	$0	$0
Medicare-covered specialist*	$45 copay	$45 copay	$40 copay	$20 copay

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
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 Any additional preventive services approved by Medicare during the contract year will be covered.			
Preventive care (non-Medicare-covered)	$0 • 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 In- and Out-of-Network	$125 copay	$140 copay	$140 copay	$140 copay
Urgently needed services (Medicare-covered) • United States In- and Out-of-Network • Worldwide In- and Out-of-Network	 $45 copay $125 copay	 $45 copay $140 copay	 $40 copay $140 copay	 $30 copay $140 copay

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Outpatient diagnostic tests and therapeutic services*				
Medicare-covered diagnostic mammograms or colonoscopy	$0	$0	$0	$0
Medicare-covered laboratory tests (e.g., A1C and Cholesterol tests)				
In- and Out-of-Network	$0	$0	$0	$0
Medicare-covered x-rays	$15 copay	$10 copay	$10 copay	$5 copay
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)	$25 copay	$30 copay	$25 copay	$10 copay
Medicare-covered diagnostic advanced imaging (e.g., specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds, angiograms)	$150 copay	$100 copay	$100 copay	$50 copay
Medicare-covered radiation (e.g., treatment of cancer)	20% coinsurance	20% coinsurance	15% coinsurance	10% coinsurance

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Hearing services				
Medicare-covered exams to diagnose and treat hearing and balance issues	$0	$0	$0	$0
Non-Medicare-covered routine hearing exam (limit 1)	$0	$0	$0	$0
Non-Medicare-covered hearing aid screening (limit 1) through TruHearing	$0	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Non-Medicare-covered hearing aid (limit 2 aids per year, 1 per ear) through TruHearing				
• Advanced Hearing Aid	$699 per aid	$599 per aid	$599 per aid	$499 per aid
• Premium Hearing Aid	$999 per aid	$899 per aid	$899 per aid	$799 per aid
• Rechargeable battery option is available on select styles	$0	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Dental services*	$50 copay	$30 copay	$30 copay	$20 copay
Medicare-covered dental services				
Routine dental services* (Non-Medicare-covered)				
Cleaning (limit 2 per year) Oral exam (limit 2 per year) Fluoride (limit 2 per year) Periodontal cleaning (limit 2 per year) X-rays (limit 1 per year)				
In- and Out-of-Network	$0	$0	$0	$0
Restorations (e.g., fillings)				
In- and Out-of-Network	Not Covered	30% coinsurance	30% coinsurance	30% coinsurance
Extractions (e.g., pulling teeth), Endodontics (e.g., root canal), Prosthetics, Crowns, Oral surgery				
In- and Out-of-Network	Not Covered	50% coinsurance	50% coinsurance	50% coinsurance
Other periodontal services (Note: no additional periodontal cleaning coverage beyond the two (2) $0 copay periodontal cleanings per year)				
In- and Out-of-Network	Not Covered	50% coinsurance	50% coinsurance	50% coinsurance
Maximum plan benefit amount per year (combined in- and out-of-network)	$2,000	$1,500	$1,500	$2,000

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Vision care				
Medicare-covered: annual glaucoma screening, diabetic retinopathy, and exams to diagnose and treat eye diseases and conditions.	$0	$0	$0	$0
Medicare-covered eyewear after cataract surgery	$0	$0	$0	$0
Non-Medicare-covered routine eye exam (limit 2 per year)	$0	$0	$0	$0
Non-Medicare-covered eyewear allowance for frames, lenses or contacts				
In- and Out-of-Network	$275 allowance per year	$125 allowance per year	$150 allowance per year	$200 allowance per year
Mental health care* (including inpatient)	Your 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	$350 copay per day for days 1 through 5	$400 copay per stay	$250 copay per stay	$150 copay per stay
Medicare-covered outpatient individual or group therapy visit	$20 copay	$20 copay	$20 copay	$10 copay
Medicare-covered partial hospitalization	$55 copay per day	$55 copay per day	$55 copay per day	$55 copay per day
Mental health office visit*				
Medicare-covered psychiatrist or psychologist	$20 copay	$20 copay	$20 copay	$10 copay
Physical therapy services*				
Medicare-covered physical and speech therapy visits	$45 copay	$45 copay	$40 copay	$20 copay
Medicare-covered occupational therapy visits	$40 copay	$45 copay	$40 copay	$20 copay

