2024 Summary of Benefits

Blue adVantage Reliance (HMO-POS)

H6453 - 017-2

Blue adVantage Premier (PPO)

H1248 - 004

Blue adVantage Platinum (HMO-POS)

H6453 - 018-2

Our plans and service areas:

H6453 - 017-2 Blue adVantage Reliance (HMO-POS) includes the following parishes: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Calcasieu, Caldwell, Cameron, Claiborne, Concordia, East Baton Rouge, East Feliciana, Evangeline, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, Lafayette, Lafourche, Livingston, Madison, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Rapides, Red River, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Terrebonne, Union, Vermilion, Vernon, Washington, West Baton Rouge, West Feliciana.

H1248 - 004 Blue adVantage Premier (PPO) is available statewide in Louisiana.

H6453 - 018-2 Blue adVantage Platinum (HMO-POS) include the following parishes: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Calcasieu, Caldwell, Cameron, Claiborne, Concordia, East Baton Rouge, East Feliciana, Evangeline, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, Lafayette, Lafourche, Livingston, Madison, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Rapides, Red River, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Terrebonne, Union, Vermilion, Vernon, Washington, West Baton Rouge, West Feliciana.

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This is a summary of drug and health services covered by Blue adVantage Reliance (HMO-POS), Blue adVantage Premier (PPO), and Blue adVantage Platinum (HMO-POS) from January 1, 2024 - December 31, 2024.

Blue Advantage from Blue Cross and Blue Shield of Louisiana 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 Reliance (HMO-POS), Blue adVantage Premier (PPO), or Blue adVantage Platinum (HMO-POS), 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 Reliance (HMO-POS), Blue adVantage Premier (PPO), and Blue adVantage Platinum (HMO-POS) have a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.bcbsla.com/blueadvantage. Because our plan is an HMO-POS plan, you can use Point-of-Service (POS) providers that are outside our network for an additional cost. The maximum benefit for services rendered by POS providers is $5,000.

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 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 Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Monthly plan premium	$46.20 You must keep paying your Medicare Part B premium.	$100 You must keep paying your Medicare Part B premium.	$169 You must keep paying your Medicare Part B premium.
Medical Deductible	$500 per year for point-of-service (POS) benefits	For in-network providers: $0 per year For out-of-network providers: $1,000 per year for Medicare-covered benefits.	$500 per year for point-of-service (POS) benefits
Maximum out-of-pocket amount *(does not include Part D prescription drugs)*	For in-network providers: $4,100 per year	For in-network providers: $4,000 per year For in-network and out-of-network providers combined: $8,000 per year	For in-network providers: $3,500 per year

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Inpatient Hospital coverage	**In-Network** $175 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 Medicare-covered 60 lifetime reserve days. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered hospital stay. *Prior Authorization is required.*	**In-Network** $140 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 Medicare-covered 60 lifetime reserve days. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered hospital stay.	**In-Network** $175 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 Medicare-covered 60 lifetime reserve days. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered hospital stay. *Prior Authorization is required.*
Outpatient Hospital coverage	Observation Services coverage applies only if you are under Observation status.		
Outpatient hospital services	**In-Network** $0 copay for diagnostic colonoscopies $250 copay for all other outpatient hospital services *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay for diagnostic colonoscopies $200 copay for all other outpatient hospital services *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay for diagnostic colonoscopies $150 copay for all other outpatient hospital services *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Outpatient hospital observation services	**In-Network** $175 copay per day *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $140 copay per day *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $175 copay per day *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Ambulatory Surgical Center (ASC)	**In-Network** $0 copay for diagnostic colonoscopies $250 copay for all other outpatient surgeries *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay for diagnostic colonoscopies $200 copay for all other outpatient surgeries *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay for diagnostic colonoscopies $150 copay for all other outpatient surgeries *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Doctor Visits			
Primary Care Provider visit	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Specialist visit	**In-Network** $30 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $40 copay **Out-of-Network** 50% coinsurance	**In-Network** $25 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Preventive Care Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • 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 **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
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 Copay is waived if you are admitted to a hospital within 72 hours.	$90 copay Copay is waived if you are admitted to a hospital within 72 hours.	$90 copay Copay is waived if you are admitted to a hospital within 72 hours.

