

2027 SUMMARY OF BENEFITS

Choice & Core

MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION DRUG COVERAGE

January 1, 2027 — December 31, 2027

This booklet is a summary of health and drug services covered by Blue Advantage (PPO). For a complete list of covered services, limitations and/or exclusions, please view the Evidence of Coverage (EOC) at [BCBSALMedicare.com/Documents](https://www.BCBSALMedicare.com/Documents) or call us at **1-888-234-8266 (TTY users call 711)**.

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

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What Should You Know About Blue Advantage (PPO)?

Who can join?

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

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

Which doctors and hospitals can I use?

This Medicare Advantage plan has a network of doctors, hospitals 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 at our website [BCBSALMedicare.com/FindaDoctor](https://www.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/Documents](https://www.bcbsalmedicare.com/Documents).

Which pharmacies can I use?

The **Choice** network offers access to select participating pharmacies and helps keep plan costs low, while the **Core** network includes a broader pharmacy network for members who want more options. You can see our plan's pharmacy directory at our website [BCBSALMedicare.com/MyPharmacies](https://www.bcbsalmedicare.com/MyPharmacies).

For information about our **Mail-Order Pharmacy Services**, please call Walgreens Mail Service at **1-800-731-3588 (TTY 711)**, Amazon Pharmacy at **1-855-745-5725 (TTY 711)** or Express Scripts® Pharmacy at **1-833-715-0967 (TTY 711)**.

Note: Injectable GLP-1s (e.g. Ozempic) are not available through Express Scripts.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan allows you to divide your out-of-pocket drug costs into monthly payments throughout the calendar year (January-December). It can help with budgeting, but it doesn't reduce your total drug costs. Visit [Medicare.gov](https://www.medicare.gov) or call **1-833-246-9619 (TTY 711)** for more information.

How can I learn about Original Medicare?

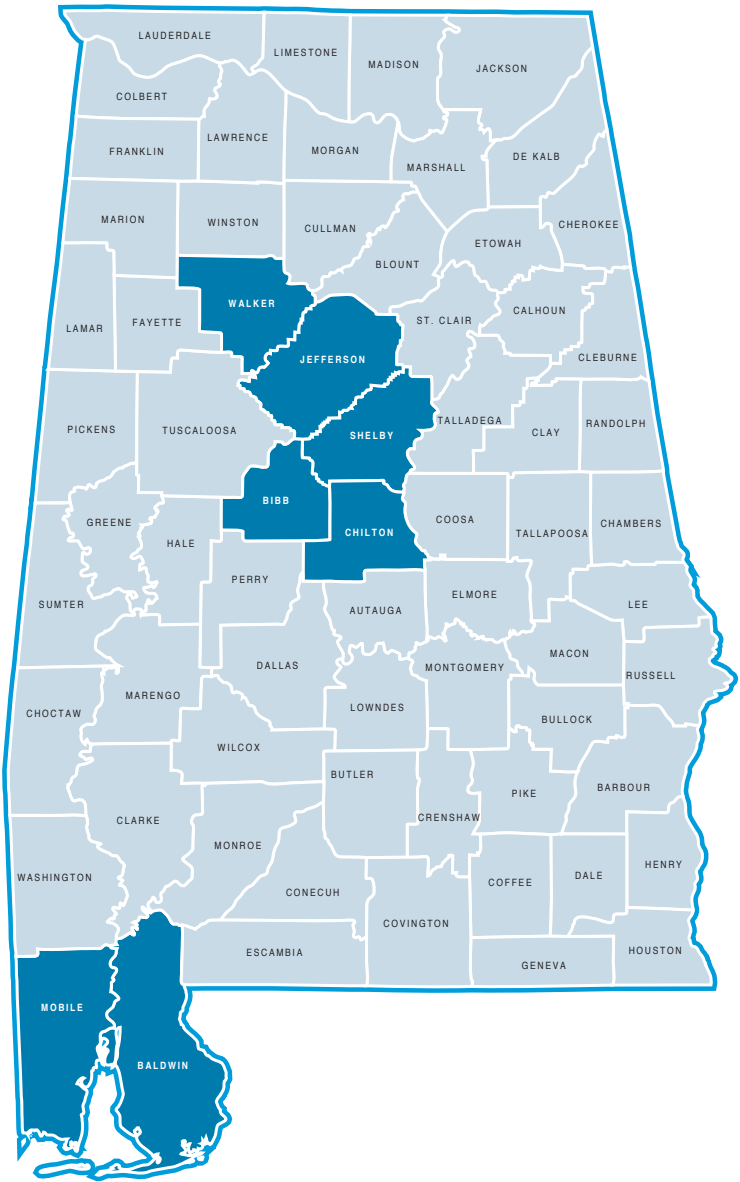
If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [Medicare.gov](https://www.medicare.gov) or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Monthly Plan Premiums for Blue Advantage (PPO) — Choice & Core