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Ambulance services* (ground and air) (Medicare-covered)				
In- and Out-of-Network	$290 copay	$250 copay	$250 copay	$200 copay
• Worldwide Transportation (Non-Medicare-covered)				
In- and Out-of-Network	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Ambulance services without transportation to a medical facility and other non-Medicare-covered transport services	Not covered	Not covered	Not covered	Not covered
Medicare Part B prescription drugs				
Medicare-covered Part B oral chemotherapy and prescription drugs (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	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	Up to $35 copay for a one-month supply

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Additional benefits and services				
Acupuncture*				
Medicare-covered acupuncture for chronic lower back pain (max. 20 visits every 12 months combined In- and Out-of-Network)				
In- and Out-of-Network	$20 copay	$20 copay	$20 copay	$20 copay
Non-Medicare-covered routine acupuncture for pain diagnosis (max. 12 visits per year combined In- and Out-of-Network)				
In- and Out-of-Network	$20 copay	$20 copay	$20 copay	$20 copay
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	$20 copay	$20 copay	$20 copay
Non-Medicare-covered routine chiropractic care (max. 12 visits per year combined In- and Out-of-Network, x-ray coverage not included)	$20 copay	$20 copay	Not covered	Not covered

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
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	$0
Medicare-covered diabetes self-management training	$0	$0	$0	$0
Medicare-covered therapeutic shoes and inserts	20% coinsurance	20% coinsurance	15% coinsurance	15% coinsurance
Durable medical equipment, prosthetic devices and medical supplies* (Medicare-covered)				
Durable medical equipment such as wheelchairs, walkers, oxygen equipment, etc.	35% coinsurance	35% coinsurance	30% coinsurance	25% coinsurance
Medical supplies such as braces, surgical dressings, splints, casts, etc.	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prosthetic devices, other than dental, such as artificial limbs, colostomy bags, etc.	35% coinsurance	35% coinsurance	30% coinsurance	25% coinsurance
Preferred continuous glucose monitoring products.	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Non-preferred continuous glucose monitoring products.	35% coinsurance	35% coinsurance	30% coinsurance	25% coinsurance

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Fitness program Gym membership at a participating SilverSneakers® facility, online fitness classes, or choose a home exercise kit	$0	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Home health agency care* (Medicare-covered)	$0	$0	$0	$0
Medicare Diabetes Prevention Program (MDPP) MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	$0	$0	$0	$0
Virtual diabetes prevention program provides personalized, digital care, guidance, support, and feedback focused on sustained weight loss, healthy lifestyle habits, and reducing the risk of developing type 2 diabetes, heart disease, and stroke.	$0	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Musculoskeletal Condition Management Program The Musculoskeletal Condition Management Program allows members with rheumatoid arthritis, joint and muscle pain, pelvic floor related urinary incontinence, osteoarthritis to access guided exercises, clinical care team, education videos, additional resources. Out-of-Network	$0 Not Covered	$0 Not Covered	$0 Not Covered	$0 Not Covered
Outpatient substance use disorder services* (Medicare-covered) Individual and group therapy visits	$20 copay	$20 copay	$20 copay	$10 copay
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. Out-of-Network	$60 Not Covered	$50 Not Covered	$50 Not Covered	$50 Not Covered
Peer support Connect with a peer specialist who has firsthand experience with mental health and substance abuse care for mentorship that supports recovery.	$0	$0	$0	$0