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Urgently Needed Services (Urgent Care)	$40 copay inside of the United States	$35 copay inside of the United States	$40 copay inside of the United States
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.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 - $30 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance	**In-Network** $0 - $30 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Diagnostic radiology services (e.g. MRI, CT Scan)	**In-Network** $0 copay for mammograms $150 copay for all other diagnostic radiology services *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay for mammograms $140 copay for all other diagnostic radiology services *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay for mammograms $125 copay for all other diagnostic radiology services *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Lab services	**In-Network** $0 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Outpatient X-rays	**In-Network** 0% - 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 - $75 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance	**In-Network** 0% - 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Therapeutic Radiology	**In-Network** 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance	**In-Network** 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Hearing services			
Exam to diagnose and treat hearing and balance issues	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance
Routine hearing exam	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** 50% coinsurance	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay
Fitting-evaluation(s) for hearing aids	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** 50% coinsurance	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Hearing aids	$0 copay up to a $1,100 maximum benefit coverage amount loaded to your Blue Advantage Flex Card for both ears combined every year for hearing aids. Hearing aid fitting is included in the maximum benefit coverage amount. Retailer restrictions apply.	$0 copay up to a $1,100 maximum benefit coverage amount loaded to your Blue Advantage Flex Card for both ears combined every year for hearing aids. Hearing aid fitting is included in the maximum benefit coverage amount. Retailer restrictions apply.	$0 copay up to a $1,100 maximum benefit coverage amount loaded to your Blue Advantage Flex Card for both ears combined every year for hearing aids. Hearing aid fitting is included in the maximum benefit coverage amount. Retailer restrictions apply.
Dental services **Preventive dental services**	Up to a $2,200 combined maximum benefit coverage amount every year for all preventive and comprehensive dental services.	Up to a $2,000 combined maximum benefit coverage amount every year for all preventive and comprehensive dental services.	Up to a $2,500 combined maximum benefit coverage amount every year for all preventive and comprehensive dental services.
Oral Exams	Limited to 2 oral exam(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay	Limited to 2 oral exam(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay	Limited to 2 oral exam(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Prophylaxis (Cleaning)	Limited to 2 cleaning(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay	Limited to 2 cleaning(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay	Limited to 2 cleaning(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay
Fluoride Treatment	Limited to 2 fluoride treatment(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay	Limited to 2 fluoride treatment(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay	Limited to 2 fluoride treatment(s) every year **In-Network** $0 copay **Out-of-Network** $0 copay
Dental X-rays	1 bitewing x-ray per year or 1 full mouth x-ray every 3 years. **In-Network** $0 copay **Out-of-Network** $0 copay	1 bitewing x-ray per year or 1 full mouth x-ray every 3 years. **In-Network** $0 copay **Out-of-Network** $0 copay	1 bitewing x-ray per year or 1 full mouth x-ray every 3 years. **In-Network** $0 copay **Out-of-Network** $0 copay

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Comprehensive dental services	**In-Network** $0 copay **Out-of-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay
Limited Medicare-covered Dental Services	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 50% coinsurance	**In-Network** $0 copay for each Medicare-covered service. **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Vision care			
Exam to diagnose and treat diseases and conditions of the eye	**In-Network** $30 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $40 copay **Out-of-Network** 50% coinsurance	**In-Network** $25 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Diabetic eye exams	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Eyeglasses or contact lenses after cataract surgery	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Glaucoma screening	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Routine eye exam	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** 50% coinsurance	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** $40 copay	Limited to 1 visit(s) every year **In-Network** $0 copay **Out-of-Network** 50% coinsurance
Supplemental eyewear Contact lenses Eyeglass lenses Eyeglass frames Eyeglasses (lenses and frames) Upgrades	$0 copay up to a $450 combined maximum benefit coverage amount loaded to your Blue Advantage Flex Card every year. Retailer restrictions may apply.	$0 copay up to a $400 combined maximum benefit coverage amount loaded to your Blue Advantage Flex Card every year. Retailer restrictions may apply.	$0 copay up to a $300 combined maximum benefit coverage amount loaded to your Blue Advantage Flex Card every year. Retailer restrictions may apply.

