

## 2027 Summary of Benefits

### Blue adVantage Premier (PPO)

Our plan and service areas:

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

January 1, 2027 – December 31, 2027

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

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

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## SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

**This is a summary of drug and health services covered by Blue adVantage Premier (PPO) from January 1, 2027 - December 31, 2027.**

Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in Blue Advantage 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, call us and ask for the "Evidence of Coverage." You can also see the Evidence of Coverage on our website, [www.lablue.com/blueadvantage](http://www.lablue.com/blueadvantage).

### 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 Premier (PPO)**).

### Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Blue adVantage Premier (PPO)** 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](http://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](http://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.

## Sections in this booklet

- Things to Know About **Blue adVantage Premier (PPO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.
- Other Covered Benefits.

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.lablue.com/blueadvantage](http://www.lablue.com/blueadvantage).

## Things to Know About Blue adVantage Premier (PPO)

### Hours of Operation & Contact Information

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.lablue.com/blueadvantage](http://www.lablue.com/blueadvantage).

## Who can join?

To join **Blue adVantage Premier (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these parishes in Louisiana: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, De Soto, East Baton Rouge, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, Lafayette, Lafourche, LaSalle, Lincoln, Livingston, Madison, Morehouse, Natchitoches, Orleans, Ouachita, Plaquemines, Pointe Coupee, Rapides, Red River, Richland, Sabine, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Tensas, Terrebonne, Union, Vermilion, Vernon, Washington, Webster, West Baton Rouge, West Carroll, West Feliciana and Winn.

## Which doctors, hospitals, and pharmacies can I use?

**Blue adVantage Premier (PPO)** has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at [www.lablue.com/blueadvantage](http://www.lablue.com/blueadvantage).

## What do we cover?

Like all Medicare Advantage health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover 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, [www.lablue.com/blueadvantage](http://www.lablue.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 medication into one of five "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: Deductible, Initial Coverage, 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.

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## SECTION II - SUMMARY OF BENEFITS

### Blue adVantage Premier (PPO)

#### MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

| Premiums and Benefits                                                                    | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Plan Premium (Includes Parts C and D)</b>                                             | \$175 per month. In addition, you must keep paying your Medicare Part B premium.                                                                                                                                                                                                                                                                                                                                     |
| <b>Medical Deductible</b>                                                                | For in-network providers: \$0 per year<br>For out-of-network providers: \$1,000 per year for Medicare-covered benefits.<br>Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. |
| <b>Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)</b> | Your yearly limit(s) in this plan: <ul style="list-style-type: none"> <li>• \$4,000 for services you receive from in-network providers.</li> <li>• \$6,200 for services you receive from in and out-of-network providers combined.</li> </ul> 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.          |

## COVERED MEDICAL AND HOSPITAL BENEFITS

| Benefits/Services                   | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Hospital</b>           | <p><b><u>In-Network:</u></b></p> <p>Days 1-10: \$170 copay per day.</p> <p>Days 11-90: \$0 copay per day.</p> <p>\$0 copay for an additional Medicare-covered 60 lifetime reserve days.</p> <p><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b></p> <p>50% coinsurance per stay.</p>                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Outpatient Hospital Coverage</b> | <p><b><u>In-Network:</u></b></p> <p>Outpatient hospital services: \$75 copay applies for non-surgical procedure/service such as hyperbaric oxygen therapy, transfusions, wound care.</p> <p><i>Prior Authorization is required.</i></p> <p>Outpatient Surgery:</p> <p>\$0 copay for diagnostic colonoscopies.</p> <p>\$200 copay for outpatient surgery.</p> <p><i>Prior Authorization is required.</i></p> <p>Observation services: \$170 copay per day.</p> <p><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b></p> <p>Outpatient hospital services: 50% coinsurance.</p> <p>Outpatient Surgery: 50% coinsurance.</p> <p>Observation services: 50% coinsurance.</p> |