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

Medicare Advantage Benefits	Core Plan	Comfort Plan	Choice Plan	Complete Plan
Podiatry services* (Medicare-covered foot care) Foot exams and treatment for diabetes-related nerve damage or certain medical conditions.	$45 copay	$45 copay	$40 copay	$20 copay
Podiatry for non-Medicare covered (routine) foot care* All types of podiatry visits, limited to 6 total visits per calendar year Services not rendered by a healthcare professional are excluded	$45 copay	$45 copay	$40 copay	$20 copay
Services to treat kidney disease Medicare-covered renal dialysis services* Medicare-covered kidney disease education services	20% coinsurance $0	20% coinsurance $0	20% coinsurance $0	20% coinsurance $0
Smoking and Tobacco use cessation (Medicare-covered) Counselling to stop smoking or tobacco use.	$0	$0	$0	$0

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

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/core-comfort-rx** for the Core or Comfort plans or **bluecrossmn.com/choice-complete-rx** for Choice or Complete plans and either search by drug name or scroll halfway down to Helpful documents to view the comprehensive formularies for the Core and Comfort plans or the Choice and Complete plans.

	Medicare Advantage Benefits	Core Plan
	Deductible	$0 Tiers 1-2; $350 Tiers 3-5
	Initial Coverage Begins after you meet your deductible	**Standard/LTC[2] Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0
	Tier 2: Generic Drugs	$0
	Tier 3: Preferred Brand Drugs	25% coinsurance
	Tier 4: Non-Preferred Drugs	45% coinsurance
	Tier 5: Specialty Drugs	28% 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
	Tier 2: Generic Drugs	$0
	Tier 3: Preferred Brand Drugs	25% coinsurance
	Tier 4: Non-Preferred Drugs	45% coinsurance
	Tier 5: Specialty Drugs	A long-term supply is not available.
	Insulin Coverage	Up to a $70 copay, even if you haven't paid your deductible.
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $2,000[1]	$0
	Additional covered drugs: These drugs are not covered by Medicare Part D.	This plan covers these additional drugs as Tier 1 medications. • Vitamin D (50,000) • Sildenafil (generic Viagra) • Cyanocobalamin (Vitamin B-12) • Folic Acid (1 mg)

[1]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.
[2]If in Long-Term Care facility (LTC), up to a 31-day supply only.

	Medicare Advantage Benefits	Comfort Plan
	Deductible	$0 Tiers 1-2; $275 Tiers 3-5
	Initial Coverage Begins after you meet your deductible	**Standard/LTC[2] Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0
	Tier 2: Generic Drugs	$0
	Tier 3: Preferred Brand Drugs	20% coinsurance
	Tier 4: Non-Preferred Drugs	42% coinsurance
	Tier 5: Specialty Drugs	28% 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
	Tier 2: Generic Drugs	$0
	Tier 3: Preferred Brand Drugs	20% coinsurance
	Tier 4: Non-Preferred Drugs	42% coinsurance
	Tier 5: Specialty Drugs	A long-term supply is not available.
	Insulin Coverage	Up to a $70 copay, even if you haven't paid your deductible.
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $2,000[1]	$0
	Additional covered drugs: These drugs are not covered by Medicare Part D.	This plan covers these additional drugs as Tier 1 medications. • Vitamin D (50,000) • Sildenafil (generic Viagra) • Cyanocobalamin (Vitamin B-12) • Folic Acid (1 mg)

[1]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.
[2]If in Long-Term Care facility (LTC), up to a 31-day supply only.

	Medicare Advantage Benefits	Choice Plan
	Deductible	$0 all Tiers
	Initial Coverage Begins after you meet your deductible	**Standard/LTC[2] Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0
	Tier 2: Generic Drugs	$0
	Tier 3: Preferred Brand Drugs	25% coinsurance
	Tier 4: Non-Preferred Drugs	42% coinsurance
	Tier 5: Specialty Drugs	33% coinsurance
	Insulin Coverage	Up to a $35 copay
60-90 Day Supply from a Network or Preferred Mail Order Pharmacy	Tier 1: Preferred Generic Drugs	$0
	Tier 2: Generic Drugs	$0
	Tier 3: Preferred Brand Drugs	25% coinsurance
	Tier 4: Non-Preferred Drugs	42% coinsurance
	Tier 5: Specialty Drugs	A long-term supply is not available.
	Insulin Coverage	Up to a $70 copay
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $2,000[1]	$0

[1]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.
[2]If in Long-Term Care facility (LTC), up to a 31-day supply only.

