2025 SUMMARY OF BENEFITS

Blue Advantage
A Medicare Approved PPO

# Blue Advantage® (PPO) — Choice, Complete & Premier

MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION DRUG COVERAGE

January 1, 2025—December 31, 2025

This is a summary of drug and health services covered by Blue Advantage (PPO). This booklet gives you a summary of what we cover and what you pay. For a complete list of every covered service or a list of every limitation or exclusion, call us at the phone number on the back cover of this booklet to request an Evidence of Coverage (EOC). You may also email **bcbsalmedicare@bcbsal.org** or view the information at **BCBSALMedicare.com/Documents**.

This document is available in other formats such as braille, large print or audio. This document may be available in a non-English language.

H0104_SBCCP25_M 09/22/2024

# Table of Contents

**In this Summary of Benefits, you will learn:**

# What Should You Know About Blue Advantage (PPO)

## Who can join?

To join **Blue Advantage (PPO) Choice, Complete** or **Premier**, you must:

- Be entitled to Medicare Part A and enrolled in Medicare Part B
- Live in our service area. Our service area includes counties in Alabama. To search for your county, refer to the chart on the following page.

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

This Medicare Advantage plan has a network of doctors, hospitals, pharmacies and other providers. You can use in-network and out-of-network providers. Typically, you will pay more for out-of-network services. You can see our plan's provider directory and pharmacy directory at our website **BCBSALMedicare.com/FindaDoctor**.

## Will I need referrals?

Blue Advantage (PPO) doesn't require a referral from a primary care physician to see a specialist. There may be some providers that require a recommendation or treatment plan from your doctor in order to see you.

## What drugs are covered?

You can see our plan's formulary (list of Part D prescription drugs) at our website **BCBSALMedicare.com/FindaDrug**. You can also call us to mail you the formulary or we can look up your drugs for you.

Please be aware:

- Prior authorization for certain Part B drugs is required for in-network providers. Step Therapy may also apply. Please visit **BCBSALMedicare.com/PartBDrugs** or contact Member Services.
- The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

## How can I learn about Original Medicare?

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **Medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

# Monthly Plan Premiums for Blue Advantage (PPO) — Choice, Complete & Premier

Our service area includes the Alabama counties in the chart below. Premiums vary by plan and county in which you permanently reside. You must continue to pay your Medicare Part B premium.

| | Choice | Complete | Premier |
|---|---|---|---|
| Autauga, Barbour, Blount, Bullock, Butler, Calhoun, Chambers, Cherokee, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Conecuh, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas, DeKalb, Elmore, Escambia, Etowah, Fayette, Franklin, Geneva, Greene, Hale, Henry, Houston, Jackson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Monroe, Montgomery, Morgan, Perry, Pickens, Pike, Randolph, Russell, St. Clair, Sumter, Talladega, Tallapoosa, Tuscaloosa, Washington, Wilcox, and Winston counties | **$0** | **$29.50** | **$153** |

# Benefit Information

There are services throughout this document that **may** require prior authorization **before** you receive them from network providers. If you do not get a prior authorization when required, you may have a reduction in benefits, even though you received services from a network provider. Please contact Member Services or refer to the Evidence of Coverage (EOC) for more information about services that **may** require prior authorization from the plan.

| | Choice | Complete | Premier |
|---|---|---|---|
| **Deductible** | **$0** Medical Deductible | | |
| **Maximum Out-of-Pocket Responsibility**<br>*(does not include prescription drugs)*<br>*Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your Maximum Out-of-Pocket.* | The most you could pay is **$5,500** for services you receive from in-network providers.<br>The most you could pay is **$7,900** for out-of-network providers. Your limit for services received from in-network providers will also count toward this limit. | The most you could pay is **$5,100** for services you receive from in-network providers.<br>The most you could pay is **$7,500** for out-of-network providers. Your limit for services received from in-network providers will also count toward this limit. | The most you could pay is **$2,900** for services you receive from in-network providers.<br>The most you could pay is **$5,100** for out-of-network providers. Your limit for services received from in-network providers will also count toward this limit. |