## COVERED MEDICAL AND HOSPITAL BENEFITS

| Benefits/Services                 | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Ambulatory Surgical Center</b> | <p><b><u>In-Network:</u></b></p> <p>Ambulatory Surgical Center:<br/>           \$0 copay for diagnostic colonoscopies.<br/>           \$200 copay for all other outpatient surgeries.<br/> <i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b></p> <p>Ambulatory Surgical Center: 50% coinsurance.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Doctor's Office Visits</b>     | <p><b><u>In-Network:</u></b></p> <p>Primary Care Provider visit: \$0 copay.<br/>           Specialist visit: \$40 copay.<br/> <i>Prior Authorization may be required for certain services.</i></p> <p><b><u>Out-of-Network:</u></b></p> <p>Primary Care Provider visit: 50% coinsurance.<br/>           Specialist visit: 50% coinsurance.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Preventive Care</b>            | <p><b><u>In-Network:</u></b></p> <p>\$0 copay for all preventive services covered under Original Medicare at zero cost sharing.</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Annual wellness visit</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cervical and vaginal cancer screening</li> <li>• Cologuard or FOBT colorectal screenings</li> <li>• Colonoscopy and all other colorectal screenings</li> <li>• Diabetes screenings</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> </ul> |

## COVERED MEDICAL AND HOSPITAL BENEFITS

| Benefits/Services                          | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
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|                                            | <ul style="list-style-type: none"> <li>• "Welcome to Medicare" preventive visit (one-time)</li> </ul> <p>Other preventive services are available. Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p><b><u>Out-of-Network:</u></b></p> <p>50% coinsurance for all preventive services covered under Original Medicare.</p>                                                                                                                                                                                                                                                                                                                             |
| <b>Emergency Care</b>                      | <p><b><u>In-Network and Out-of-Network:</u></b></p> <p>\$150 copay per visit.</p> <p>If you are admitted to the hospital within 72 hours, the copay is waived.</p> <p>Worldwide Emergency Coverage: \$150 copay.</p> <p>The copay is not waived if you are admitted to a hospital outside of the United States.</p>                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Urgently Needed Services</b>            | <p><b><u>In-Network and Out-of-Network:</u></b></p> <p>\$35 copay per visit inside the United States.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Diagnostic Services / Labs/ Imaging</b> | <p><b><u>In-Network:</u></b></p> <p>Diagnostic tests and procedures: \$0 - \$30 copay.</p> <p><i>Prior Authorization may be required.</i></p> <p>Diagnostic Radiology Services (such as MRI, CAT Scan):</p> <p>\$0 copay for mammograms.</p> <p>\$280 copay for all other diagnostic radiology services.</p> <p><i>Prior Authorization may be required.</i></p> <p>Lab services: \$0 - \$35 copay.</p> <p><i>Prior Authorization may be required.</i></p> <p>Outpatient X-rays: \$0 - \$75 copay.</p> <p><i>Prior Authorization may be required.</i></p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.</p> <p><i>Prior Authorization may be required.</i></p> |

## COVERED MEDICAL AND HOSPITAL BENEFITS

| Benefits/Services | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                   | <p><b><u>Out-of-Network:</u></b></p> <p>Diagnostic tests and procedures: 50% coinsurance.</p> <p>Diagnostic Radiology Services (such as MRI, CAT Scan): 50% coinsurance.</p> <p>Lab services: 50% coinsurance.</p> <p>Outpatient X-rays: 50% coinsurance.</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 50% coinsurance.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Hearing Services  | <p><b><u>In-Network:</u></b></p> <p>Exam to diagnose and treat hearing and balance issues: \$0 copay.</p> <p>Routine hearing exam (up to 1 visit(s) every year): \$0 copay.</p> <p>Prescription hearing aids: \$0 copay. Some restrictions apply.</p> <p>Fitting-evaluation(s) for prescription hearing aids (Unlimited visits every year. Some restrictions apply.): \$0 copay.</p> <p>\$800 toward the cost of two non-implantable hearing aids from the applicable TruHearing catalog for both ears combined every three years (limit 1 hearing aid per ear).</p> <p><b><u>Out-of-Network:</u></b></p> <p>Exam to diagnose and treat hearing and balance issues: 50% coinsurance.</p> <p>Routine hearing exam (up to 1 visit(s) every year): 50% coinsurance.</p> <p>Prescription hearing aids: 80% coinsurance. Some restrictions apply.</p> <p>Fitting-evaluation(s) for prescription hearing aids (Unlimited visits every year. Some restrictions apply.): 80% coinsurance.</p> |
| Dental Services   | <p><b><u>In-Network:</u></b></p> <p>Medicare-covered Dental Services: \$0 copay.</p> <p>Up to a \$2,200 combined maximum benefit coverage amount every year for all preventive and comprehensive dental services.</p> <p>Preventive and Comprehensive dental services:</p> <ul style="list-style-type: none"> <li>• Oral exam (up to 2 visit(s) every year): \$0 copay.</li> <li>• Cleaning (up to 2 visit(s) every year): \$0 copay.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