Our service area includes the Alabama counties listed below. Premiums vary by plan. You must continue to pay your Medicare Part B premium.

Choice	Core
\$0	\$19.50

Baldwin, Bibb, Chilton, Jefferson, Mobile, Shelby and Walker counties (shown in dark blue on the below map)



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 EOC for more information about services that **may** require prior authorization from the plan.

	Choice	Core
DEDUCTIBLE	\$450 Medical Deductible	\$295 Medical Deductible
MAXIMUM OUT-OF-POCKET RESPONSIBILITY <i>(does not include prescription drugs)</i> <i>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.</i>	\$7,150 for services you receive from in-network providers \$10,000 for services received from in-network and out-of-network providers combined	\$6,000 for services you receive from in-network providers \$10,000 for services received from in-network and out-of-network providers combined

The Blue Advantage Choice and Core medical deductibles do not apply to the following in-network and out-of-network services: Inpatient Hospital, Inpatient Mental Health, Doctor Visits (Primary Care and Specialist), Preventive Care, Urgently Needed Services (Primary Care and Specialist), Annual Routine Hearing Exam, Hearing Aids, Plan-Covered Dental Allowance, Annual Routine Eye Exam, Plan-Covered Vision Allowance, Mental Health Services, Medicare Part B Drugs and Hospice. Additional medical services not listed in this Summary of Benefits may be subject to the annual medical deductible. Please refer to the Blue Advantage Choice or Blue Advantage Core EOC at [BCBSALMedicare.com/Documents](https://www.bcbsalmedicare.com/Documents).



WANT TO LEARN MORE?
 Scan the QR code to watch short videos about certain parts of your health coverage.



INPATIENT HOSPITAL COVERAGE

*The copay applies **per admission**, regardless of the number of days, and resets with each new admission.*

INPATIENT MENTAL HEALTH COVERAGE

*The copay applies **per admission**, subject to lifetime limits.*

The limit does not apply to psychiatric services in a general hospital.

Choice	Core
Your In-Network Costs: Days 1-7: \$410 copay per day Days 8 and after: \$0 copay per day until discharge Your Out-of-Network Costs: 50% coinsurance	Your In-Network Costs: Days 1-7: \$385 copay per day Days 8 and after: \$0 copay per day until discharge Your Out-of-Network Costs: 50% coinsurance
Your In-Network Costs: Days 1-7: \$335 copay per day Days 8 and after: \$0 copay per day until discharge, up to 190-day lifetime limit for inpatient psychiatric hospital Your Out-of-Network Costs: 50% coinsurance	Your In-Network Costs: Days 1-7: \$315 copay per day Days 8 and after: \$0 copay per day until discharge, up to 190-day lifetime limit for inpatient psychiatric hospital Your Out-of-Network Costs: 50% coinsurance
<i>For inpatient psychiatric care, each admission counts toward the Medicare 190-day lifetime limit, which does not reset. Once the limit is reached, no further inpatient psychiatric stays are covered by the plan or Original Medicare.</i>	

For both Inpatient Hospital coverage and Inpatient Mental Health coverage, transfers to a different facility type are treated as new admissions.

