BlueCross BlueShield Minnesota

2015

SUMMARY of BENEFITS

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

H2461

January 1, 2015 – December 31, 2015

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PLATINUM BLUE CORE, CHOICE AND COMPLETE PLANS AND PLATINUM BLUE CORE, CHOICE AND COMPLETE PLANS WITH RX

(a Cost Plan offered by Blue Cross and Blue Shield of Minnesota with a Medicare contract)

Summary of Benefits
January 1, 2015 – December 31, 2015

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."

YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Cost plan (such as Platinum Blue Plan (Cost) and Platinum Blue Plan with Rx (Cost)).

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what Platinum Blue Plan (Cost) and Platinum Blue Plan with Rx (Cost) covers and what you pay.

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

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get 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**.

SECTIONS IN THIS BOOKLET

- Things to Know About Platinum Blue Plan (Cost) and Platinum Blue Plan with Rx (Cost)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

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

This document may be available in a non-English language. For additional information, call us at the phone number listed below.

THINGS TO KNOW ABOUT PLATINUM BLUE PLAN (COST) AND PLATINUM BLUE PLAN WITH RX (COST)

Hours of operation
You can call us 7 days a week from 8 a.m. to 8 p.m. Central Time.

Platinum Blue Plan (Cost) and Platinum Blue Plan with Rx (Cost) phone numbers and website

- If you are a member of this plan, call toll-free **1-866-340-8654**. TTY users call **711**.
- If you are not a member of this plan, call toll-free **1-877-662-2583**
- Our website: **bluecrossmn.com**

WHO CAN JOIN?

To join Platinum Blue Plan (Cost) and Platinum Blue Plan with Rx (Cost), you must be enrolled in Medicare Part B (or have both Medicare Part A and Medicare Part B), and live in our service area. Our service area includes: Minnesota.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Platinum Blue Plan (Cost) and Platinum Blue Plan with Rx (Cost) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider directory at our website (**bluecrossmn.com**).

You can see our plan's pharmacy directory at this website (**primetherapeutics.com**).

Or, call us and we will send you a copy of the provider and pharmacy directories.

WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers — and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare.

Some of the extra benefits are outlined in this booklet.

Platinum Blue with Rx (Cost) covers Part D drugs. In addition, Platinum Blue (Cost) and Platinum Blue with Rx (Cost) covers Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **bluecrossmn.com**.
- Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COSTS?

Our plan groups each medication into one of four "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

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Benefit	Platinum Blue Core Plan (Cost)	Platinum Blue Choice Plan (Cost)	Platinum Blue Complete Plan (Cost)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
How much is the monthly premium?	$29 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$74 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$109 per month. In addition, you must keep paying your monthly Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.

Benefit	Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan with Rx (Cost)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
How much is the monthly premium?	$48.40 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$120.90 per month. In addition, you must keep paying your monthly Medicare Part B premium.	$155.90 per month. In addition, you must keep paying your montlhly Medicare Part B premium.
How much is the deductible?	$320.00	This plan does not have a deductible.	This plan does not have a deductible.

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
Is there any limit on how much I will pay for my covered service?	Yes. Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $5,000 for services you receive from in-network providers If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.	Yes. Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,000 for services you receive from in-network providers If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.	Yes. Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,000 for services you receive from in-network providers If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Medical and Hospital Benefits – Outpatient Care and Services			
Acupuncture and Other Alternative Therapies	Not covered	Not covered	Not covered
Ambulance	20% of the cost	$25 copay	You pay nothing
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). 20% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). $15 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). You pay nothing
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). In general, preventive dental benefits (such as cleaning) not covered. 20% of the cost	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). In general, preventive dental benefits (such as cleaning) not covered. $15 copay	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). In general, preventive dental benefits (such as cleaning) not covered. You pay nothing
Diabetes Supplies and Services	Diabetes monitoring supplies: 20% of the cost Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost	Diabetes monitoring supplies: 20% of the cost Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Medical and Hospital Benefits – Outpatient Care and Services			
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost Diagnostic tests and procedures: 0-20% of the cost, depending on the service Lab services: You pay nothing Outpatient X-rays: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost	Diagnostic radiology services (such as MRIs, CT scans): You pay nothing Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient X-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing	Diagnostic radiology services (such as MRIs, CT scans): You pay nothing Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient X-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing
Doctor's Office Visits	Primary care physician visit: 20% of the cost Specialist visit: 20% of the cost	Primary care physician visit: $15 copay Specialist visit: $15 copay	Primary care physician visit: You pay nothing Specialist visit: You pay nothing

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Durable Medical Equipment (wheelchairs, oxygen, etc.)	20% of the cost	20% of the cost	You pay nothing
Emergency Care	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	You pay nothing
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: 20% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $15 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing
Hearing Services	Exam to diagnose and treat hearing and balance issues: 20% of the cost	Exam to diagnose and treat hearing and balance issues: $15 copay Routine hearing exam (for up to 1 every year): $15 copay Hearing aid fitting/ evaluation (for up to 1 every year): $15 copay Hearing aid exam: You pay nothing Our plan pays up to $450 every year for hearing aids	Exam to diagnose and treat hearing and balance issues: You pay nothing Routine hearing exam (for up to 1 every year): You pay nothing Hearing aid fitting/ evaluation (for up to 1 every year): You pay nothing Hearing aid exam: You pay nothing Our plan pays up to $450 every year for hearing aids
Home Health Care	You pay nothing	You pay nothing	You pay nothing