## COVERED MEDICAL AND HOSPITAL BENEFITS

| Benefits/Services | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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|                   | <ul style="list-style-type: none"> <li>• Fluoride treatment (up to 2 visit(s) every year): \$0 copay.</li> <li>• Dental X-rays (One bitewing X-ray per year or one full mouth X-ray every three years.): \$0 copay.</li> <li>• Comprehensive dental services: \$0 copay.</li> </ul> <p><b><u>Out-of-Network:</u></b></p> <p>Medicare-covered Dental Services: 50% coinsurance.</p> <p>Preventive and Comprehensive dental services:</p> <ul style="list-style-type: none"> <li>• Oral exam (up to 2 visit(s) every year): 15% coinsurance.</li> <li>• Cleaning (up to 2 visit(s) every year): 15% coinsurance.</li> <li>• Fluoride treatment (up to 2 visit(s) every year): 15% coinsurance.</li> <li>• Dental X-rays (One bitewing X-ray per year or one full mouth X-ray every three years.): 15% coinsurance.</li> <li>• Comprehensive dental services: 15% coinsurance.</li> </ul> |
| Vision Services   | <p><b><u>In-Network:</u></b></p> <p>Exam to diagnose and treat diseases and conditions of the eye: \$40 copay.</p> <p><i>Prior Authorization may be required for certain services.</i></p> <p>Diabetic eye exams: \$0 copay.</p> <p>Routine eye exam (up to 1 visit(s) every year): \$0 copay.</p> <p>Eyeglasses or contact lenses after cataract surgery: \$0 copay.</p> <p>Glaucoma screening: \$0 copay.</p> <p>Up to a \$200 combined maximum benefit coverage amount loaded to your Blue Advantage Flex Card every year for additional routine eyewear. Retailer restrictions may apply.</p> <p>Additional routine eyewear: \$0 copay.</p> <ul style="list-style-type: none"> <li>• Contact lenses</li> <li>• Eyeglass lenses</li> <li>• Eyeglass frames</li> <li>• Eyeglasses (lenses and frames)</li> <li>• Upgrades</li> </ul>                                                 |

## COVERED MEDICAL AND HOSPITAL BENEFITS

| Benefits/Services                     | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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|                                       | <p><b><u>Out-of-Network:</u></b></p> <p>Exam to diagnose and treat diseases and conditions of the eye: 50% coinsurance.</p> <p>Diabetic eye exams: 50% coinsurance.</p> <p>Routine eye exam (up to 1 visit(s) every year): \$40 copay.</p> <p>Eyeglasses or contact lenses after cataract surgery: 50% coinsurance.</p> <p>Glaucoma screening: 50% coinsurance.</p> <p>Additional routine eyewear: \$0 copay.</p> <ul style="list-style-type: none"> <li>• Contact lenses</li> <li>• Eyeglass lenses</li> <li>• Eyeglass frames</li> <li>• Eyeglasses (lenses and frames)</li> <li>• Upgrades</li> </ul>                                                                                                        |
| <b>Mental Health Care</b>             | <p><b><u>In-Network:</u></b></p> <p>Inpatient Mental Health Care:</p> <p>Days 1-7: \$205 copay per day.</p> <p>Days 8-90: \$0 copay per day.</p> <p>\$0 copay for an additional Medicare-covered 60 lifetime reserve days.</p> <p><i>Prior Authorization is required.</i></p> <p>Outpatient group therapy visit: \$40 copay.</p> <p><i>Prior Authorization is required.</i></p> <p>Outpatient Individual therapy visit: \$40 copay.</p> <p><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b></p> <p>Inpatient Mental Health Care: 50% coinsurance per stay.</p> <p>Outpatient group therapy visit: 50% coinsurance.</p> <p>Outpatient Individual therapy visit: 50% coinsurance.</p> |
| <b>Skilled Nursing Facility (SNF)</b> | <p><b><u>In-Network:</u></b></p> <p>Three-day prior hospital stay is required.</p> <p>Days 1-20: \$0 copay per day.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