OUTPATIENT HOSPITAL COVERAGE

Including:

- Observation services
- Outpatient surgery
- Diagnostic procedures
- Therapeutic radiology services

AMBULATORY SURGICAL CENTER SERVICES

Choice	Core
Your In-Network Costs: \$0 – \$440 copay per visit, depending upon the service, after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your In-Network Costs: \$0 – \$380 copay per visit, depending upon the service, after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met
Your In-Network Costs: \$0 – \$385 copay, depending upon the service, for each outpatient surgery or service received after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your In-Network Costs: \$0 – \$325 copay, depending upon the service, for each outpatient surgery or service received after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met



DOCTOR VISITS

The plans cover telehealth services including those for primary care and specialist physician services and behavioral health services provided by these type physicians.



PREVENTIVE CARE

Preventive Care screenings are subject to limitations. Please consult with your doctor prior to scheduling any preventive care screening.

Coinsurance/ copayments/deductibles may apply for Medicare-covered items or kits required to prepare for the colorectal cancer screening exam.

Choice	Core
Your In-Network Costs: Primary Care: \$10 copay Specialist: \$15-\$40 copay The lower copay applies to specialist visits received at a skilled nursing facility. The higher copay applies to all other specialist visits. Your Out-of-Network Costs: 50% coinsurance	Your In-Network Costs: Primary Care: \$6 copay Specialist: \$10-\$35 copay The lower copay applies to specialist visits received at a skilled nursing facility. The higher copay applies to all other specialist visits. Your Out-of-Network Costs: 50% coinsurance
Choice	Core
Your In-Network Costs: You pay nothing Your Out-of-Network Costs: 50% coinsurance	

- Abdominal aortic aneurysm screening
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammograms)
- Cardiovascular disease risk reduction visit
- Cardiovascular disease screening tests
- Cervical and vaginal cancer screening
- Colorectal cancer screening (blood-based biomarker test, colonoscopy, computed tomography colonography, fecal occult blood test, flexible sigmoidoscopy, multi-target stool DNA test)
- Depression screening
- Diabetes screening
- HIV screening
- Immunizations (pneumonia, flu/influenza, hepatitis B, COVID-19)
- Medical nutrition therapy
- Medicare Diabetes Prevention Program
- Obesity screening and therapy to promote sustained weight loss
- PrEP for HIV prevention
- Prostate cancer screening exams
- Screening and counseling to reduce alcohol misuse
- Screening for Hepatitis C virus infection
- Screening for lung cancer with low dose computed tomography
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation
- Welcome to Medicare preventive visit



EMERGENCY CARE

This copay is waived if you are admitted to the hospital within 24 hours of an emergency room visit.

URGENTLY NEEDED SERVICES

Out-of-network providers may be covered at the same cost-sharing when in-network providers are temporarily unavailable.

WORLDWIDE EMERGENCY CARE SERVICES



DIAGNOSTIC SERVICES/ LABS/ IMAGING

Choice	Core
Your In- and Out-of-Network Costs: \$130 copay after the medical deductible is met If you get emergency care at an out-of-network hospital, you may pay more unless you move to an in-network hospital once your condition is stable.	Your In- and Out-of-Network Costs: \$130 copay after the medical deductible is met If you get emergency care at an out-of-network hospital, you may pay more unless you move to an in-network hospital once your condition is stable.
Your In- and Out-of-Network Costs: \$10 copay for Medicare-covered urgently needed primary care physician visits \$40 copay for Medicare-covered urgently needed specialist visits	Your In- and Out-of-Network Costs: \$6 copay for Medicare-covered urgently needed primary care physician visits \$35 copay for Medicare-covered urgently needed specialist visits
\$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. Medical deductible and copays will apply for each covered worldwide emergency/urgent service rendered. (For Emergency and Urgently Needed Services benefits, see the chart on this page. For Ambulance benefits, see page 11 of this book.) For more information, call Member Services or refer to your EOC.	