| | Choice | Complete | Premier |
|---|---|---|---|
| **Inpatient Hospital Coverage**<br>*(Unlimited number of days)* | **Your In-Network Costs:**<br>**$290** copay per day for days 1 – 7<br>**$0** copay per day for days 8 – 90<br>**$0** copay for days 91 and after<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$290** copay per day for days 1 – 7<br>**$0** copay per day for days 8 – 90<br>**$0** copay for days 91 and after<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$175** copay per day for days 1 – 5<br>**$0** copay per day for days 6 – 90<br>**$0** copay for days 91 and after<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| **Inpatient Mental Health Coverage**<br>*(The limit does not apply to psychiatric services in a general hospital.)* | **Your In-Network Costs:**<br>**$290** copay per day for days 1 – 7<br>**$0** copay per day for days 8 – 90<br>**$0** copay for each additional day up to 190 day lifetime limit for inpatient psychiatric hospital.<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$290** copay per day for days 1 – 7<br>**$0** copay per day for days 8 – 90<br>**$0** copay for each additional day up to 190 day lifetime limit for inpatient psychiatric hospital.<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$175** copay per day for days 1 – 5<br>**$0** copay per day for days 6 – 90<br>**$0** copay for each additional day up to 190 day lifetime limit for inpatient psychiatric hospital.<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| *The copays for inpatient hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods.* | | | |

| | Choice | Complete | Premier |
|---|---|---|---|
| **Outpatient Hospital Coverage**<br>*Including Outpatient Surgery and Observation Services* | **Your In-Network Costs:**<br>**$0 – $265** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$0 – $265** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$0 – $150** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| **Ambulatory Surgical Center Services** | **Your In-Network Costs:**<br>**$0 – $265** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$0 – $265** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$0 – $150** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| **Doctor Visits**<br>*The plans cover telehealth services including those for primary care and specialist physician services and behavioral health providers.*<br>*No referrals required to see an in-network specialist.* | **Your In-Network Costs:**<br>**Primary Care:** **$0** copay<br>**Specialist:** **$35** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**Primary Care:** **$5** copay<br>**Specialist:** **$35** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**Primary Care:** **$0** copay<br>**Specialist:** **$20** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |

| | Choice | Complete | Premier |
|---|---|---|---|
| **Preventive Care**<br><br>**NOTE:** *Preventive Care screenings are subject to limitations. Please consult with your doctor prior to scheduling any preventive care screening.* | **Your In-Network Costs: $0** copay<br>**Your Out-of-Network Costs: 50%** coinsurance | | |
| | • Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Annual Wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammograms)<br>• Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)<br>• Cardiovascular disease testing<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>**NOTE:** *Coinsurance/copayments/deductibles may apply for Medicare-covered items or kits required to prepare for the colorectal cancer screening exam.*<br>• Depression screening<br>• Diabetes screening<br>• HIV screening<br>• Lung cancer screening<br>• Medical nutrition therapy<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including flu shots, hepatitis B and pneumonia shots<br>• “Welcome to Medicare” preventive visit (one-time) | | |

