

**2021**

# **SUMMARY OF BENEFITS**

Group Medicare Advantage  
Standard (MA-only)

H5959

January 1, 2021 – December 31, 2021



# INTRODUCTION

This guide is a summary of the medical and prescription drug benefits covered by Group Medicare Advantage (MA-Only) plans. In this booklet, you will find an overview of our plan, an easy-to-read chart of plan coverage options, and contact information for customer service representatives who can assist you and answer questions.

## WHAT'S INCLUDED

Frequently Asked Questions . . . . .	2
Benefit Charts . . . . .	6
Get Help in Your Language: Multi-Language Interpreter Services . . . . .	13

### CONTACT US

We are available for phone calls 8 a.m. to 8 p.m., Central Time. We are available seven days a week October 1 through March 31, and available Monday through Friday the rest of the year.



#### Members

Call toll-free **1-800-711-9865**

TTY users call **711**

#### Non-Members

Call **1-855-579-7658**



Visit **[bluecrossmnonline.com](http://bluecrossmnonline.com)**

# 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 Group Medicare Advantage if you are entitled to Medicare Part A and enrolled in Medicare Part B (or have both Medicare Part A and Medicare Part B) and live in the plan availability area.

## WHAT DOES THE PLAN COVER?

Group Medicare Advantage members get all the benefits covered in Original Medicare. Group Medicare Advantage plans also help pay the deductible, copayments and coinsurance Original Medicare doesn't cover.

### **What is the difference between an annual physical exam, a Welcome to Medicare visit and a Medicare annual wellness visit?**

- **Annual physical exam** — A yearly preventive visit with your primary care doctor that includes a discussion about your health, a review of your medical history, screenings, immunizations, and some lab work.
- **Welcome to Medicare visit** — A one-time preventive visit within the first 12 months of your new Medicare Part B plan. This visit includes a review of your medical history, screenings, vaccinations and a discussion of preventive services available to you that you may need.
- **Medicare annual wellness visit** — An annual visit with your doctor after you've been enrolled in Medicare Part B for at least 12 months. This visit includes a review of your medical history, screenings and personalized health advice, and a checklist of appropriate preventive services.

Medicare will pay for a Medicare annual wellness visit and a Welcome to Medicare visit. Your Group Medicare Advantage plan will pay for an annual physical exam.

To see a complete list of your services and benefits, please review your *Evidence of Coverage* (EOC). You can find this document at **bluecrossmnonline.com** by clicking Medicare > Search Medicare Forms. You also may order a copy by calling member services.

## WHICH DOCTORS AND HOSPITALS CAN I USE?

The Group Medicare Advantage network offers a large list of providers covered under the Group Medicare Advantage plan. You may pay less when you use doctors, hospitals and other providers in this network. You can see the plan's provider directory at **bluecrossmnonline.com**. Or, call us and we will send you a copy.

## ABOUT ORIGINAL MEDICARE AND HOW TO GET BENEFITS

You have choices about how to get your Medicare benefits through Original Medicare, a program run directly by the federal government.

You can also choose to get Medicare benefits by joining a Part C plan like Group Medicare Advantage.

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

If you want to know more about the coverage and costs of Original Medicare, look in your 2021 *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**.

Medicare Advantage is a PPO plan with a Medicare contract. Enrollment in Medicare Advantage depends on contract renewal. Either CMS or the plan may choose not to renew the contract, or the plan may choose to change the area it serves. Any such change may result in termination of your enrollment. This information is not a complete description of benefits. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. Limitations, copayments, and restrictions may apply. Contact the plan for more information.

# HEALTH CARE TERMS AND WHAT THEY MEAN

**Allowed amount** — The contracted rate, or “Blue Cross discount,” set by your plan and providers when you see in-network hospital and clinics. Providers are required to accept the allowed amount as payment in full, and cannot charge above it when you see an in-network provider.

**Copay** — A set fee you pay for some services and prescriptions. Copays vary by type of service and prescription. In most cases, your copay is due at the time you receive the service or prescription.

