2022 Summary of Benefits

Blue Advantage (HMO)

H6453 - 008-1

Blue Advantage (HMO)

H6453 - 008-2

Blue Advantage (PPO)

H1248 - 007

Our plans and service areas:

H6453 - 008-1 Blue Advantage (HMO) includes the following parishes: Jefferson, Lafourche, Orleans, St. Charles, Terrebonne.

H6453 - 008-2 Blue Advantage (HMO) includes the following parishes: Assumption, Plaquemines, St. Bernard, St. James, St. John the Baptist.

H1248 - 007 Blue Advantage (PPO) is available statewide in Louisiana.

This is a summary of drug and health services covered by Blue Advantage (HMO) and Blue Advantage (PPO) from January 1, 2022 - December 31, 2022.

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Customer Service and request 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 Medicare Advantage health plan, such as Blue Advantage.

Tips for comparing your Medicare choices:

This Summary of Benefits booklet gives you a summary of what Blue Advantage covers and what you pay.

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

Contact us

Please contact our Customer Service number at 1-866-508-7145 for additional information. (TTY users should call 711.) Our phone lines are open 8 a.m. to 8 p.m. CST, 7 days a week from October – March and 8 a.m. to 8 p.m. CST, Monday – Friday from April – September. You may also visit our website at www.bcbsla.com/blueadvantage.

Who can join?

To join Blue Advantage (HMO) or Blue Advantage (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Which doctors, hospitals, and pharmacies can I use?

Blue Advantage (HMO) and Blue Advantage (PPO) have a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.bcbsla.com/blueadvantage. If you use providers that are not in our network, the plan may not pay for these services.

What do we cover?

Like all Medicare Advantage 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.

What drugs do we cover?

We cover Part D drugs. In addition, we cover Part B drugs such as most oral 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, www.bcbsla.com/blueadvantage.
- Or call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each prescription drug into one of five "tiers." You will need to use our 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, if applicable: Initial Coverage, Coverage Gap, and Catastrophic Coverage. If you have questions about the different benefit stages, please contact the Plan for more information or access the *Evidence of Coverage* on our website.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. Please contact our Customer Service number at 1-866-508-7145 for additional information. (TTY users should call 711.) Our phone lines are open 8 a.m. to 8 p.m. CST, 7 days a week from October – March and 8 a.m. to 8 p.m. CST, Monday – Friday from April – September. You may also visit our website at www.bcbsla.com/blueadvantage.

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Monthly plan premium	$0 You must keep paying your Medicare Part B premium.	$0 You must keep paying your Medicare Part B premium.	$0 You must keep paying your Medicare Part B premium.
Medical Deductible	$0 per year	$0 per year	For in-network providers: $0 per year For out-of-network providers: $1,000 per year for non-Medicare covered benefits.
Maximum out-of-pocket amount (does not include prescription drugs)	$3,900 per year	$4,900 per year	For in-network providers: $7,550 per year For in-network and out-of-network providers combined: $11,300 per year

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Inpatient Hospital coverage	**In-Network** $125 copay each day for days 1 to 10 and $0 copay each day for days 11 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days. *Prior Authorization is required.*	**In-Network** $125 copay each day for days 1 to 10 and $0 copay each day for days 11 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days. *Prior Authorization is required.*	**In-Network** $290 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered hospital stay.
Outpatient Hospital coverage	Observation Services coverage applies only if you are under Observation status.		
Outpatient hospital services	**In-Network** $200 copay or a 20% coinsurance *Prior Authorization is required.*	**In-Network** $200 copay or a 20% coinsurance *Prior Authorization is required.*	**In-Network** $75 - $300 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Outpatient hospital observation services	**In-Network** $125 copay per day *Prior Authorization is required.*	**In-Network** $125 copay per day *Prior Authorization is required.*	**In-Network** $295 copay per day *Prior Authorization is required.* **Out-of-Network** 50% coinsurance

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Ambulatory surgical center	**In-Network** $200 copay *Prior Authorization is required.*	**In-Network** $200 copay *Prior Authorization is required.*	**In-Network** $300 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Doctor Visits			
Primary Care Provider visit	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 50% coinsurance
Specialist visit	**In-Network** $40 copay	**In-Network** $40 copay	**In-Network** $50 copay **Out-of-Network** 50% coinsurance

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Preventive Care Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Bone mass measurement • Breast cancer screening (mammogram) • Cervical and vaginal cancer screening • Cologuard or FOBT colorectal screenings • Colonoscopy and all other colorectal screenings • Diabetes screenings • Glaucoma screenings • Prostate cancer screenings (PSA) • 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) Other preventive services are available. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 50% coinsurance
Emergency care Emergency coverage is worldwide, but the copay is not waived if you are admitted to a hospital outside of the United States.	$90 copay Copayment is waived if you are admitted to a hospital within 72 hours.	$90 copay Copayment is waived if you are admitted to a hospital within 72 hours.	$90 copay Copayment is waived if you are admitted to a hospital within 72 hours.