## COVERED MEDICAL AND HOSPITAL BENEFITS

| Benefits/Services                | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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|                                  | <p>Days 21-100: \$200 copay per day.</p> <p><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b></p> <p>50% coinsurance per stay.</p>                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Outpatient Rehabilitation</b> | <p><b><u>In-Network:</u></b></p> <p>Occupational therapy visit: \$35 copay.</p> <p><i>Prior Authorization is required.</i></p> <p>Physical therapy and speech and language therapy visit: \$35 copay.</p> <p><i>Prior Authorization is required.</i></p> <p>Separate cost share will apply for each type of therapy services rendered on the same day.</p> <p><b><u>Out-of-Network:</u></b></p> <p>Occupational therapy visit: 50% coinsurance.</p> <p>Physical therapy and speech and language therapy visit: 50% coinsurance.</p> |
| <b>Ambulance</b>                 | <p><b><u>In-Network:</u></b></p> <p>Copay applies to each one-way trip.</p> <p>Ground Ambulance: \$260 copay.</p> <p>Air Ambulance: \$260 copay.</p> <p><b><u>Out-of-Network:</u></b></p> <p>Copay applies to each one-way trip.</p> <p>Ground Ambulance: \$260 copay.</p> <p>Air Ambulance: \$260 copay.</p>                                                                                                                                                                                                                       |
| <b>Transportation</b>            | <p><b><u>In-Network:</u></b></p> <p>Not Covered.</p> <p><b><u>Out-of-Network:</u></b></p> <p>Not Covered.</p>                                                                                                                                                                                                                                                                                                                                                                                                                       |

## COVERED MEDICAL AND HOSPITAL BENEFITS

| Benefits/Services            | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Medicare Part B Drugs</b> | <p><b><u>In-Network:</u></b></p> <p>For Part B drugs such as chemotherapy drugs: 0% - 20% coinsurance.</p> <p><i>Prior Authorization is required.</i></p> <p>Other Part B drugs: 0% - 20% coinsurance.</p> <p><i>Prior Authorization may be required.</i></p> <p>Insulin drugs: \$35 copay.</p> <p><i>Prior Authorization may be required.</i></p> <p><b><u>Out-of-Network:</u></b></p> <p>For Part B drugs such as chemotherapy drugs: 0% - 50% coinsurance.</p> <p>Other Part B drugs: 0% - 50% coinsurance.</p> <p>Insulin drugs: \$35 copay.</p> |

## PRESCRIPTION DRUG BENEFITS

### Deductible

Prescription Drug Deductible: \$450 for Tiers 3, 4 and 5.  
The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.

### Initial Coverage

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,400. You then move on to the Catastrophic Coverage Stage.

#### Standard Retail and Mail-Order Cost-Sharing

| Tier                          | One-month supply | Two-month supply | Three-month supply |
|-------------------------------|------------------|------------------|--------------------|
| Tier 1<br>(Preferred Generic) | \$10 copay       | \$20 copay       | \$30 copay         |
| Tier 2<br>(Generic)           | \$18 copay       | \$36 copay       | \$54 copay         |
| Tier 3**<br>(Preferred Brand) | \$47 copay       | \$94 copay       | \$141 copay        |
| Tier 4 (Non-Preferred Drug)   | 50% coinsurance  | 50% coinsurance  | 50% coinsurance    |
| Tier 5<br>(Specialty Tier)    | 28% coinsurance  | 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.

## PRESCRIPTION DRUG BENEFITS

|                            | Preferred Retail and Mail-Order Cost-Sharing*                                                                                                                                                                                                                                                                                                                                                |                  |                  |                    |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------|--------------------|
|                            | Tier                                                                                                                                                                                                                                                                                                                                                                                         | One-month supply | Two-month supply | Three-month supply |
|                            | Tier 1<br>(Preferred Generic)                                                                                                                                                                                                                                                                                                                                                                | \$0 copay        | \$0 copay        | \$0 copay          |
|                            | Tier 2<br>(Generic)                                                                                                                                                                                                                                                                                                                                                                          | \$12 copay       | \$24 copay       | \$36 copay         |
|                            | Tier 3**<br>(Preferred Brand)                                                                                                                                                                                                                                                                                                                                                                | \$45 copay       | \$90 copay       | \$135 copay        |
|                            | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                                                                                                                                                                                                  | 45% coinsurance  | 45% coinsurance  | 45% coinsurance    |
|                            | Tier 5<br>(Specialty Tier)                                                                                                                                                                                                                                                                                                                                                                   | 28% coinsurance  | Not Offered      | Not Offered        |
|                            | <p>*If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy.</p> <p>**Some generics may be included on Tier 3.</p> <p>Please call us or see the plan's <b>"Evidence of Coverage"</b> on our website (<a href="http://www.lablue.com/blueadvantage">www.lablue.com/blueadvantage</a>) for complete information about your costs for covered drugs.</p> |                  |                  |                    |
| <b>Catastrophic Amount</b> | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,400, you pay nothing.                                                                                                                                                                                                                                   |                  |                  |                    |

For each covered insulin product, you won't pay more than \$35 for a 1-month supply, \$70 for a 2-month supply, and \$105 for a 3-month supply, regardless of the cost-sharing tier, even if you haven't paid your deductible.