<table>
<tr><th></th><th>Choice</th><th>Complete</th><th>Premier</th></tr>
<tr><td rowspan="3">Emergency Care</td><td colspan="3">Medicare-Covered Emergency Care<br>This copay is waived if you are admitted to the hospital within 24 hours of an emergency room visit.</td></tr>
<tr><td>Your In-Network Costs:<br>$125 copay</td><td>Your In-Network Costs:<br>$125 copay</td><td>Your In-Network Costs:<br>$120 copay</td></tr>
<tr><td colspan="3">Worldwide Emergency Care Services<br>$50,000 annual coverage for medical services provided outside the United States that would be classified as emergency or urgently needed services had they been covered in the United States. The coverage includes ambulance services. In-network copays will apply. (For Emergency and Urgently Needed Services benefits, see the chart on this page. For Ambulance benefits, see page 12 of this book.) For more information, call Member Services or refer to your Evidence of Coverage (EOC).</td></tr>
<tr><td>Urgently Needed Services<br>NOTE: Out-of-network providers may be covered at the same cost-sharing when in-network providers are temporarily unavailable.</td><td>Your In-Network Costs:<br>$0 copay for Medicare-covered urgently needed Primary Care Physician visits<br>$35 copay for Medicare-covered urgently needed Specialists visits</td><td>Your In-Network Costs:<br>$5 copay for Medicare-covered urgently needed Primary Care Physician visits<br>$35 copay for Medicare-covered urgently needed Specialists visits</td><td>Your In-Network Costs:<br>$0 copay for Medicare-covered urgently needed Primary Care Physician visits<br>$20 copay for Medicare-covered urgently needed Specialists visits</td></tr>
<tr><td rowspan="2">Diagnostic Services/Labs/ Imaging</td><td colspan="3">Diagnostic radiology services (such as MRIs, CT scans)</td></tr>
<tr><td>Your In-Network Costs:<br>$125 copay<br>Your Out-of-Network Costs:<br>50% coinsurance</td><td>Your In-Network Costs:<br>$95 copay<br>Your Out-of-Network Costs:<br>50% coinsurance</td><td>Your In-Network Costs:<br>$25 copay<br>Your Out-of-Network Costs:<br>50% coinsurance</td></tr>
</table>

| | Choice | Complete | Premier |
|---|---|---|---|
| **Diagnostic Services/ Labs/ Imaging** (continued) | **Diagnostic tests and procedures** | | |
| | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| | **Lab services** | | |
| | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| | **Outpatient X-rays** | | |
| | **Your In-Network Costs:** **$20** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$15** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$5** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| | **Therapeutic radiology services** (such as radiation treatment for cancer) | | |
| | **Your In-Network Costs:** **$80** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$60** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$50** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance |

| | Choice | Complete | Premier |
|---|---|---|---|
| **Hearing Services** | **Medicare-covered diagnostic hearing exam** | | |
| | **Your In-Network Costs:**<br>**$10** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$10** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$10** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| | **Annual routine hearing exam**[1] | | |
| | **Your In-Network or Out-of-Network Costs:**<br>You pay nothing | **Your In-Network or Out-of-Network Costs:**<br>You pay nothing | **Your In-Network or Out-of-Network Costs:**<br>You pay nothing |
| | **Hearing Aids** (one per ear, per year)[1] | | |
| | **$499** copay per aid for **TruHearing Standard**<br><br>**$699** copay per aid for **TruHearing Advanced**<br><br>**$999** copay per aid for **TruHearing Premium** | | |

[1]For Choice, Complete and Premier, a TruHearing Provider must be used for in-network and out-of-network hearing aid benefit and the annual Routine Hearing Exam. Please call **1-844-255-7140 (TTY 711)** to locate a TruHearing provider and to schedule an appointment.

<table>
<tr><th></th><th>Choice</th><th>Complete</th><th>Premier</th></tr>
<tr><td rowspan="2">Dental Services<br><br>• Oral exams<br>• Prophylaxis (cleaning)<br>• Fluoride treatment<br>• Dental X-rays<br>• Extractions<br>• Fillings<br><br>For a list of dental providers, visit our website BCBSALMedicare.com/FindaDoctor.</td><td colspan="3">Medicare-covered dental benefits</td></tr>
<tr><td>Your In-Network Costs:<br>$40 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance<br><br>Dental Allowance:<br>$375 allowance (preventive only)<br><br>Benefits for extractions, fillings and other comprehensive services are NOT included with this plan.</td><td>Your In-Network Costs:<br>$40 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance<br><br>Dental Allowance:<br>$1,000 allowance toward Preventive and Comprehensive dental benefits annually</td><td>Your In-Network Costs:<br>$25 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance<br><br>Dental Allowance:<br>$1,300 allowance toward Preventive and Comprehensive dental benefits annually</td></tr>
<tr><td rowspan="4">Vision Services<br><br>One routine eye exam is covered once per year. A refraction is included in the routine eye exam, but not the diabetic retinopathy screening.<br><br>Note: See limitations for the purchase of eyewear in the Evidence of Coverage (EOC).</td><td colspan="3">Annual routine eye exam</td></tr>
<tr><td>Your In-Network Costs:<br>$0 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance</td><td>Your In-Network Costs:<br>$0 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance</td><td>Your In-Network Costs:<br>$0 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance</td></tr>
<tr><td colspan="3">$100 allowance toward non-Medicare-covered prescription eyewear (glasses, lenses, frames, or contact lenses) per calendar year</td></tr>
<tr><td colspan="3">Medicare-covered eye exam</td></tr>
<tr><td>Your In-Network Costs:<br>$35 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance</td><td>Your In-Network Costs:<br>$35 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance</td><td>Your In-Network Costs:<br>$20 copay<br><br>Your Out-of-Network Costs:<br>50% coinsurance</td></tr>
</table>