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Mental Health Services			
Inpatient stay	**In-Network** $195 copay each day for days 1 to 8 and $0 copay each day for days 9 to 90 for Medicare-covered hospital care. $0 copay for an additional Medicare-covered 60 lifetime reserve days. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered hospital stay. *Prior Authorization is required.*	**In-Network** $175 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 Medicare-covered 60 lifetime reserve days. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered hospital stay.	**In-Network** $195 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 Medicare-covered 60 lifetime reserve days. *Prior Authorization is required.* **Out-of-Network** 50% coinsurance for each Medicare-covered hospital stay. *Prior Authorization is required.*
Outpatient group therapy visit	**In-Network** $30 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Outpatient individual therapy visit	**In-Network** $30 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
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.* **Out-of-Network** 50% coinsurance for each Medicare-covered skilled nursing facility stay. *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.	**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. *Prior Authorization is required.*
Physical Therapy Cost share applies to each Medicare-covered therapy visit. Separate cost share will apply for each type of therapy services rendered on the same day.	**In-Network** $10 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $10 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Ambulance services			

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Ground Ambulance Copay applies to each one-way trip.	**In-Network** $250 copay *Prior Authorization may be required.* **Out-of-Network** $250 copay *Prior Authorization may be required.*	**In-Network** $260 copay *Prior Authorization may be required.* **Out-of-Network** $260 copay	**In-Network** $250 copay *Prior Authorization may be required.* **Out-of-Network** $250 copay *Prior Authorization may be required.*
Air Ambulance Copay applies to each one-way trip.	**In-Network** $260 copay *Prior Authorization is required.* **Out-of-Network** $260 copay *Prior Authorization is required.*	**In-Network** $260 copay *Prior Authorization is required.* **Out-of-Network** $260 copay	**In-Network** $260 copay *Prior Authorization is required.* **Out-of-Network** $260 copay *Prior Authorization is required.*
Transportation	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Not covered **Out-of-Network** Not covered	**In-Network** Not covered **Out-of-Network** Not covered
Medicare Part B prescription drugs			
Chemotherapy/Radiation drugs	**In-Network** 0% - 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 0% - 50% coinsurance *Prior Authorization is required.*	**In-Network** 0% - 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 0% - 50% coinsurance	**In-Network** 0% - 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 0% - 50% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Other Part B drugs	**In-Network** 0% - 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 0% - 50% coinsurance *Prior Authorization is required.*	**In-Network** 0% - 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 0% - 50% coinsurance	**In-Network** 0% - 20% coinsurance *Prior Authorization may be required.* **Out-of-Network** 0% - 50% coinsurance *Prior Authorization is required.*
Insulin	**In-Network** $35 copay *Prior Authorization may be required.* **Out-of-Network** $35 copay *Prior Authorization is required.*	**In-Network** $35 copay *Prior Authorization may be required.* **Out-of-Network** $35 copay	**In-Network** $35 copay *Prior Authorization may be required.* **Out-of-Network** $35 copay *Prior Authorization is required.*

Prescription Drug Coverage	Blue adVantage Reliance (HMO-POS) 017-2			Blue adVantage Premier (PPO) 004			Blue adVantage Platinum (HMO-POS) 018-2		
Stage 1: Annual Prescription Deductible									
Deductible	$0 prescription drug deductible			$0 prescription drug deductible			$0 prescription drug deductible		
Stage 2: Initial Coverage (after you meet your deductible, if applicable)									
You pay the following until your total yearly drug costs reach $5,030. 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*									
	1-month supply	2-month supply	3-month supply	1-month supply	2-month supply	3-month supply	1-month supply	2-month supply	3-month supply
Tier 1 (Preferred Generics)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tier 2 (Generics)	$12	$24	$36	$12	$24	$36	$12	$24	$36
Tier 3** (Preferred Brand)	$45	$90	$135	$45	$90	$135	$45	$90	$135
Tier 4 (Non-Preferred Drug)	$100	$200	$300	$100	$200	$300	$100	$200	$300
Tier 5 (Specialty)	33%	Not Offered	Not Offered	33%	Not Offered	Not Offered	33%	Not Offered	Not Offered
*If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy. **Some generics may be included on Tier 3.									