Choice	Core
DIAGNOSTIC TESTS, PROCEDURES AND LAB SERVICES	
Your In-Network Costs: You pay nothing after the medical deductible is met	Your In-Network Costs: You pay nothing after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met

DIAGNOSTIC SERVICES/LABS/IMAGING

(continued)

Choice	Core
DIAGNOSTIC RADIOLOGY SERVICES (SUCH AS AN MRI OR CT SCAN)	
Your In-Network Costs: \$340 copay after the medical deductible is met	Your In-Network Costs: \$130 copay after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met
OUTPATIENT X-RAYS	
Your In-Network Costs: \$20 copay after the medical deductible is met	Your In-Network Costs: \$20 copay after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met
THERAPEUTIC RADIOLOGY SERVICES (SUCH AS RADIATION TREATMENT FOR CANCER)	
Your In-Network Costs: \$85 copay after the medical deductible is met	Your In-Network Costs: \$85 copay after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met



HEARING SERVICES

Choice	Core
MEDICARE-COVERED DIAGNOSTIC HEARING EXAM	
Your In-Network Costs: \$10 copay after the medical deductible is met	Your In-Network Costs: \$10 copay after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met

HEARING SERVICES

(continued)

*A TruHearing provider must be used for in-network routine hearing exam and hearing aid benefits. Please call **1-844-255-7140 (TTY 711)** to locate a TruHearing provider and to schedule an appointment.*

Choice	Core
ANNUAL ROUTINE HEARING EXAM	
Your In-Network Costs: You pay nothing	Your In-Network Costs: You pay nothing
Your Out-of-Network Costs: 80% coinsurance	Your Out-of-Network Costs: 80% coinsurance
HEARING AIDS (ONE PER EAR, PER YEAR)	
Your In-Network Costs: \$499 copay per aid for TruHearing Standard	Your In-Network Costs: \$499 copay per aid for TruHearing Standard
\$699 copay per aid for TruHearing Advanced	\$699 copay per aid for TruHearing Advanced
\$999 copay per aid for TruHearing Premium	\$999 copay per aid for TruHearing Premium
Your Out-of-Network Costs: 80% coinsurance	Your Out-of-Network Costs: 80% coinsurance

Here are five signs that you may be experiencing hearing loss:



It's hard to hear the TV or radio



Conversations are confusing



You avoid noisy places



Children are hard to understand



You have ringing in your ears



HOW MANY OF THESE SIGNS ARE AFFECTING YOUR DAILY LIFE?

Use this QR code to check your hearing from the comfort of your couch in just a few minutes.



DENTAL SERVICES

Medicare only covers **limited, medically necessary dental care** tied to a covered medical procedure; **routine dental services aren't covered.**

In addition, we cover:

- Oral exams
- Prophylaxis (cleaning)
- Fluoride treatment
- Dental X-rays

Choice	Core
MEDICARE-COVERED DENTAL BENEFITS	
Your In-Network Costs: \$40 copay after the medical deductible is met	Your In-Network Costs: \$40 copay after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met
PLAN-COVERED DENTAL ALLOWANCE	
Dental Allowance: The plan pays up to \$375 per year toward Preventive dental benefits. You pay any costs after this dental allowance is used.	Dental Allowance: The plan pays up to \$650 per year toward Preventive and Comprehensive dental benefits. You pay any costs after this dental allowance is used.
Preventive: You pay nothing Comprehensive: Not available	Preventive: You pay nothing Comprehensive: 50% coinsurance
Benefits for extractions, fillings and other Comprehensive services are NOT included with this plan.	The majority of Comprehensive services, such as fillings and extractions, are covered. Please call Member Services for any questions relating to your dental coverage.



VISION SERVICES

One routine exam is covered each calendar year. A refraction is included in the routine eye exam, but not the diabetic retinopathy screening.

Note: See limitations for the purchase of eyewear in the EOC.