| | Choice | Complete | Premier |
|---|---|---|---|
| **Vision Services** (continued) | **Eyeglasses or contact lenses after cataract surgery** | | |
| | **Your In-Network Costs:** **$0** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$0** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$0** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| **Mental Health Services**<br>*Outpatient group therapy / individual therapy visit* | **Your In-Network Costs:** **$35** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$35** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$20** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| **Skilled Nursing Facility (SNF)**<br>*Our plan covers up to 100 days in a SNF.* | **Your In-Network Costs:** **$10** copay per day for days **1 – 20**<br>**$214** copay per day for days **21 – 100**<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$0** copay per day for days **1 – 20**<br>**$214** copay per day for days **21 – 100**<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$0** copay per day for days **1 – 20**<br>**$100** copay per day for days **21 – 55**<br>**$0** copay per day for days **56 – 100**<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| *The copays for inpatient hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods.* | | | |

| | Choice | Complete | Premier |
|---|---|---|---|
| **Physical, Occupational, Speech Therapy**<br>*A pre-certification by the physician is required after the combined 20th therapy visit.* | **Your In-Network Costs:**<br>**$30** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$30** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$20** copay<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| **Ambulance** | **$405** copay (per one-way trip) | **$405** copay (per one-way trip) | **$175** copay (per one-way trip) |
| **Transportation** | **Not covered** | | |
| **Medicare Part B Drugs**<br>*Including chemotherapy and other Part B drugs* | **Your In-Network Costs:**<br>**20%** coinsurance<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**20%** coinsurance<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**20%** coinsurance<br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| **Part B Insulin Drugs** | **In- and Out-of-network:** No more than a **$35** copay for a one-month supply. | | |
| **NOTE:** Prior authorization for certain Part B drugs is required for in-network providers. Step Therapy may also apply. Please visit **BCBSALMedicare.com/PartBDrugs** or contact Member Services at **1-888-234-8266 (TTY 711)**. | | | |

# Additional Benefits Information

| | Choice | Complete | Premier |
|---|---|---|---|
| **Medicare-Covered Foot Care (Podiatry)** | **Your In-Network Costs:** **$35** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$20** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **$20** copay<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| **Home Health** | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| **Hospice** | **Your In-Network Costs:** You pay nothing for a Medicare-certified hospice<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** You pay nothing for a Medicare-certified hospice<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** You pay nothing for a Medicare-certified hospice<br>**Your Out-of-Network Costs:** **50%** coinsurance |
| **Durable Medical Equipment** | **Your In-Network Costs:** **22%** coinsurance<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **23%** coinsurance<br>**Your Out-of-Network Costs:** **50%** coinsurance | **Your In-Network Costs:** **22%** coinsurance<br>**Your Out-of-Network Costs:** **50%** coinsurance |

| | Choice | Complete | Premier |
|---|---|---|---|
| **Outpatient Rehabilitation** | | | |
| Cardiac Rehabilitation | **Your In-Network Costs:**<br>**$20** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$20** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$20** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| Pulmonary Rehabilitation | **Your In-Network Costs:**<br>**$15** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$15** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$15** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| Supervised Exercise Therapy (SET) | **Your In-Network Costs:**<br>**$10** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$10** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance | **Your In-Network Costs:**<br>**$10** copay<br><br>**Your Out-of-Network Costs:**<br>**50%** coinsurance |
| **Over-the-Counter Allowance (Premier only)**<br><br>Over-the-Counter (OTC) items are health and wellness products that do not need a prescription.<br><br>This benefit covers certain approved non-prescription over-the-counter drugs and health-related items. | You do **NOT** have this benefit. | You do **NOT** have this benefit. | **$50** Quarterly allowance |
| | **NOTE:** The allowance is available at the beginning of each quarter of the plan year (January, April, July, and October) on the FlexCard mailed to you.<br><br>**Any unused quarterly allowance amount will not carry over to the next quarter.** | | |