	Medicare Advantage Benefits	Complete Plan
	Deductible	$0 all Tiers
	Initial Coverage Begins after you meet your deductible	**Standard/LTC[2] Cost-Sharing**
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0
	Tier 2: Generic Drugs	$0
	Tier 3: Preferred Brand Drugs	$47 copay
	Tier 4: Non-Preferred Drugs	45% coinsurance
	Tier 5: Specialty Drugs	33% coinsurance
	Insulin Coverage	Up to a $35 copay
60-90 Day Supply from a Network or Preferred Mail Order Pharmacy	Tier 1: Preferred Generic Drugs	$0
	Tier 2: Generic Drugs	$0
	Tier 3: Preferred Brand Drugs	$94 copay
	Tier 4: Non-Preferred Drugs	45% coinsurance
	Tier 5: Specialty Drugs	A long-term supply is not available.
	Insulin Coverage	Up to a $70 copay
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $2,000[1]	$0

[1]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.
[2]If in Long-Term Care facility (LTC), up to a 31-day supply only.

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

- [ ] 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 **1-855-579-7658** (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, 2026.
- [ ] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, 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.
- [ ] 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 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: Becker, Beltrami, Benton, Big Stone, Brown, Cass, Chippewa, Clay, Clearwater, Cottonwood, Crow Wing, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Marshall, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Redwood, Renville, Roseau, Stearns, Swift, Todd, Wadena and Wilkin. Counties are subject to change annually.

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. Some Medicare Advantage plans combine 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 Medicare Advantage provider network offers a large list of providers covered under the Medicare Advantage 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.

HOW CAN I FIND A LIST OF COVERED DRUGS?

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/core-comfort-rx** or **bluecrossmn.com/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 previously 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/Pharmacy.** 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: 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 hospitals, 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 Medicare Advantage, 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, providers 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. It does not include your monthly premiums.

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 receive certain 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.

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY

At Blue Cross and Blue Shield of Minnesota and Blue Plus, we treat everyone fairly. We don't exclude you, or treat you less favorably, because of your race, skin color, national origin, age, disability status, or sex (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes). We follow federal civil rights laws and don't discriminate against anyone based on these traits.

If you communicate best in a language other than English, you can request free language assistance services.

If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge.

Need these services? Call **1-855-903-2583**, TTY **711** or call the number on the back of your member identification card.

Discrimination is against the law.

If we failed to provide services or discriminated in another way based on your race, skin color, national origin, age, disability status, or sex, (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes), you can file a complaint by contacting our Nondiscrimination Civil Rights Coordinator:

Email: Civil.Rights.Coord@bluecrossmn.com

Telephone: 1-800-509-5312

Mail: Blue Cross and Blue Shield of Minnesota
ATTN: Civil Rights Coordinator P3-2
PO Box 64560, Eagan, MN 55164-0560

Nondiscrimination complaint forms are available on our website at bluecrossmn.com/NDL, or from the Nondiscrimination Civil Rights Coordinator.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services

- electronically through the Office for Civil Rights complaint portal: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201
- or by phone at: 1-800-368-1019, 1-800-537-7697 (TDD)

Civil rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

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ENGLISH
ATTENTION: If you speak a language other than English, language services are available free of charge. If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge. Call 1-855-903-2583 (TTY 711).

ESPAÑOL (Spanish)
ATENCIÓN: Si habla Español, puede solicitar servicios gratuitos de asistencia lingüística. Si tiene una deficiencia visual, auditiva o del habla, podemos comunicarnos de la manera que le resulte mejor a usted. Esto puede incluir el uso de intérpretes de lengua de señas, el suministro de documentos en letra grande o braille, grabaciones de audio u otras ayudas sin cargo. Llame al 1-855-903-2583 (TTY 711).

