

2025

SUMMARY OF BENEFITS

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

H2461

January 1, 2025 – December 31, 2025

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.

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	\$37 per month. In addition, you must keep paying your monthly Medicare Part B premium.	\$129 per month. In addition, you must keep paying your monthly Medicare Part B premium.	\$214 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	\$60.40 per month. In addition, you must keep paying your monthly Medicare Part B premium.	\$176.20 per month. In addition, you must keep paying your monthly Medicare Part B premium.	\$282.20 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			
<p>Maximum Out-of-Pocket Amount</p> <p>Your yearly out-of-pocket limit in this plan is for services you receive from in-network providers.</p> <p>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.</p>	\$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			
<p>Inpatient hospital care (Medicare-covered)</p> <p>Skilled nursing facility (SNF) care (Medicare-covered) This plan pays up to 100 days in a SNF</p>	<p>\$600 copay per stay (coverage up to 90 days)</p> <p>\$0 per day for days 1 through 20</p> <p>\$214 copay per day for days 21 through 100</p>	<p>\$200 copay per stay (coverage for unlimited days)</p> <p>\$0 per day for days 1 through 20</p> <p>\$0 per day for days 21 through 100</p>	<p>\$100 copay per stay (coverage for unlimited days)</p> <p>\$0 per day for days 1 through 20</p> <p>\$0 per day for days 21 through 100</p>
<p>Outpatient hospital care</p> <p>Medicare-covered outpatient hospital surgery</p> <p>Medicare-covered ambulatory surgical center services</p> <p>Medicare-covered outpatient hospital all other services</p> <p>Medicare-covered outpatient observation</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>\$50 copay</p> <p>\$50 copay</p> <p>\$0</p> <p>\$50 copay</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>

* 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
Doctor's office visits Medicare-covered primary care physician Medicare-covered specialist*	\$20 copay 20% coinsurance	\$0 \$15 copay	\$0 \$0
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: <ul style="list-style-type: none"> • Annual wellness visit • 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	\$125 copay	\$100 copay	\$0
Urgently needed services (Medicare-covered) <ul style="list-style-type: none"> • United States In- and Out-of-Network • Worldwide In- and Out-of-Network 	\$55 copay Not covered	\$15 copay Not covered	\$0 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 colonoscopy	\$25 copay	\$0	\$0
Medicare-covered diagnostic mammograms	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)	\$25 copay	\$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 1)	\$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			
<ul style="list-style-type: none"> Advanced Hearing Aid 	\$699 per aid	\$599 per aid	\$499 per aid
<ul style="list-style-type: none"> Premium Hearing Aid 	\$999 per aid	\$899 per aid	\$799 per aid
<ul style="list-style-type: none"> Rechargeable battery option is available on select styles 	\$0	\$0	\$0
Dental services*	20% coinsurance	\$15 copay	\$0
Medicare-covered dental services			
Routine dental services (non-Medicare-covered)			
Cleaning (limit 2 per year)	Not covered	\$0	\$0
Oral exam (limit 2 per year)			
Fluoride (limit 2 per year)			
Periodontal cleaning (limit 2 per year)			
Dental x-rays (limit 1 per year)			
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	\$20 copay	\$0	\$0
Medicare-covered partial hospitalization	\$60 copay per day	\$15 copay per day	\$0
Mental health office visit	\$20 copay	\$0	\$0
Medicare-covered psychiatrist or psychologist			

* 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
<p>Physical therapy services</p> <p>Medicare-covered physical, occupational and speech therapy visits</p>	\$40 copay	\$15 copay	\$0
<p>Ambulance services (ground and air) (Medicare-covered)</p> <p style="padding-left: 40px;">In- and Out-of-Network</p> <ul style="list-style-type: none"> • Worldwide Transportation (Non-Medicare-covered) <p style="padding-left: 40px;">In- and Out-of-Network</p>	20% coinsurance	\$100 copay	\$0
<p>Ambulance services without transportation to a medical facility and other non-Medicare-covered transport services</p>	Not covered	Not covered	Not covered
<p>Medicare Part B prescription drugs</p> <p>Medicare-covered Part B oral chemotherapy and prescription drugs*</p> <p>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.)*</p> <p>Medicare-covered Part B Insulin for use in an insulin pump</p>	0%–20% coinsurance	0%–20% coinsurance	0%–20% coinsurance
	0%–20% coinsurance	0%–20% coinsurance	0%–20% coinsurance
	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) Non-Medicare-covered routine acupuncture for pain diagnosis (max. 12 visits per year)	\$20 copay \$20 copay	\$15 copay \$15 copay	\$0 \$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) Medicare-covered diabetes self-management training Medicare-covered therapeutic shoes and inserts	\$0 \$0 20% coinsurance	\$0 \$0 20% coinsurance	\$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
<p>Durable medical equipment, prosthetic devices and medical supplies* (Medicare-covered)</p> <p>Durable medical equipment such as wheelchairs, walkers, oxygen equipment, etc.</p> <p>Medical supplies such as braces, surgical dressings, splints, casts, etc.</p> <p>Prosthetic devices, other than dental, such as artificial limbs, colostomy bags, etc.</p> <p>Preferred continuous glucose monitoring products.</p> <p>Non-preferred continuous glucose monitoring products</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>40% coinsurance</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>40% coinsurance</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>20% coinsurance</p>
<p>Fitness program</p> <p>Gym membership at a participating SilverSneakers® facility, online fitness classes, or choose a home exercise kit</p>	\$0	\$0	\$0
<p>Home health agency care (Medicare-covered)</p>	\$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
<p>Medicare Diabetes Prevention Program (MDPP)</p> <p>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.</p> <p>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.</p>	\$0	\$0	\$0
<p>Outpatient substance use disorder services (Medicare-covered)</p> <p>Individual and group therapy visits</p>	\$20 copay	\$0	\$0
<p>Over-The-Counter (OTC) items</p> <p>Quarterly allowance for the purchase of covered OTC medications and supplies through CVS OTC Health Solutions. This is not a reimbursement.</p>	\$25	\$50	\$50
<p>Podiatry services (Medicare-covered foot care)</p> <p>Foot exams and treatment for diabetes-related nerve damage or certain medical conditions.</p>	\$50 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
Services to treat kidney disease Medicare-covered renal dialysis services Medicare-covered kidney disease education services	20% coinsurance \$0	\$15 copay \$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	\$590 all Tiers
	Initial Coverage Begins after you meet your deductible	Standard/LTC² Cost-Sharing
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	\$0
	Tier 2: Generic Drugs	\$5 copay
	Tier 3: Preferred Brand Drugs	25% 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
	Tier 2: Generic Drugs	\$10 copay
	Tier 3: Preferred Brand Drugs	25% coinsurance
	Tier 4: Non-Preferred Drugs	44% 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