**Coinsurance** — The amount you may pay for some services once you reach your deductible. The cost is a percent of the allowed amount and is set by your plan. The amount you pay for coinsurance will vary if the provider is in-network or out-of-network.

**Deductible** — A set amount of money you must pay before your plan begins to pay. Usually, you will have a separate deductible for Medicare Part A , Part B and Part D.

**In-network** — The hospitals and clinics that are included in your plan. Typically, in-network providers result in lower member costs.

**Out-of-pocket costs** — The amount you must pay for health care. It includes copays, coinsurance and deductibles, plus any costs for care that is not covered.

**Out-of-network** — The hospitals, clinics and pharmacies that are not included in your plan. Typically, out-of-network providers result in higher member costs.

**Out-of-pocket maximum** — The most you could pay for covered care in a plan year. Once you reach this amount, your plan will pay 100 percent for in-network covered care.

**Premium** — The amount you pay each month to be a member of your plan.

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

This page is intentionally blank.

Benefit	Group Medicare Advantage Standard
<b>Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services</b>	
<b>How much is the monthly premium?</b>	<p>Please contact your previous employer, union or benefits administrator for premium information.</p> <p>Your premium for Group Medicare Advantage is in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their plan premium. Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium. For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>
<b>How much is the deductible?</b>	\$0
<b>Is there any limit on how much I will pay for my covered service?</b>	\$3,000 in network; \$3,000 combined out-of-pocket limit
<b>Is there a limit on how much the plan will pay?</b>	No



Benefit	Group Medicare Advantage Standard
<b>Covered Medical and Hospital Benefits</b>	
<b>Inpatient hospital coverage</b>  <b>Meals following in-patient stay</b> 2 meals per day for 28 days	Our plan covers an unlimited number of days for an inpatient hospital stay.  \$200 per admittance  \$0
<b>Outpatient hospital coverage</b>  <b>Ambulatory surgical center</b>  <b>Outpatient hospital</b>	  \$75 copay  \$75 surgery \$0 all other services
<b>Doctor's office visits</b>  <b>Primary care physician</b>  <b>Specialist</b>	  \$20 copay  \$20 copay

Benefit	Group Medicare Advantage Standard
<b>Covered Medical and Hospital Benefits</b>	
<b>Preventive care</b>	<p data-bbox="605 352 643 384">\$0</p> <p data-bbox="605 426 1292 457">Our plan covers many preventive services, including:</p> <ul data-bbox="605 495 1471 1486" style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse screenings and counseling</li> <li>• Annual physical exam</li> <li>• Bone mass measurements (bone density screening)</li> <li>• Cardiovascular disease screenings</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cervical &amp; vaginal cancer screening</li> <li>• Colorectal cancer screenings</li> <li>• Depression screenings</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• Glaucoma tests</li> <li>• Hepatitis C screening</li> <li>• HIV screening</li> <li>• Lung cancer screening</li> <li>• Mammograms (breast cancer screening)</li> <li>• Nutrition therapy services</li> <li>• Obesity screenings and counseling</li> <li>• One-time “Welcome to Medicare” preventive visit</li> <li>• Prostate cancer screenings</li> <li>• Routine annual physical exam</li> <li>• Sexually transmitted infections screening &amp; counseling</li> <li>• Shots (vaccines): (If administered in a doctor’s office or hospital setting, vaccines will be filed as a Part B claim. If administered at a pharmacy, vaccines will be filed as a Part D claim.)</li> <li>• Flu shots</li> <li>• Hepatitis B shots</li> <li>• Pneumococcal shots</li> <li>• Tobacco cessation counseling</li> </ul> <p data-bbox="605 1524 1487 1589">Any additional preventive services approved by Medicare during the contract year will be covered</p>