العربية (Arabic)
تنبيه: إذا كنت تتحدث العربية، يمكنك طلب خدمات المساعدة اللغوية المجانية. إذا كنت تعاني من إعاقة بصرية أو سمعية أو نطقية، يمكننا التواصل معك بالطريقة التي تناسبك. وقد يشمل ذلك استخدام مترجمين للغة الإشارة، أو توفير المستندات بحروف كبيرة أو بطريقة برايل، أو تسجيلات صوتية، أو غيرها من الوسائل المساعدة من دون مقابل. اتصل على الرقم 1-855-903-2583 (الهاتف النصي 711).

አማርኛ (Amharic)
ትኩረት ይሰጥ፦ አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እገዛ አገልግሎቶችን መጠየቅ ይችላሉ። የማየት፣ የመስማት ወይም የመናገር ችግር ካለብዎት ለእርስዎ በተሻለ በሚሠራው መንገድ መግባባት እንችላለን። ይህ ደግሞ የምልክት ቋንቋ አስተርጓሚዎችን መጠቀምን፣ በትላልቅ ህትመቶች ወይም በብሬይል የተጻፉ ሰነዶችን፣ የድምፅ ቅጂዎችን ወይም ሌሎች መርጃዎችን ያለ ክፍያ ማቅረብን ይጨምራል። 1-855-903-2583 (TTY 711) ላይ ይደውሉ።

LUS HMOOB (Hmong)
LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob, koj tuaj yeem thov cov kev pab cuam uas pab hom lus tau dawb. Yog hais tias koj qhov muag tsis pom kev zoo, tsis hnov lus, los sis hais tsis tau lus, peb tuaj yeem sib txuas lus hauv ib txoj hau kev uas ua hauj lwm tau zoo tshaj plaws rau koj. Qhov no tej zaum yuav muaj xam nrog kev siv cov neeg txhais lus piav tes, kev muab cov ntaub ntawv luam tawm ua tus ntawv loj los sis Ua Ntawv Su Rau Cov Neeg Tsis Pom Kev Siv Tau (Braille), kev kaw ua suab lus, los sis lwm yam kev pab yam tsis tau them nqi. Hu rau 1-855-903-2583 (TTY 711).

廣東話 (Cantonese – Traditional Chinese)
請注意：如果您說 廣東話 您可要求免費語言協助服務。 如果您有視力、聽力或言語障礙，我們會以最適合您的方式與您溝通 這可能包括使用手語傳譯員、免費提供大字體或點字文件、 錄音或其他輔助工具。請致電 1-855-903-2583 聽障熱線 (TTY 711)。

简体中文 (Chinese Simplified)
注意：**如果您**说普通话，则可以免费申请语言协助服务。 **如果您有**视力、听力或语言障碍，我们可以用最适合您的方式 **与您交流**。这可能包括免费提供手语翻译、大字体或盲文文件、 录音或其 **他**辅助工具。 请致电 1-855-903-2583（**文字**电话 711）。

SOOMALI (Somali)
XASUUSIN: Haddii aad ku hadasho Soomali, waxaad codsan kartaa adeegyada caawimaadda luqada oo bilaash ah. Haddii aad laxaad la'aan kataahy aragga, maqalka, ama hadalka, waxaanu kugula xidhiidhi karnaa habka adiga kuugu habboon. Tan waxaa ka mid ah in aan isticmaalno turjumaanada luuqada dhegoolaha, in la bixiyo waraaqo ku qoran xarfaha waaweyn ama qoraalka indhoolayaasha, in la sameeyo cajalado la duubay, ama in la helo waxyaabo kale oo caawimaad ah oo bilaash ah. Wac 1-855-903-2583 (TTY 711).