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 Premier (PPO)                                                                                                                                |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cardiac (Heart) Rehabilitation Services</b>              | <p><b><u>In-Network:</u></b><br/>\$20 copay.<br/><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>      |
| <b>Chiropractic services</b>                                | <p><b><u>In-Network:</u></b><br/>\$20 copay.</p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>                                                  |
| <b>Diabetic monitoring supplies</b>                         | <p><b><u>In-Network:</u></b><br/>\$0 copay.<br/><i>Prior Authorization may be required.</i></p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>   |
| <b>Diabetes Self-Management Training</b>                    | <p><b><u>In-Network:</u></b><br/>\$0 copay.</p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>                                                   |
| <b>Diabetic therapeutic shoes or inserts</b>                | <p><b><u>In-Network:</u></b><br/>\$0 copay.<br/><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>       |
| <b>Durable medical equipment (DME) and related supplies</b> | <p><b><u>In-Network:</u></b><br/>20% coinsurance.<br/><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p> |
| <b>Podiatry services (foot care)</b>                        | <p><b><u>In-Network:</u></b><br/>\$40 copay.<br/><i>Prior Authorization may be required for certain services.</i></p>                                       |

| Other Covered Benefits Blue adVantage Premier (PPO)  |                                                                                                                                                             |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                      | <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>                                                                                                   |
| Home health agency care                              | <p><b><u>In-Network:</u></b><br/>\$0 copay.<br/><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>       |
| Outpatient substance use disorder services           | <p><b><u>In-Network:</u></b><br/>\$40 copay.<br/><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>      |
| Prosthetic and orthotic devices and related supplies | <p><b><u>In-Network:</u></b><br/>20% coinsurance.<br/><i>Prior Authorization is required.</i></p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p> |
| Renal Dialysis Services                              | <p><b><u>In-Network:</u></b><br/>20% coinsurance.</p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>                                             |
| Annual routine physical exam                         | <p><b><u>In-Network:</u></b><br/>\$0 copay.</p> <p><b><u>Out-of-Network:</u></b><br/>50% coinsurance.</p>                                                   |

| Other Covered Benefits          | Blue adVantage Premier (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Fitness benefit</b>          | You are covered for a fitness benefit through SilverSneakers® at participating locations, where you can take classes and use exercise equipment and other amenities at no additional cost to you. You also have access to instructor-led online group exercise classes seven days a week with SilverSneakers LIVE. Additional resources include SilverSneakers On-Demand workout videos, the SilverSneakers GO mobile app, and a free at-home fitness kit each year. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved. If you choose to use an out-of-network fitness facility, you are responsible for 80% of the fitness membership fees. Plan limitations and restrictions apply. |
| <b>Over-the-counter benefit</b> | You are eligible for a \$40 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Additional Telehealth</b>    | Includes qualifying appointments with primary care providers, physician specialists, podiatrists, other healthcare professionals, dietitians, 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.lablue.com/blueadvantage](http://www.lablue.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, 2028.
- ☐ 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 situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.



## **Notice of Nondiscriminatory Practices**

Blue Cross and Blue Shield of Louisiana (Louisiana Blue) and its subsidiary, HMO Louisiana, Inc., comply with applicable federal civil rights laws and do not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiary:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Customer Service at 1-866-508-7145 (TTY 711). Our phone lines are open 8 a.m. to 8 p.m., 7 days a week from October – March and 8 a.m. to 8 p.m., Monday – Friday from April – September.

If you believe that Louisiana Blue or its subsidiary has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person or by mail, fax or email.

If you would like to file a complaint directly with Blue Advantage, you can reach us in person, by mail, by fax, or by email at the addresses below:

### **Section 1557 Coordinator**

**In Person: 5525 Reitz Ave. Baton Rouge, LA 70809**

**Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012**

**Phone: (318) 998-4018 (TTY 711)**

**Fax: (318) 361-2165**

**Email: [civilrightscordinator@lablue.com](mailto:civilrightscordinator@lablue.com)**

If you need help filing a grievance, our Section 1557 Coordinator is available to help you. 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>**, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Ave., SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

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

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

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.

## Notice of Availability

Blue adVantage provides language assistance services and appropriate auxiliary aids and services free of charge. To speak to an interpreter about our health or drug plan, please call us at 1-866-508-7145 (711).