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Urgently Needed Services (Urgent Care)	$40 copay	$40 copay	$50 copay
Diagnostic Services/Labs/Imaging	Authorization rules may apply for certain outpatient diagnostic procedures, X-rays, or tests.		
Diagnostic tests and procedures	**In-Network** $0 - $30 copay *Prior Authorization may be required.*	**In-Network** $0 - $30 copay *Prior Authorization may be required.*	**In-Network** $0 - $30 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance
Diagnostic radiology services (e.g. MRI, CT Scan)	**In-Network** $0 copay for mammograms $40 copay for Holter Monitors $175 copay for all other diagnostic radiology services *Prior Authorization may be required.*	**In-Network** $0 copay for mammograms $40 copay for Holter Monitors $175 copay for all other diagnostic radiology services *Prior Authorization may be required.*	**In-Network** $0 copay for mammograms $295 copay for all other diagnostic radiology services *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance
Lab services	**In-Network** $0 copay *Prior Authorization may be required.*	**In-Network** $0 copay *Prior Authorization may be required.*	**In-Network** $0 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance
Outpatient X-rays	**In-Network** $35 copay *Prior Authorization may be required.*	**In-Network** $35 copay *Prior Authorization may be required.*	**In-Network** $75 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Therapeutic Radiology	**In-Network** $45 copay *Prior Authorization may be required.*	**In-Network** $45 copay *Prior Authorization may be required.*	**In-Network** 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance
Hearing services			
Exam to diagnose and treat hearing and balance issues	**In-Network** $10 copay	**In-Network** $10 copay	**In-Network** $10 copay **Out-of-Network** 50% coinsurance
Routine hearing exam	**In-Network** $10 copay Limited to 1 visit(s) every year	**In-Network** $10 copay Limited to 1 visit(s) every year	**In-Network** $10 copay Limited to 1 visit(s) every year **Out-of-Network** 50% coinsurance
Fitting-evaluation(s) for hearing aids	**In-Network** $0 copay Limited to 1 visit(s) every year	**In-Network** $0 copay Limited to 1 visit(s) every year	**In-Network** $0 copay Limited to 1 visit(s) every year **Out-of-Network** 50% coinsurance
Hearing aids	Up to a $500 maximum benefit coverage amount for both ears combined every year for hearing aids.	Up to a $500 maximum benefit coverage amount for both ears combined every year for hearing aids.	Up to a $500 maximum benefit coverage amount for both ears combined every year for hearing aids.

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
	In-Network $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay
Dental services **Preventive dental services**	Up to a $1,000 combined maximum benefit coverage amount every year for all preventive and basic dental services.	Up to a $1,000 combined maximum benefit coverage amount every year for all preventive and basic dental services.	Up to a $1,000 combined maximum benefit coverage amount every year for all preventive and basic dental services.
○ Oral Exams	**In-Network** $0 copay Limited to 2 oral exam(s) every year	**In-Network** $0 copay Limited to 2 oral exam(s) every year	**In-Network** $0 copay Limited to 2 oral exam(s) every year **Out-of-Network** 50% coinsurance
○ Prophylaxis (Cleaning)	**In-Network** $0 copay Limited to 2 cleaning(s) every year	**In-Network** $0 copay Limited to 2 cleaning(s) every year	**In-Network** $0 copay Limited to 2 cleaning(s) every year **Out-of-Network** 50% coinsurance
○ Dental X-rays	**In-Network** $0 copay Limited to 1 set(s) of horizontal bitewing x-rays every year	**In-Network** $0 copay Limited to 1 set(s) of horizontal bitewing x-rays every year	**In-Network** $0 copay Limited to 1 set(s) of horizontal bitewing x-rays every year **Out-of-Network** 50% coinsurance

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Basic dental services	**In-Network** 50% coinsurance	**In-Network** 50% coinsurance	**In-Network** 50% coinsurance **Out-of-Network** 50% coinsurance
Vision care			
Exam to diagnose and treat diseases and conditions of the eye	**In-Network** $40 copay	**In-Network** $40 copay	**In-Network** $50 copay **Out-of-Network** 50% coinsurance
○ Diabetic eye exams	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 50% coinsurance
Eyeglasses or contact lenses after cataract surgery	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 50% coinsurance
Glaucoma screening	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 50% coinsurance
Routine eye exam	**In-Network** $0 copay Limited to 1 visit(s) every year	**In-Network** $0 copay Limited to 1 visit(s) every year	**In-Network** $0 copay Limited to 1 visit(s) every year **Out-of-Network** $40 copay