FRANÇAIS (French)
ATTENTION : Si vous parlez Français, vous pouvez demander des services d'assistance linguistique gratuits. Si vous avez une déficience visuelle, auditive ou vocale, nous pouvons communiquer de la manière qui vous convient le mieux. Il peut s'agir d'interprètes en langue des signes, de documents en gros caractères ou en braille, d'enregistrements audio ou d'autres aides gratuites. Composez le 1-855-903-2583 (ATS 711).

ខ្មែរ (Khmer)
ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រាស្រ័យទាក់ទងជាមួយអ្នកតាមរបៀបផ្សេងដែលមានប្រសិទ្ធភាពល្អបំផុតសម្រាប់អ្នក។ ការប្រាស្រ័យទាក់ទងនេះអាចមានដូចជាអ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំៗ ឬអក្សរស្ទាប ឬការថតទុកជាសំឡេង ឬជំនួយផ្សេងទៀត ដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-855-903-2583 (TTY 711)។

한국어 (Korean)
주의: 한국어를 사용하시는 경우 귀하는 무료 언어 지원 서비스를 요청하실 수 있습니다. 시각 장애, 청각 장애 또는 언어 장애가 있는 경우 저희는 귀하에게 가장 적합한 방법으로 연락을 드릴 수 있습니다. 여기에는 수화통역사 이용, 대형 활자 또는 점자로 작성된 문서 제공, 음성 녹음 또는 기타 무료 지원이 포함될 수 있습니다. 1-855-903-2583 (TTY 711) 번으로 전화하십시오.

ကညီကျိာ် (Karen)

ဟ်သူဉ်ဟ်သး- နမ့်၊ကတိၤ ကညီကျိာ် နှဉ်,
နဃ့ကျိာ်ဂ့်၊ဝီတ၊်တိစၢၤမၤစၢၤလၢတလၫ်ဘူးလဲ သ့နှဉ်လီၤ.
နမ့်၊အိဉ်ဒီးတ၊်တလၢတပ့ၤလၢ မဲာ်တ၊်ထံဉ်, တ၊်နှ်၊ဟူ, မ့တမ့်၊
တ၊်စံးကတိၤတ၊်နှဉ် ပဆဲးကျၢဆဲးကျိးတ၊်လၢ
ကျဲကဲထိဉ်လိာ်ထိဉ်အဂ့ၤကတ၊်၊်လၢနဂီၢ်သ့နှဉ်လီၤ. တ၊်အံၤ
ပဉ်ဃာ်ဒီး တ၊်စူးကါ နီၢ်ခိက့်၊်ဂီၤကျိာ်အပှၤကျိာ်ထံတ၊်တဖဉ်,
တ၊်ဟ့ဉ်လံာ်လံ၊်တဖဉ်လၢ အလံာ်ဖျၢဉ်ဖးဒိဉ်, မ့တမ့်၊
ပှၤမဲာ်ဘျိဉ်အလံာ်, တ၊်ကလုၢ်, မ့တမ့်၊ တ၊်မၤစၢၤဂုၤဂၤတဖဉ်
လၢတလၫ်အဘူးလဲနှဉ်လီၤ. ကိးလီတဲစိဆူ
1-855-903-2583 (TTY 711) တက့၊်.

မြန်မာဘာသာ (Burmese)

သတိပြုရန်- သင်သည် မြန်မာဘာသာ စကားကို ပြောပါက၊
အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို
တောင်းဆိုနိုင်ပါသည်။ သင့်တွင် အမြင်အာရုံ၊ အကြားအာရုံ၊
သို့မဟုတ် စကားပြောခြင်း ချို့ယွင်းမှုရှိနေပါက သင့်အတွက်
အသင့်လျော်ဆုံးဖြစ်မည့်နည်းလမ်းဖြင့် ကျွန်ုပ်တို့ထံသို့
ဆက်သွယ်နိုင်ပါသည်။ ၎င်းတွင် လက်ဟန်ပြဘာသာစကား
စကားပြန်များကို အသုံးပြုခြင်း၊ စာရွက်စာတမ်းများကို
ပုံနှိပ်စာလုံးကြီးများ သို့မဟုတ် မျက်မမြင်စာဖြင့် ပံ့ပိုးပေးခြင်း၊
အသံဖမ်းယူခြင်းများ သို့မဟုတ်
အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပိုးပေးခြင်းတို့
ပါဝင်ပါသည်။ 1-855-903-2583
(TTY 711) သို့ ဖုန်းခေါ်ဆိုပါ။