Choice	Core
ANNUAL ROUTINE EYE EXAM	
Your In-Network Costs: You pay nothing	Your In-Network Costs: You pay nothing
Your Out-of-Network Costs: 50% coinsurance	Your Out-of-Network Costs: 50% coinsurance
PLAN-COVERED VISION ALLOWANCE	
\$100 allowance toward non-Medicare-covered prescription eyewear (glasses, lenses, frames, or contact lenses) per calendar year	

VISION SERVICES
(continued)

Choice	Core
MEDICARE-COVERED EYE EXAM	
Your In-Network Costs: \$15-\$40 copay after the medical deductible is met The lower copay applies to Medicare-covered eye exams received at a skilled nursing facility. The higher copay applies to all other Medicare-covered eye exams.	Your In-Network Costs: \$10-\$35 copay after the medical deductible is met The lower copay applies to Medicare-covered eye exams received at a skilled nursing facility. The higher copay applies to all other Medicare-covered eye exams.
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met
EYEGLASSES OR CONTACT LENSES AFTER CATARACT SURGERY	
Your In-Network Costs: You pay nothing after the medical deductible is met	Your In-Network Costs: You pay nothing after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met



MENTAL HEALTH SERVICES

This benefit includes telehealth services, such as those provided by behavioral health professionals, and offers access to both individual therapy and outpatient group therapy.

Choice	Core
Your In-Network Costs: \$10-\$40 copay The lower copay applies to mental health services provided during a primary care physician visit. The higher copay applies to mental health services provided by other providers.	Your In-Network Costs: \$6-\$35 copay The lower copay applies to mental health services provided during a primary care physician visit. The higher copay applies to mental health services provided by other providers.
Your Out-of-Network Costs: 50% coinsurance	Your Out-of-Network Costs: 50% coinsurance



SKILLED NURSING FACILITY (SNF)

Our plan covers up to 100 days in a SNF per benefit period, with no prior 3-day inpatient hospital stay required.

Choice	Core
Your In-Network Costs: Days 1-20: \$10 copay per day Days 21-100: \$221 copay per day The above copays apply after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your In-Network Costs: Days 1-20: \$10 copay per day Days 21-100: \$221 copay per day The above copays apply after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met
<i>The copays for SNF benefits are based on benefit periods. A benefit period begins the day you're admitted as inpatient and ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. You must pay the copay for each benefit period. There's no limit to the number of benefit periods.</i>	



PHYSICAL, OCCUPATIONAL, SPEECH THERAPY

A pre-certification by the physician is required after the combined 20th therapy visit.

Choice	Core
Your In-Network Costs: \$40 copay after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your In-Network Costs: \$35 copay after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met



AMBULANCE (GROUND OR AIR, ONE-WAY TRIP)

Choice	Core
\$355 copay (per one-way trip) after the medical deductible is met	\$345 copay (per one-way trip) after the medical deductible is met
Not covered	Not covered

TRANSPORTATION (ROUTINE)

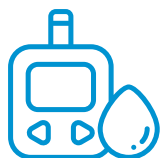


MEDICARE PART B DRUGS

*Prior authorization for certain Part B drugs is required for in-network providers. Step Therapy may also apply. Please visit [BCBSALMedicare.com/PartBDrugs](https://www.bcbsalmedicare.com/PartBDrugs) or contact Member Services at **1-888-234-8266 (TTY 711)**.*

Choice	Core
CHEMOTHERAPY AND OTHER PART B DRUGS	
Your In-Network Costs: 20% coinsurance	Your In-Network Costs: 20% coinsurance
Your Out-of-Network Costs: 50% coinsurance	Your Out-of-Network Costs: 50% coinsurance
PART B INSULIN	
In- and Out-of Network: You pay the following copays for Medicare Part B insulin used with an insulin pump. The medical deductible does not apply. 30 day supply: \$35 60 day supply: \$70 90 day supply: \$105	

Additional Benefits



DIABETES MANAGEMENT

Monitoring supplies and Continuous Glucose Monitors (CGM) from Durable Medical Equipment (DME) suppliers follow standard DME cost-sharing.

Choice	Core
MONITORING SUPPLIES	
Your In-Network Costs: You pay nothing after the medical deductible is met Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met After the medical deductible is met, a \$0 copay applies to Ascensia (Contour®) and Abbott (FreeStyle®) test strips and meters when obtained through an in-network pharmacy. Other brands require prior approval. Limit: 204 test strips every 30 days After the medical deductible is met, a \$0 copay applies to Medicare-covered Dexcom® and Abbott CGMs when obtained through an in-network pharmacy. Other brands require prior approval. Limits: 1 receiver/year, 1 transmitter/90 days, sensors per product labeling.	
SELF-MANAGEMENT TRAINING, THERAPEUTIC SHOES/INSERTS	
Your In-Network Costs: You pay nothing after the medical deductible is met	Your In-Network Costs: You pay nothing after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met