Benefit	Group Medicare Advantage Standard
<b>Covered Medical and Hospital Benefits</b>	
<b>Emergency care</b>	\$50 copay  Copayment is waived if you are admitted to the hospital within 24 hours for the same condition. See the "Inpatient Hospital Care" section of this booklet for other costs.
<b>Urgently needed services</b>	\$20 copay
<b>Diagnostic radiology services (MRIs and CT scans)</b>	\$0
<b>Diagnostic tests and procedures</b>	\$0
<b>Outpatient x-rays</b>	\$0
<b>Therapeutic radiology services (Radiation treatment for cancer)</b>	\$0
<b>Hearing services</b> <b>Non Medicare-covered hearing exam (for up to 1 every year)</b> <b>Hearing aid fitting/evaluation with TrueHearing provider only (for up to 1 every year)</b> <b>Hearing Aids</b>	\$0 \$0 \$499 for the Advanced Aid or \$799 for the Premium Aid from TruHearing. Specific models only.
<b>Dental services</b> 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.  <b>Medicare-covered comprehensive dental</b>	   \$20 copay

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.

Benefit	Group Medicare Advantage Standard
<b>Vision services</b>	
<b>Medicare-covered exams to diagnose and treat diseases and conditions of the eye</b>	\$0
<b>Medicare-covered eyewear after cataract surgery</b>	\$0
<b>Non Medicare-covered eye exam (for up to 2 every year)</b>	\$0
<b>Non-Medicare covered eyewear (frames, lenses or contacts)</b>	\$150 allowance per year
<b>Covered Medical and Hospital Benefits</b>	
<b>Mental health care inpatient visit*</b>	\$200 copay per admittance
<b>Outpatient group and individual therapy visit</b>	\$20 copay
<b>Skilled nursing facility (SNF)</b> Our plan covers up to 100 days in a SNF	\$0
<b>Meals following SNF stay</b> 2 meals per day for 28 days	\$0
<b>Cardiac (heart) rehab services</b>	\$20 copay
<b>Occupational therapy, physical therapy and speech and language therapy visit</b>	\$20 copay
<b>Ambulance</b>	\$75 copay
<b>Transportation</b>	Not covered

<b>Prescription Drugs</b>	
<b>Part B prescription drugs</b>	For Part B drugs such as chemotherapy drugs: 20% of the cost

\*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.

Benefit	Group Medicare Advantage Standard
<b>Additional Covered Services</b>	
<b>Medicare-covered acupuncture</b> Covered for chronic lower back pain	\$20 copay (max. 20 visits every 12 months)
<b>Non-Medicare covered acupuncture</b> Covered for pain diagnosis, except chronic lower back pain	\$20 copay (max. 20 visits per year)
<b>Chiropractic care</b> Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	\$20 copay
<b>Diabetes monitoring supplies through Ascensia</b>	\$0
<b>Diabetes self-management training</b>	\$0
<b>Therapeutic shoes or inserts</b>	\$0
<b>Durable medical equipment (wheelchairs, oxygen, etc.)</b>	20% coinsurance
<b>Foot care (podiatry services)</b> Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	\$20 copay
<b>Home health agency care</b>	\$0
<b>Hospice care</b>	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.
<b>Outpatient substance abuse Group and individual therapy visits</b>	\$20 copay
<b>Over-the-counter items</b>	\$50 per quarter for the purchase of covered over-the-counter (OTC) items through CVS Over The Counter Health Solutions (OTCHS).
<b>Prosthetic devices (braces, artificial limbs and related medical supplies.)</b>	20% coinsurance
<b>Fitness program</b>	\$0

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

CVS Health Corporation is an independent company providing pharmacy benefit management services.

**NOTICE OF NONDISCRIMINATION PRACTICES**  
**Effective July 18, 2016**

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: [Civil.Rights.Coord@bluecrossmn.com](mailto:Civil.Rights.Coord@bluecrossmn.com)
- by mail at: Nondiscrimination Civil Rights Coordinator  
Blue Cross and Blue Shield of Minnesota and Blue Plus  
M495  
PO Box 64560  
Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိကညီကိတ်ဒီး, တၢ်ကဟ့ၣ်နၢကိတ်တၢ်မၤစၢၤကလိတဖၣ်န့ၣ်လီၤ. ကိး 1-866-251-6744 လၢ TTY  
အဂီၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي  
اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ລຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583 ។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711 ។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojí éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyego éí 711 jí' béésh bee hodíílnih.

Image\_0002R02\_General\_Portrait (01/17)