| | Choice | Complete | Premier |
|---|---|---|---|
| **Fitness Allowance (Choice & Premier only)**<br><br>This benefits allows memberships at a gym or health club.<br><br>For complete benefit information and additional details, please call FlexCard Member Services at **1-800-962-1964 (TTY 711)**. | **$90** Quarterly allowance | You do **NOT** have this benefit. | **$90** Quarterly allowance |
| | **NOTE:** The allowance is available at the beginning of each quarter of the plan year (January, April, July, and October) on the FlexCard mailed to you.<br><br>**Any unused quarterly allowance amount will not carry over to the next quarter.** | | |

| | Choice | Complete | Premier |
|---|---|---|---|
| **Diabetes Management** | | | |
| Insulin | **For Part B and Part D Benefits In- and Out-of-network:** No more than a **$35** copay for a one-month supply no matter what tier it's on, even if you haven't paid your deductible. | | |
| Diabetes Monitoring Supplies | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs: 50%** coinsurance<br>**NOTE:** Ascensia (Contour) and LifeScan (OneTouch) products must be used for diabetic test strips and blood glucose meters to obtain the $0 cost-sharing at our in-network pharmacy or through our home delivery pharmacies. All other brands are non-covered. Diabetic test strips are limited to 204 strips every 30 days. If you obtain the diabetic supplies (blood glucose meters and blood glucose test strips) through one of our Durable Medical Equipment (DME) suppliers, you will pay the standard DME benefit for diabetic supplies.<br>Continuous Glucose Monitoring (CGM) products obtained through the pharmacy are limited to Medicare-covered Dexcom branded products (currently the Dexcom G6, Dexcom G7 when used with a Dexcom Receiver) and Abbott branded products (currently the Freestyle Libre and Freestyle Libre 2 products, and Freestyle Libre 3 used with a Freestyle Libre receiver) products. Prior Approval will be required for any other CGM brands. All receivers and transmitters will be subject to quantity limits. 1 receiver per calendar year, 1 transmitter every 90 days, and sensor per product labeling. If you obtain a CGM or supplies through one of our DME suppliers, standard DME benefits apply.<br>For DME benefits, see page 13 in this booklet. | | |
| Diabetes Self-Management | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs: 50%** coinsurance | | |
| Diabetes Therapeutic Shoes or Inserts | **Your In-Network Costs:** You pay nothing<br>**Your Out-of-Network Costs: 50%** coinsurance | | |

# Part D Prescription Drugs Benefit Information

## Deductible Stage

| Choice | Complete | Premier |
|---|---|---|
| **$440** Drug Deductible<br>(For Tiers 3, 4 & 5) | **$0** Drug Deductible | **$0** Drug Deductible |
| Your plan requires prior authorization and has step therapy and quantity limit restrictions for certain drugs.<br>Please refer to your formulary to determine if your drugs are subject to any limitations.<br><br>For a complete listing of drugs and drug tiers, please visit **BCBSALMedicare.com/FindaDrug** | | |

## Initial Coverage Stage

You pay copays and/or coinsurance until your total yearly out-of-pocket drug costs reach **$2,000**. For **Choice**, you must pay your deductible (for drugs on tiers 3, 4 & 5), copays and coinsurance until your total yearly drug costs reach **$2,000**. You may get your drugs at network retail pharmacies and our home delivery pharmacy service.