DURABLE MEDICAL EQUIPMENT

Choice	Core
Your In-Network Costs: 11% coinsurance after the medical deductible is met	Your In-Network Costs: 18% coinsurance after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met



HOME HEALTH

Choice	Core
Your In-Network Costs: You pay nothing after the medical deductible is met	Your In-Network Costs: You pay nothing after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met



HOSPICE

Choice	Core
Your In-Network Costs: You pay nothing for a Medicare-certified hospice	Your In-Network Costs: You pay nothing for a Medicare-certified hospice
Your Out-of-Network Costs: 50% coinsurance	Your Out-of-Network Costs: 50% coinsurance



OUTPATIENT REHABILITATION

Choice	Core
CARDIAC REHABILITATION	
Your In-Network Costs: \$40 copay after the medical deductible is met	Your In-Network Costs: \$40 copay after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met
PULMONARY REHABILITATION	
Your In-Network Costs: \$35 copay after the medical deductible is met	Your In-Network Costs: \$35 copay after the medical deductible is met
Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met	Your Out-of-Network Costs: 50% coinsurance after the medical deductible is met

Part D Prescription Drug Benefit Information

People with limited income and resources may qualify for “Extra Help” from Medicare to assist with prescription drug costs. Your cost sharing may be lower if you qualify for “Extra Help”.

The Deductible Stage

The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn’t apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. Until you meet your yearly Part D deductible, you will pay full price for your covered Tier 3, Tier 4 and Tier 5 prescription drugs. There is no Part D deductible for covered Tier 1 and Tier 2 drugs.

Choice	Core
\$700 (applies to tiers 3, 4 & 5)	\$625 (applies to tiers 3, 4 & 5)

After you pay your annual drug deductible, you leave the Deductible Stage and move on to the Initial Coverage Stage.

The Initial Coverage Stage

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription. You can still use a pharmacy that isn’t in your plan’s network, but it may cost more. What you pay might also change depending on whether you choose a 30 day or up to a 100 day supply. **Please see page 16 for your share of the cost when you get a covered Part D prescription drug.**

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

The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, **you pay nothing** for covered Part D drugs. Once you’re in the Catastrophic Coverage Stage, you’ll stay in this payment stage until the end of the calendar year.



WANT TO LEARN MORE?

Scan the QR code to watch short videos about certain parts of your Part D Prescription Drug coverage.

Your Cost-Sharing at Retail, Mail-Order and Long-Term Care (LTC) during the Initial Coverage Stage

Your share of the cost when you get a covered Part D prescription drug

Blue Advantage requires prior authorization and has step therapy and quantity limit restrictions for certain drugs. Please refer to the plan's formulary to determine if your drugs are subject to any limitations.

Choice

	30 day Retail	30 day Mail-Order	31 day LTC	Up to a 100 day Retail	Up to a 100 day Mail-Order
Tier 1 – Preferred Generic	\$0	\$0	\$0	\$0	\$0
Tier 2 – Generic	\$0	\$0	\$0	\$0	\$0
Tier 3 – Preferred Brand	23%	23%	23%	23%	23%
Tier 4 – Non-Preferred Drug	28%	28%	28%	28%	28%
Tier 5 – Specialty (limited to a one-month supply)	25%	25%	25%	Not Available	Not Available

You won't pay more than \$35 for a one-month supply or \$70 for up to a 100 day supply of each covered Part D insulin product, even if you haven't paid your deductible. Insulins on Tier 5 are limited to a one-month supply.

Core

	30 day Retail	30 day Mail-Order	31 day LTC	Up to a 100 day Retail	Up to a 100 day Mail-Order
Tier 1 – Preferred Generic	\$0	\$0	\$0	\$0	\$0
Tier 2 – Generic	\$5	\$5	\$5	\$10	\$10
Tier 3 – Preferred Brand	17%	17%	17%	17%	17%
Tier 4 – Non-Preferred Drug	36%	36%	36%	36%	36%
Tier 5 – Specialty (limited to a one-month supply)	26%	26%	26%	Not Available	Not Available

You won't pay more than \$35 for a one-month supply or \$70 for up to a 100 day supply of each covered Part D insulin product, even if you haven't paid your deductible. Insulins on Tier 5 are limited to a one-month supply.