¹Your 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.

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

	Platinum Blue with Rx Benefits	Choice Plan with Rx
	Deductible	\$0 Tiers 1-2; \$590 Tiers 3-5
	Initial Coverage Begins after you meet your deductible	Standard/LTC² Cost-Sharing
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	\$0
	Tier 2: Generic Drugs	\$10 copay
	Tier 3: Preferred Brand Drugs	24% 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
	Tier 2: Generic Drugs	\$20 copay
	Tier 3: Preferred Brand Drugs	24% 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

¹Your 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.

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

	Platinum Blue with Rx Benefits	Complete Plan with Rx
	Deductible	\$0 Tiers 1-2; \$590 Tiers 3-5
	Initial Coverage Begins after you meet your deductible	Standard/LTC² Cost-Sharing
31 Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	\$0
	Tier 2: Generic Drugs	\$2 copay
	Tier 3: Preferred Brand Drugs	25% 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
	Tier 2: Generic Drugs	\$4 copay
	Tier 3: Preferred Brand Drugs	25% coinsurance
	Tier 4: Non-Preferred Drugs	40% 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

¹Your 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.

²If 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 **1-877-662-2583 (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, 2026.
- 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 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 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.

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.

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 (الهاتف النصي) 1-855-903-2583 (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 መጠቀም፣ 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 ntauv luam tawm ua tus ntauv 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៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រើប្រាស់វិធីសាស្ត្រជាមួយអ្នកតាមរបៀបផ្សេងដែលមានប្រសិទ្ធភាពបំផុតសម្រាប់អ្នក។ ការប្រើប្រាស់វិធីសាស្ត្រនេះអាចមានដូចជា អ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំៗ ឬអក្សរស្នាប 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.

ကညီကျိန် (Karen)

ဟ်သုဉ်ဟ်သး- နမ့ၢ်ကတိၤ ကညီကျိန် န့ၣ်, နယုကျိန်ဂ့ၢ်ဝီတၢ်တိၤစၢၤမၤစၢၤလၢတလၢကတိၤလဲၤ သ့န့ၣ်လီၤ. နမ့ၢ်အိၣ်ဒီးတၢ်တလၢတပဲ့ၤလၢ မဲၣ်တၢ်ထံၣ်, တၢ်နၢ်ဟူ, မ့တမ့ၢ် တၢ်စံးကတိၤတၢ်န့ၣ် ပဆဲးကျၢဆဲးကျိးတၢ်လၢ ကျဲကဲထီၣ်လိာ်ထီၣ်အဂ့ၢ်ကတၢ်လၢနဂီၢ်သ့န့ၣ်လီၤ. တၢ်အံၤ ပၣ်ယုဒီး တၢ်စူးကါ နီၢ်ခိက့ၢ်ဂီၤကျိန်အပူၤကျိန်ထံတၢ်တဖၣ်, တၢ်ဟ့ၣ်လံာ်လံာ်တဖၣ်လၢ အလံာ်ဖျၢၣ်ဖးဒိၣ်, မ့တမ့ၢ် ပုၤမဲာ်ဘျီၣ်အလံာ်, တၢ်ကလုာ်, မ့တမ့ၢ် တၢ်မၤစၢၤဂ့ၢ်ဂၤတဖၣ် လၢတလၢကတိၤအဘူးလဲၤန့ၣ်လီၤ. ကိးလီၤတဲစိဆူ 1-855-903-2583 (TTY 711) တက့ၢ်.

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 kennamu:- 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, waraabbiwwan 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)

ເຂົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ຖ້າທ່ານມີຄວາມບໍ່ກວມຄອບຄົວດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື ການປາກເວົ້າ, ພວກເຮົາສາມາດສ້າງສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ. ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນ້ຳຍພາສາມື, 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).

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.



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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 *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**.

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