OROMOO (Oromo)

Xiyyeeffannoon haa kennamuː- Oromo Afaan kan dubbatan yoo ta'e, tajaajiloota gargaarsa afaanii bilisaa gaafachuu ni dandeessu. Rakkoo ilaaluu, dhaga'u ykn dubbachuu yoo qabaattan, karaa isiniif mijatuun haala isiniif galuun mari'achuu ni dandeenya. Kunis of keessatti kan qabatu, hiiktota afaan mallattoo fayyadamuun maxxansa gurguddaa ykn bireeylii, waraabbiiwwan sagalee ykn gargaarsota biroo kaffaltii tokkoo malee gaafachuu dha. 1-855-903-2583 (TTY 711) irratti bilbilaa.

РУССКИЙ (Russian)

ВНИМАНИЕ: Если ваш язык — РУССКИЙ, вы можете запросить бесплатные услуги языковой поддержки. Если у вас есть нарушение зрения, слуха или речи, мы можем общаться таким образом, который лучше всего подходит вам. Это может включать бесплатное использование переводчиков на языке жестов, предоставление документов крупным шрифтом или шрифтом Брайля, использование аудиозаписей или других вспомогательных средств. Звоните по телефону 1-855-903-2583 (TTY 711).

ພາສາລາວ (Lao)

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ,
ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ.
ຖ້າທ່ານມີຄວາມບົກຜ່ອງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື
ການປາກເວົ້າ,
ພວກເຮົາສາມາດສື່ສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ.
ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື,
ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ,
ການບັນທຶກສຽງ ຫຼື
ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໂທ
1-855-903-2583 (TTY 711).

Tagalog (Tagalog)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang humingi ng mga libreng serbisyo na tulong sa wika. Kung may kapansanan ka sa paningin, pandinig, o pananalita, maaari tayong mag-usap sa paraan na pinakamabuti para sa iyo. Maaaring kabilang dito ang paggamit ng mga interpreter ng sign language, pagbibigay ng mga dokumento na malalaki ang pagkaprinta o Braille, mga audio recording, o iba pang mga tulong nang walang bayad. Tumawag sa 1-855-903-2583 (TTY 711).

VIETNAMESE (Vietnamese)

LƯU Ý: Nếu quý vị nói Vietnamese, quý vị có thể yêu cầu dịch vụ hỗ trợ ngôn ngữ miễn phí. Nếu quý vị bị khiếm thị, khiếm thính hoặc khuyết tật về âm ngữ, chúng tôi có thể giao tiếp theo cách phù hợp nhất với quý vị. Điều này có thể bao gồm việc sử dụng thông dịch viên ngôn ngữ ký hiệu, cung cấp tài liệu dạng bản in cỡ chữ lớn hoặc chữ nổi, bản ghi âm hoặc các phương tiện hỗ trợ khác miễn phí. Xin gọi số 1-855-903-2583 (TTY 711).

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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 **1-800-711-9865**
TTY users call **711**

Non-Members
Call toll-free **1-855-579-7658**
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 Blue Cross Medicare Advantage (PPO) plan members, except in emergency situations. Please call Customer Service or see the *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

If you want to know more about the coverage and costs of Original Medicare, look in your 2025 *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**.

The pharmacy benefits information is provided by Prime Therapeutics LLC, an independent company that provides pharmacy solutions.

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.

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.

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

Blue Cross Medicare Advantage is a PPO plan with a Medicare contract. Enrollment in Blue Cross Medicare Advantage depends on contract renewal.

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