The pharmacy network for our **Complete** and **Premier** plans include pharmacies that offer both preferring cost-sharing and standard cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. However, your costs may be less for your covered drugs if you use a pharmacy in our preferred network. Our Preferred Pharmacies for **Complete and Premier** include **Walmart, Walgreens, Publix, Kroger, Costco, Sam's Club** and many local independent pharmacies. Our **Choice** plan offers standard cost-sharing only and has a pharmacy network that includes **Walgreens, Publix, Kroger, Costco** and many local independent pharmacies.

The network pharmacies listed may change at any time. Blue Advantage members will receive notice when necessary.

For additional information about other pharmacies, physicians and providers in our network please contact Member Services at **1-888-234-8266 (TTY 711)** or go to our website at **BCBSALMedicare.com/FindaDoctor**. For more information about our **Home Delivery Pharmacy Services**, please call Walgreens Mail Service at **1-800-731-3588**, Amazon Pharmacy at **1-855-793-5326** or Express Scripts® Pharmacy at **1-833-715-0967**.

Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

# Preferred Retail Cost-Sharing & Home Delivery Pharmacy Service

| | Choice | | Complete | | Premier | |
|---|---|---|---|---|---|---|
| | **30-day supply** | **100-day supply** | **30-day supply** | **100-day supply** | **30-day supply** | **100-day supply** |
| **Tier 1** Preferred Generic[2] | This plan does not have Preferred Retail Cost-Sharing or Preferred Home Delivery Pharmacy Services. | | **$4** copay | **$8** copay | **$0** copay | **$0** copay |
| **Tier 2** Generic | | | **$13** copay | **$26** copay | **$8** copay | **$16** copay |
| **Tier 3** Preferred Brand | | | **$40** copay | **$80** copay | **$40** copay | **$80** copay |
| **Tier 4** Non-Preferred Drug[3] | | | **38%** coinsurance | **38%** coinsurance | **33%** coinsurance | **33%** coinsurance |
| **Tier 5** Specialty[3] | | | **33%** coinsurance | **33%** coinsurance | **33%** coinsurance | **33%** coinsurance |
| **Tier 6** Select Care | | | **$0** copay | **$0** copay | **Tier 6 does not apply to Blue Advantage Premier** | |

[2]**For Preferred Home Delivery ONLY, Tier 1 drugs have a $0 copay for up to 30-day and up to 100-day supply.**
[3]Tiers 4 and 5 have coinsurance applied and do not have a reduced cost-share for drugs purchased at a Preferred Retail Pharmacy or with a Home Delivery Service.

# Standard Retail Cost-Sharing

| | Choice | | Complete | | Premier | |
|---|---|---|---|---|---|---|
| | 30-day supply | 100-day supply | 30-day supply | 100-day supply | 30-day supply | 100-day supply |
| **Tier 1** Preferred Generic | **$0** copay | **$0** copay | **$11** copay | **$33** copay | **$7** copay | **$21** copay |
| **Tier 2** Generic | **$13** copay | **$39** copay | **$20** copay | **$60** copay | **$15** copay | **$45** copay |
| **Tier 3** Preferred Brand | **20%** coinsurance | **20%** coinsurance | **$47** copay | **$141** copay | **$47** copay | **$141** copay |
| **Tier 4** Non-Preferred Drug | **40%** coinsurance | **40%** coinsurance | **43%** coinsurance | **43%** coinsurance | **38%** coinsurance | **38%** coinsurance |
| **Tier 5** Specialty | **27%** coinsurance | **27%** coinsurance | **33%** coinsurance | **33%** coinsurance | **33%** coinsurance | **33%** coinsurance |
| **Tier 6** Select Care | **Tier 6 does not apply to Blue Advantage Choice** | | **$0** copay | **$0** copay | **Tier 6 does not apply to Blue Advantage Premier** | |
| Some Tiers offer savings on 30-day and 100-day supply with Home Delivery. Call Member Services or refer to your EOC for information. | | | | | | |

## Insulins

Your out-of-pocket costs for insulins will be no more than **$35** for a one-month supply covered by your plan no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

## Long-Term Care

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy. Cost-sharing may differ relative to the pharmacy's status as preferred or non-preferred, home delivery pharmacy service, Long Term Care (LTC) or home infusion, and 30-day or 100-day supply.

## Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through our home delivery pharmacy service) reach **$2,000**, you pay **$0** for the rest of the calendar year.

For detailed information about your costs in these stages, look at Chapter 6, Section 6, in the Evidence of Coverage online at **BCBSALMedicare.com/Documents**.

## The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. To learn more about this payment option, please visit **Medicare.gov** or contact Blue Advantage's Medicare Prescription Payment Plan Support Line at **1-833-696-2087 (TTY 711)**, 7 a.m. – 7 p.m. CST Monday-Friday. During AEP (October 15 – December 7), 7 a.m. – 10 p.m. CST 7 days a week.

# More Benefits with Your Plan

Blue Advantage Choice, Complete & Premier offer the supplemental benefits below, in addition to Part C and Part D benefits.

## 24-Hour Online Access

Claims, ID cards, health and wellness tools and much more can be found at **AlabamaBlue.com/myBlueCross**.

## AirMed International

If you're hospitalized more than 150 miles from your home, AirMed International will provide an air ambulance to bring you to your local hospital. There is no cost to you for this service.

## Emotional Support Helpline

**1-833-848-1764 (TTY 711)** Behavioral Health Services are available to you. Lucet offers customized counseling to meet your needs. You also have 24-hour access to caring confidential emotional support during personal crises and disasters at no cost to you.

## Nurse Hotline

24-hour Health Information Line: **1-800-896-2724 (TTY 711)**
$0 copay to talk one-on-one with a clinician
Available 24/7/365 for guidance and information

## Post Discharge Meals (Does **not** apply to Choice)

Up to 14 home delivered meals provided by the approved vendor upon each inpatient hospital discharge with two of the following diagnoses:

• COPD • Congestive Heart Failure • Diabetes • Rheumatoid Arthritis • Vascular Disease

*The benefit mentioned above is part of a supplemental program for the chronically ill. Not all members qualify.*

# Notice of Nondiscrimination

## Discrimination is Against the Law

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 1557 Compliance Coordinator. If you believe that we have 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 at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance 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 Avenue, 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.

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English:** ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.

**Arabic:** انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

**Chinese:** 注意： 如果您说 普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-855-216-3144 (TTY 用户请拨 711) 或致电客户服务部。

**French:** À NOTER: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

**Gujarati:** ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

**Hindi:** ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

**Japanese:** ご案内：日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

**Korean:** 주의: 한국어을(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144 (TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

**Lao:** ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການ ບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

**Portuguese:** ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

**Russian:** ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

**Spanish:** ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

**Tagalog:** ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

**Turkish:** DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

**Vietnamese:** CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.

# Contact Reference

| Contact name | Phone number | Website |
|---|---|---|
| Before you enroll | **1-888-873-4707 (TTY 711)** | **BCBSALMedicare.com** |
| After you enroll | **1-888-234-8266 (TTY 711)** | **BCBSALMedicare.com** |
| Your agent/broker (use this space to write down your agent/broker's phone number) | | |
| Find a network doctor, hospital or pharmacy | **1-888-234-8266 (TTY 711)** | **BCBSALMedicare.com/ FindaDoctor** |
| 24-Hour Nurse Line | **1-800-896-2724 (TTY 711)** | Please call |
| Dental Services | **1-888-234-8266 (TTY 711)** | **BCBSALMedicare.com** |
| FlexCard Member Services | **1-800-962-1964 (TTY 711)** | Please call |
| Emotional Support Helpline | **1-833-848-1764 (TTY 711)** | Please call |
| Home Delivery Pharmacy Services | Walgreens Mail Service **1-800-731-3588**<br>Amazon Pharmacy **1-855-793-5326**<br>Express Scripts Pharmacy **1-833-715-0967** | **BCBSALMedicare.com/ PreferredPharmacies** |
| Medicare | **1-800-633-4227**<br>**TTY:1-877-486-2048** | **Medicare.gov** |
| TruHearing | **1-844-255-7140 (TTY 711)** | Please call |
| Worldwide Emergency/Urgent Coverage | **1-888-234-8266 (TTY 711)** | |
| Vision Services | **1-888-234-8266 (TTY 711)** | **BCBSALMedicare.com** |

# 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 Member Services at **1-888-234-8266 or, for TTY users, 711, Monday – Friday, 8 a.m. – 8 p.m. CST. From October 1 to March 31, the hours of operation are Monday – Sunday, 8 a.m. – 8 p.m. CST**. You may be required to leave a message for calls made after hours, weekends and holidays. Calls will be returned the next business day.