Prescription Drug Coverage	Blue adVantage Reliance (HMO-POS) 017-2			Blue adVantage Premier (PPO) 004			Blue adVantage Platinum (HMO-POS) 018-2		
Standard Retail and Mail-Order Cost-Sharing									
	1-month supply	2-month supply	3-month supply	1-month supply	2-month supply	3-month supply	1-month supply	2-month supply	3-month supply
Tier 1 (Preferred Generics)	$5	$10	$15	$10	$20	$30	$5	$10	$15
Tier 2 (Generics)	$14	$28	$42	$18	$36	$54	$14	$28	$42
Tier 3** (Preferred Brand)	$47	$94	$141	$47	$94	$141	$47	$94	$141
Tier 4 (Non-Preferred Drug)	$100	$200	$300	$100	$200	$300	$100	$200	$300
Tier 5 (Specialty)	33%	Not Offered	Not Offered	33%	Not Offered	Not Offered	33%	Not Offered	Not Offered
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. **Some generics may be included on Tier 3.									
Stage 3: Coverage Gap									
Most Medicare drug plans have a coverage gap (also called “donut hole”). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you will continue to pay your regular copay for Tier 1 and 2 generics. For drugs in Tiers 3, 4, and 5, 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 $8,000. 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 $8,000, you pay nothing.									

For each covered insulin product, you won't pay more than $35 for a one-month supply, $70 for a two-month supply, and $105 for a three-month supply, regardless of the cost-sharing tier.

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (1-month supply) or long-term (3-month supply).

Other Covered Benefits

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Cardiac (Heart) Rehabilitation Services	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Chiropractic services	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Diabetic monitoring supplies	**In-Network** $0 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay *Prior Authorization may be required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Diabetes Self-Management Training	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Diabetic therapeutic shoes or inserts	**In-Network** $0 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Durable medical equipment (DME) and related supplies	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Podiatry services (foot care)	**In-Network** $30 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $40 copay **Out-of-Network** 50% coinsurance	**In-Network** $25 copay **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Home health agency care	**In-Network** $0 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $0 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Outpatient rehabilitation services Services provided by an occupational therapist. Cost share applies to each Medicare-covered therapy visit. Separate cost share will apply for each type of therapy services rendered on the same day.	**In-Network** $10 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $10 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Outpatient substance abuse services	**In-Network** $30 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $40 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $20 copay *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Prosthetic devices and related supplies	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Renal Dialysis Services	**In-Network** 20% coinsurance **Out-of-Network** 20% coinsurance *Prior Authorization is required.*	**In-Network** 20% coinsurance **Out-of-Network** 50% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 20% coinsurance *Prior Authorization is required.*

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
Speech and Language Therapy Cost share applies to each Medicare-covered therapy visit. Separate cost share will apply for each type of therapy services rendered on the same day.	**In-Network** $10 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*	**In-Network** $20 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance	**In-Network** $10 copay per visit *Prior Authorization is required.* **Out-of-Network** 50% coinsurance *Prior Authorization is required.*
Worldwide emergency coverage	$90 copay	$90 copay	$90 copay
Annual routine physical exam	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance	**In-Network** $0 copay **Out-of-Network** 50% coinsurance

Extra Benefits

	Blue adVantage Reliance (HMO-POS) 017-2	**Blue adVantage Premier (PPO)** 004	**Blue adVantage Platinum (HMO-POS)** 018-2
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.		
Over-the-counter benefit	You are eligible for a $150 maximum benefit coverage amount loaded to your Blue Advantage Flex Card every three months to be used toward the purchase of over-the-counter (OTC) health-related items.	You are eligible for $150 maximum benefit coverage amount loaded to your Blue Advantage Flex Card every three months to be used toward the purchase of over-the-counter (OTC) health-related items.	You are eligible for $150 maximum benefit coverage amount loaded to your Blue Advantage Flex Card every three months to be used toward the purchase of over-the-counter (OTC) health-related items.
BlueCare 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.		
Personal emergency response system (PERS)	$0 copay	Not covered	Not covered
Additional Telehealth	Includes qualifying appointments with primary care providers, physician specialists, podiatrists, other healthcare professionals, dieticians, behavioral health providers, and occupational/physical/speech therapists.		

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).

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 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.
- ☐ 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/co-insurance may change on January 1, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.