Blue adVantage ofrece servicios de asistencia lingüística, ayudas y servicios auxiliares adecuados de forma gratuita. Para hablar con un intérprete sobre nuestro plan de salud o de medicamentos, llámenos al 1-866-508-7145 (711).

Blue adVantage offre gratuitement des services d'assistance linguistique et des aides et services auxiliaires adéquats. Pour parler à un interprète sur notre régime de soins de santé ou de médicaments, appelez-nous au 1-866-508-7145 (711).

Blue adVantage cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ cũng như các dịch vụ và thiết bị hỗ trợ phù hợp. Để trao đổi với thông dịch viên về chương trình sức khỏe hoặc kế hoạch sử dụng thuốc của quý vị, vui lòng gọi cho chúng tôi theo số điện thoại 1-866-508-7145 (711).

Blue adVantage 免費提供語言援助服務與適當的輔助器具及服務。若需口譯人員協助瞭解醫療或藥物保險計畫，請撥打專線：1-866-508-7145 (711)。

توفر Blue adVantage خدمات المساعدة اللغوية وخدمات ووسائل المساعدة المناسبة مجانًا. للتحدث إلى مترجم فوري حول خطتنا الصحية أو الدوائية، يُرجى التواصل معنا على الرقم (711) 1-866-508-7145.

Nagbibigay ng libreng serbisyo ng tulong sa wika ang Blue adVantage at ng angkop na pantulong at sebisyo. Para makausap ang isang interpreter tungkol sa kalusugan namin o plano tungkol sa gamot, pakitawagan kami sa 1-866-508-7145 (711).

Blue adVantage 는 언어 지원 서비스와 적절한 보조 도구 및 서비스를 무료로 제공합니다. 당사의 건강 또는 의약 보험에 관해 통역사와 상담하려면 1-866-508-7145(711)로 전화해 주십시오.

A Blue adVantage disponibiliza, gratuitamente, serviços de assistência linguística e recursos assistivos pertinentes. Para falar com um intérprete sobre nosso plano de saúde ou de medicamentos, ligue para 1-866-508-7145 (711).

Blue adVantage ໃຫ້ບໍລິການການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອເສີມ ແລະ ການບໍລິການທີ່ເໝາະສົມໂດຍບໍ່ເສຍຄ່າ. ເພື່ອເວົ້າກັບນາຍພາສາກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນຢາຂອງພວກເຮົາ, ກະລຸນາໂທຫາພວກເຮົາທີ່ 1-866-508-7145 (711).

Blue adVantage は、言語支援サービスや適切な補助具とサービスを無料でご提供しています。健康保険または医薬品プランに関する通訳をご希望の場合は、1-866-508-7145 (711) までお電話ください。

Blue adVantage زبان کی مدد کی خدمات اور مناسب معاون آلات اور خدمات مفت فراہم کرتا ہے۔ اپنی صحت یا دوا کے منصوبے کے حوالے سے مترجم سے بات کرنے کے لیے، برائے مہربانی ہمیں (711) 1-866-508-7145 پر کال کریں۔

Bei Bedarf stellt Blue adVantage kostenlos unterstützende Sprachdienste sowie besondere Hilfsmittel und Hilfsdienste zur Verfügung. Möchten Sie mit einem Dolmetscher über unseren Kranken- oder Arzneimittelversicherungsschutz sprechen, rufen Sie uns bitte unter der 1-866-508-7145 (711) an.

Blue adVantage خدمات کمک زبانی و کمک‌ها و خدمات امدادی مناسب را به صورت رایگان ارائه می‌دهد. برای صحبت با یک مترجم شفاهی در مورد طرح سلامت یا دارویی ما، لطفاً با شماره (711) 1-866-508-7145 تماس بگیرید.

Blue adVantage бесплатно предоставляет услуги языковой поддержки и соответствующие вспомогательные средства и услуги. Чтобы поговорить с переводчиком о нашем плане медицинского обслуживания или покрытия расходов на лекарства, позвоните нам по телефону 1-866-508-7145 (711).

Blue adVantage ให้บริการช่วยเหลือด้านภาษาและบริการเสริมต่าง ๆ ตามที่เหมาะสมโดยไม่คิดค่าบริการ หากต้องการพูดคุยกับล่ามเกี่ยวกับแผนสุขภาพหรือแผนการใช้จ่ายของเรา โปรดโทรหาเราได้ที่ 1-866-508-7145 (711)