## 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 **BCBSALMedicare.com** or call **1-888-234-8266 or, for TTY users, 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. Go online to **BCBSALMedicare.com/FindaDoctor** to see if your doctor is in network or call Member Services for a copy of our Provider Directory.
- ☐ 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. Go online to **BCBSALMedicare.com/PreferredPharmacies** to see if your pharmacy is in network or call Member Services for a copy of our Pharmacy Directory.
- ☐ Review the formulary to make sure your drugs are covered. Go online to **BCBSALMedicare.com/Documents** to see if your drug is covered or call Member Services for a copy of our Drug Formulary.

## 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/coinsurance may change on January 1, 2026.
- ☐ Our plan allows you to see providers outside of the network (non-contracted providers). 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.

# Disclosures

All content ©2024 TruHearing, Inc. All Rights Reserved. TruHearing® is a registered trademark of TruHearing, Inc. All other trademarks, product names, and company names are the property of their respective owners. Savings and retail pricing based on a survey of national average hearing aid prices compared to TruHearing pricing. Savings may vary. Listed hearing aid prices are subject to change. Confirm hearing aid pricing at your appointment with your provider. Pricing of TruHearing-branded aids based on prices for comparable aids. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing Hearing Consultant. TruHearing® is an independent company offering exclusive hearing aid savings for Blue Cross and Blue Shield of Alabama members.

Air medical transport services are provided through a contract with AirMed International, LLC, is an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical services terminate if coverage by your plan ends.

Benefits for Special Supplemental Benefit for the Chronically Ill. Eligibility is determined by whether you have a chronic condition associated with this benefit. Members must have two of the following conditions to be eligible for this benefit: COPD, Diabetes, Congestive Heart Failure, Vascular Disease or Rheumatoid Arthritis. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.

The Alabama FlexCard Mastercard® Prepaid Card is issued by Stride Bank, N.A., Member FDIC, pursuant to license by Mastercard International.

In some cases, Blue Advantage (PPO) networks are only available in portions of participating states. As of August 2024, only two states are not participating: Alaska and Wyoming.

Lucet is an independent company providing behavioral health services to Blue Cross and Blue Shield of Alabama members.

Worldwide Emergency/Urgent Coverage refers to coverage of services outside the United States and its territories. Under this benefit, enrollees may obtain only services that would be classified as emergency and urgently needed services had they been covered in the United States. Members utilizing this benefit may remain enrolled in this plan while temporarily outside the United States or its territories for up to six months. This coverage also includes ambulance services worldwide. In-network copays will apply for each covered worldwide emergency/urgent service received.

Amazon Pharmacy and Express Scripts® Pharmacy are independent companies providing mail-order medication delivery services for Blue Cross and Blue Shield of Alabama members.

Walgreens, an independent company, provides mail-order medication delivery services and specialty pharmacy services for Blue Cross and Blue Shield of Alabama members.

For more information, please call us at the phone numbers below or visit us at **BCBSALMedicare.com**.

If you are not a member of this plan, call toll-free **1-888-873-4707**. TTY users should call **711**.

If you are a member of this plan, call toll-free **1-888-234-8266**. TTY users should call **711**.

**Monday – Friday, 8 a.m. – 8 p.m. CST. From October 1 to March 31,**
**the hours of operation are Monday – Sunday, 8 a.m. – 8 p.m. CST.**
You may be required to leave a message for calls made after hours, weekends and holidays.
Calls will be returned the next business day.

Blue Advantage is a PPO with a Medicare contract.
Enrollment in Blue Advantage (PPO) depends on contract renewal.


Blue Advantage (PPO) is provided by Blue Cross and Blue Shield of Alabama,
an independent licensee of the Blue Cross and Blue Shield Association.