More Benefits with Your Plan

Blue Advantage Choice & Core 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](https://alabamablue.com/myBlueCross).



Emotional Support Helpline

In partnership with Lucet, Blue Cross and Blue Shield of Alabama offers behavioral health services to our members as part of your mental health benefits. You also have 24-hour access to caring confidential emotional support during personal crises and disasters at no cost to you. Please call **1-855-339-9812 (TTY 711)** for more information.



Nurse Advice Line

Clinical specialists can assess your needs and advise if treatment can be provided at home or if you should seek medical attention. They are also able to connect you with a registered nurse if needed. This expert advice is available 24 hours a day, seven days a week. Please call **1-800-896-2724 (TTY 711)** to access covered services through our network at no cost to you. **Out-of-network benefits are available for Medicare-covered health information services at 80% coinsurance.**



[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. Please call **1-877-872-8624 (TTY 711)** for more information.

Keep-Me Contact Sheet

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
Find a doctor/hospital/ pharmacy	1-888-234-8266 (TTY 711)	BCBSALMedicare.com/ FindaDoctor
24-Hour Nurse Line	1-800-896-2724 (TTY 711)	
Dental Services	1-888-234-8266 (TTY 711)	BCBSALMedicare.com
Emotional Support Helpline	1-855-339-9812 (TTY 711)	
Mail-Order Pharmacy Services	Walgreens Mail Service 1-800-731-3588 (TTY 711)	Walgreensmailservice.com
	Amazon Pharmacy 1-855-745-5725 (TTY 711)	Pharmacy.amazon.com/ medicaremyw
	Express Scripts Pharmacy 1-833-715-0967 (TTY 711)	Express-scripts.com/rx
Medicare	1-800-633-4227 (TTY 1-877-486-2048)	Medicare.gov
TruHearing	1-844-255-7140 (TTY 711)	TruHearing.com
Worldwide Emergency/ Urgent Coverage	1-888-234-8266 (TTY 711)	BCBSALMedicare.com
Vision Services	1-888-234-8266 (TTY 711)	BCBSALMedicare.com
AirMed International	1-877-872-8624 (TTY 711)	
Medicare Prescription Payment Plan	1-833-246-9619 (TTY 711)	BCBSALMedicare.com/M3P

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/Documents 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 medicine 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/MyPharmacies 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, 2028.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain 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 co-pay for services received by non-contracted providers.

Disclosures

All content ©2026 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 of equivalent aids compared to TruHearing pricing. Actual savings may vary. 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.

In some cases, Blue Advantage PPO networks are only available in portions of participating states. As of August 2026, only three states are not participating: Alaska, Arkansas and Mississippi.

Lucet is an independent company managing behavioral health benefits and employee assistance programs on behalf of Blue Cross and Blue Shield of Alabama.

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. The medical deductible and copays will apply for each covered worldwide emergency/urgent service received.

Express Scripts Pharmacy, Walgreens Mail Service and Amazon Pharmacy are independent companies providing mail pharmacy services to members of Blue Cross and Blue Shield of Alabama.

The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

1-800-896-2724 (TTY 711); \$0 copay to speak one-on-one with a clinician when using the 24-Hour Nurse Line. Available 24/7/365 for health guidance and information. 80% coinsurance for Medicare-covered health information services received from out-of-network providers.

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>.

Visit AlabamaBlue.com/NoticeofNondiscrimination to view an electronic version of this notice.

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: 请注意：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，以易读格式向您提供信息。请拨打 1-855-216-3144（TTY: 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 Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie 1-855-216-3144 (TTY: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક 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 नि:शुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नि:शुल्क 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: 한국어(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, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. 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: Paunawa: 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.

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For more information, please call us at the phone numbers below
or visit us at [BCBSALMedicare.com](https://www.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.