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Supplemental eyewear	Up to a $130 combined maximum benefit coverage amount every year.	Up to a $130 combined maximum benefit coverage amount every year.	Up to a $130 combined maximum benefit coverage amount every year. If you use an out-of-network provider, you will pay the copay first and then file a claim to be reimbursed up to the maximum benefit coverage amount.
○ Contact lenses	**In-Network** $0 copay Limited to 1 pair(s) of contact lenses	**In-Network** $0 copay Limited to 1 pair(s) of contact lenses	**In-Network** $0 copay Limited to 1 pair(s) of contact lenses **Out-of-Network** OON Eyewear Benefits Are As Follows: Frames $50, Single Vision Lenses $40, Bifocal/Progressive Lenses $60, Trifocal Lenses $80, Lenticular Lenses $100, Elective Contact Lenses $105, Visually Required CL $225.

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
○ Eyeglass lenses	**In-Network** $0 copay Limited to 1 set(s) of eyeglass lenses	**In-Network** $0 copay Limited to 1 set(s) of eyeglass lenses	**In-Network** $0 copay Limited to 1 set(s) of eyeglass lenses **Out-of-Network** OON Eyewear Benefits Are As Follows: Frames $50, Single Vision Lenses $40, Bifocal/Progressive Lenses $60, Trifocal Lenses $80, Lenticular Lenses $100, Elective Contact Lenses $105, Visually Required CL $225.
○ Eyeglass frames	**In-Network** $0 copay Limited to 1 pair(s) of eyeglass frames	**In-Network** $0 copay Limited to 1 pair(s) of eyeglass frames	**In-Network** $0 copay Limited to 1 pair(s) of eyeglass frames **Out-of-Network** OON Eyewear Benefits Are As Follows: Frames $50, Single Vision Lenses $40, Bifocal/Progressive Lenses $60, Trifocal Lenses $80, Lenticular Lenses $100, Elective Contact Lenses $105, Visually Required CL $225.

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Mental Health Services			
Inpatient stay	**In-Network** $125 copay each day for days 1 to 10 and $0 copay each day for days 11 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days. *Prior Authorization is required.*	**In-Network** $125 copay each day for days 1 to 10 and $0 copay each day for days 11 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days. *Prior Authorization is required.*	**In-Network** $265 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered hospital stay.
Outpatient group therapy visit	**In-Network** $40 copay *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Outpatient individual therapy visit	**In-Network** $40 copay *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Skilled nursing facility (SNF) care Our plan covers up to 100 days in a Skilled Nursing Facility. Three-day prior hospital stay is required.	**In-Network** $0 copay each day for days 1 to 20 and $165 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care. *Prior Authorization is required.*	**In-Network** $0 copay each day for days 1 to 20 and $165 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care. *Prior Authorization is required.*	**In-Network** $0 copay each day for days 1 to 20 and $165 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered skilled nursing facility stay.
Physical Therapy A separate copayment for Occupational Therapy will apply if other outpatient therapy services are rendered on the same day.	**In-Network** $20 copay per visit *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Ambulance services			
Ground Ambulance Copay applies to each one-way trip.	**In-Network** $260 copay *Prior Authorization may be required.*	**In-Network** $260 copay *Prior Authorization may be required.*	**In-Network** $300 copay *Prior Authorization may be required.* **Out-of-Network** $300 copay
Air Ambulance Copay applies to each one-way trip.	**In-Network** $260 copay *Prior Authorization is required.*	**In-Network** $260 copay *Prior Authorization is required.*	**In-Network** $300 copay *Prior Authorization is required.* **Out-of-Network** $300 copay

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Transportation	**In-Network** Not covered	**In-Network** Not covered	**In-Network** Not covered **Out-of-Network** Not covered
Medicare Part B prescription drugs			
Chemotherapy/Radiation drugs	**In-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Other Part B drugs	**In-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance

Prescription Drug Coverage	Blue Advantage (HMO) 008-1 & 008-2			Blue Advantage (PPO) 007		
Stage 1: Annual Prescription Deductible						
Deductible	$0 prescription drug deductible			$195 prescription drug deductible, applies to drugs in Tiers 3-5		
Stage 2: Initial Coverage						
After you meet your deductible (if applicable), you pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.						
Preferred Retail and Mail-Order Cost-Sharing*						
	30-Day	60-Day	90-Day	30-Day	60-Day	90-Day
Tier 1 (Preferred Generics)	$3	$6	$0	$3	$6	$0
Tier 2 (Generics)	$12	$24	$36	$12	$24	$36
Tier 3 (Preferred Brand)	$45	$90	$135	$45	$90	$135
Tier 4 (Non-Preferred Drug)	$100	$200	$300	$100	$200	$300
Tier 5 (Specialty)	33%	N/A	N/A	29%	N/A	N/A
*If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy.						
Standard Retail and Mail-Order Cost-Sharing						
Tier 1 (Preferred Generics)	$10	$20	$30	$10	$20	$30
Tier 2 (Generics)	$18	$36	$54	$18	$36	$54
Tier 3 (Preferred Brand)	$47	$94	$141	$47	$94	$141
Tier 4 (Non-Preferred Drug)	$100	$200	$300	$100	$200	$300
Tier 5 (Specialty)	33%	N/A	N/A	29%	N/A	N/A
If an in-network pharmacy is not available, you may get drugs from an out-of-network pharmacy. Your prescription cost may be more at an out-of-network pharmacy than at an in-network pharmacy.						

Stage 3: Coverage Gap
Most Medicare drug plans have a coverage gap (also called the “donut hole”). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you will continue to pay your regular copay for Tier 1 and Tier 2 generics. You will pay 25% of the plan’s cost for covered generic drugs and 25% of the plan’s cost for covered brand-name drugs until your true out-of-pocket costs total $7,050. Not everyone will enter the coverage gap.
Stage 4: Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% coinsurance, or • $3.95 copay for generic drugs (including brand drugs treated as generic) and a $9.85 copay for all other drugs.

Other Covered Benefits

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Cardiac (Heart) Rehabilitation Services	**In-Network** $30 copay per visit *Prior Authorization is required.*	**In-Network** $30 copay per visit *Prior Authorization is required.*	**In-Network** $30 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Chiropractic office visit	**In-Network** $20 copay *Prior Authorization is required.*	**In-Network** $20 copay *Prior Authorization is required.*	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Diabetic monitoring supplies	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 50% coinsurance
Diabetes Self-Management Training	**In-Network** $0 copay	**In-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** 50% coinsurance
Diabetic therapeutic shoes or inserts	**In-Network** $0 copay *Prior Authorization is required.*	**In-Network** $0 copay *Prior Authorization is required.*	**In-Network** $0 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Durable medical equipment (DME) and related supplies	**In-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Podiatry services (foot care)	**In-Network** $40 copay	**In-Network** $40 copay	**In-Network** $50 copay **Out-of-Network** 50% coinsurance
Home health agency care	**In-Network** $0 copay *Prior Authorization is required.*	**In-Network** $0 copay *Prior Authorization is required.*	**In-Network** $0 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Hospice Services must be provided by a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Contact the plan for more details.	$0 copay	$0 copay	$0 copay
Outpatient rehabilitation services Services provided by an occupational therapist. A separate copayment for Physical Therapy will apply if other outpatient therapy services are rendered on the same day.	**In-Network** $20 copay per visit *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Outpatient substance abuse services	**In-Network** $40 copay *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Prosthetic devices and related supplies	**In-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Renal Dialysis Services	**In-Network** 20% coinsurance	**In-Network** 20% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 50% coinsurance
Speech and Language Therapy	**In-Network** $20 copay per visit *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance
Worldwide emergency coverage	$90 copay	$90 copay	$90 copay

Extra Benefits

	Blue Advantage (HMO) 008-1	**Blue Advantage (HMO)** 008-2	**Blue Advantage (PPO)** 007
Member Rewards	Receive up to $50 per year. Receive gift cards for completing approved wellness exams and/or screenings.		
Fitness program	Members have access to a Fitness Facility Membership with fitness advisors onsite to assist and provide orientation to the facility. Members have access to over 11,000 facilities throughout the U.S. Home fitness kits offering a broad range of activity levels may be used by members who prefer exercise at home or while traveling.		
Meal benefit	Up to 5 days of pre-cooked, frozen meals (2 meals per day) following discharge from an inpatient stay.		
Over-the-counter benefit	You are eligible for 50 credits every three months to be used toward the purchase of over-the-counter (OTC) health and wellness products.		
Telehealth (online doctor visits)	$0 copay Available 24/7 through BlueCare on a computer, tablet or smartphone. Primary Care Provider services only. Network restrictions may apply.		

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 at 1-800-363-9152 (TTY users should call 711), 7 days a week from 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.bcbsla.com/blueadvantage or call 1-800-363-9152 (TTY users should call 711) to view 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

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/co-insurance may change on January 1, 2023.

If selecting Blue Advantage (HMO):

- ☐ 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).

If selecting Blue Advantage (PPO):

- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.