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Mental Health Care	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $500 copay per stay Outpatient group therapy visit: 20% of the cost Outpatient individual therapy visit: 20% of the cost	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $100 copay per stay Outpatient group therapy visit: $15 copay Outpatient individual therapy visit: $15 copay	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. You pay nothing Outpatient group therapy visit: You pay nothing Outpatient individual therapy visit: You pay nothing

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Outpatient Rehabilitation	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost Occupational therapy visit: 20% of the cost Physical therapy and speech and language therapy visit: 20% of the cost	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $15 copay Occupational therapy visit: $15 copay Physical therapy and speech and language therapy visit: $15 copay	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing Occupational therapy visit: You pay nothing Physical therapy and speech and language therapy visit: You pay nothing
Outpatient Substance Abuse	Group therapy visit: 20% of the cost Individual therapy visit: 20% of the cost	Group therapy visit: $15 copay Individual therapy visit: $15 copay	Group therapy visit: You pay nothing Individual therapy visit: You pay nothing
Outpatient Surgery	Ambulatory surgical center: 20% of the cost Outpatient hospital: 20% of the cost	Ambulatory surgical center: $50 copay Outpatient hospital: $50 copay	Ambulatory surgical center: You pay nothing Outpatient hospital: You pay nothing
Over-the-Counter Items	Not covered	Not covered	Not covered
Prosthetic Devices (braces, artificial limbs, etc.)	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: You pay nothing Related medical supplies: You pay nothing

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Renal Dialysis	20% of the cost	$15 copay	You pay nothing
Transportation	Not covered	Not covered	Not covered
Urgent Care	$25 copay	$25 copay	You pay nothing
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 0-20% of the cost, depending on the service Eyeglasses or contact lenses after cataract surgery: 20% of the cost	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-15 copay, depending on the service Routine eye exam (for up to 1 every year): You pay nothing Contact lenses: You pay nothing Eyeglasses (frames and lenses): You pay nothing Eyeglasses or contact lenses after cataract surgery: 20% of the cost Our plan pays up to $125 every year for contact lenses and eyeglasses (frames and lenses).	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Routine eye exam (for up to 1 every year): You pay nothing Contact lenses: You pay nothing Eyeglasses (frames and lenses): You pay nothing Eyeglasses or contact lenses after cataract surgery: 20% of the cost Our plan pays up to $125 every year for contact lenses and eyeglasses (frames and lenses).

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Preventive Care	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Hospital and Medical Benefits – Outpatient Care and Services			
Preventive Care	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Covered Hospital and Medical Services – Inpatient Care			
Inpatient Hospital Care	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $500 copay per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. • $100 copay per stay • You pay nothing per day for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay nothing
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20 • $150 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. You pay nothing	Our plan covers up to 100 days in a SNF. You pay nothing

Benefit	Platinum Blue Core Plan (Cost) and Platinum Blue Core Plan with Rx (Cost)	Platinum Blue Choice Plan (Cost) and Platinum Blue Choice Plan with Rx (Cost)	Platinum Blue Complete Plan (Cost) and Platinum Blue Complete Plan with Rx (Cost)
Prescription Drug Benefits			
How much do I pay?	For Part B drugs such as chemotherapy drugs: 20% of the cost Other Part B drugs: 0-20% of the cost depending on the drug	For Part B drugs such as chemotherapy drugs: 20% of the cost Other Part B drugs: 0-20% of the cost depending on the drug	For Part B drugs such as chemotherapy drugs: 20% of the cost Other Part B drugs: 0-20% of the cost depending on the drug

PRESCRIPTION DRUG MEDICARE PART D COVERAGE

You can add prescription drug coverage to your Platinum Blue plan. Bundling medical and Part D coverage into one plan gives you the convenience of a single member ID card, customer service center and bill for both your medical and prescription costs. The monthly premium and deductible costs below reflect both your medical and prescription drug coverage.

Benefits	**Platinum Blue Core with Rx Plan (Cost)**			**Platinum Blue Choice with Rx Plan (Cost) and Platinum Blue Complete with Rx Plan (Cost)**		
Initial Coverage						
	You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.					
	1 month supply	2 month supply	3 month supply	1 month supply	2 month supply	3 month supply
Standard Retail Cost-Sharing						
• Tier 1: Preferred Generic	$3	$6	$9	$4	$8	$12
• Tier 2: Non-Preferred Generic	$11	$22	$33	$14	$28	$42
• Tier 3: Preferred Brand	$35	$70	$105	$40	$80	$120
• Tier 4: Non-Preferred Brand	45%	45%	45%	45%	45%	45%
Standard Mail Order Cost-Sharing						
• Tier 1: Preferred Generic	$3	$6	$6	$4	$8	$8
• Tier 2: Non-Preferred Generic	$11	$22	$22	$14	$28	$28
• Tier 3: Preferred Brand	$35	$70	$70	$40	$80	$80
• Tier 4: Non-Preferred Brand	45%	45%	45%	45%	45%	45%

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs.

The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45 percent of the plan's cost for covered brand-name drugs and 65 percent of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:

- 5% of the cost, or
- $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-662-2583. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-662-2583. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-662-2583。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-662-2583。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-662-2583. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-662-2583. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-662-2583 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-662-2583. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-662-2583번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-662-2583. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-778-266-3852. سيقوم شخص ما بمساعدتك. هذه خدمة مجانية يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-662-2583 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-662-2583. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-662-2583. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-662-2583. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-662-2583. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-662-2583 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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