2025 Summary of Benefits BlueCross Total Value (PPO)

H8003, Plans 004, 005 and 006

This is a summary of the health and drug service covered by BlueCross Total Value (PPO): January 1, 2025 – December 31, 2025.

This plan, **BlueCross Total Value**, is offered by BlueCross BlueShield of South Carolina. **BlueCross Total Value** is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in BlueCross BlueShield of South Carolina depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover, or list every limitation, or exclusion. To get a complete list of services we cover, please request the *Evidence of Coverage* by calling Customer Service at 1-855-204-2744 (TTY users should call 711). The *Evidence of Coverage* is also available online at www.SCBluesMedAdvantage.com.

To join BlueCross Total Value (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes these counties in South Carolina:

BlueCross Total Value (PPO) – Upstate (004): Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, and York.

BlueCross Total Value (PPO) – Midlands/Coastal (005): Aiken, Calhoun, Chesterfield, Dillon, Fairfield, Florence, Horry, Kershaw, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Saluda, and Sumter.

BlueCross Total Value (PPO) – Lowcountry (006): Beaufort, Berkeley, Charleston, Dorchester, and Georgetown.

BlueCross Total Value (PPO) has a network of doctors, hospitals, pharmacies, and other providers, as well as access to out-of-network providers. As a member of our plan, you do not need a referral from a Primary Care Provider to see a Specialist or to obtain a service. However, you are required to obtain prior authorization from our plan for some services.

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

Customer Service has free language interpreter services available for non-English speakers. This information is available in other formats. To get this information in other formats, please call Customer Service.

For more information or to enroll, call us at 1-800-930-2836 (TTY users should call 711), or visit us at www.SCBluesMedAdvantage.com. We are available for phone calls from October 1 to March 31; you can call us 8 am to 8 pm, 7 days a week. For all other times, we're here 8 am to 8 pm, Monday through Friday. Calls to this number are answered by a licensed insurance agent.

H8003_VSB2025_M

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Premiums and Benefits	**BlueCross Total Value (PPO)**
Monthly Plan Premium	You pay $0. You must continue to pay your Medicare Part B premium.
Deductible	No Deductible.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $9,350 for services you receive from in-network providers. • $14,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**BlueCross Total Value (PPO)**
Inpatient Hospital	**In-Network:** Days 1-2: You pay a $465 copay per day for each admission. Days 3-90: You pay a $0 copay per day. **Out-of-Network:** You pay 40% of the total cost per stay. This benefit will begin on day 1 each time you are admitted to a specific facility type. You pay your cost share per admission. **May require prior authorization.**
Outpatient Hospital	**In-Network:** You pay a $0 - $295 copay. You pay a $0 copay if a polyp is found and removed during colonoscopy. You pay a $325 copay for each Medicare covered observation service. **Out-of-Network:** You pay 50% of the total cost. **May require prior authorization.**

Benefits/Services	BlueCross Total Value (PPO)
Ambulatory Surgical Center	**In-Network:** You pay a $0 - $250 copay. **Out-of-Network:** You pay 50% of the total cost. **May require prior authorization.**
Doctor's Office Visits	**In-Network:** Primary care physician visit: You pay a $0 copay. Specialist visit: You pay a $17 - $47 copay. **Out-of-Network:** Primary care physician visit: You pay a $40 copay. Specialist visit: You pay a $55 copay.
Telehealth	PCP: You pay a $0 copay. Dermatology Specialist: You pay a $25 copay. Psychiatric and Mental Health services: You pay a $45 copay. *Members must use Blue CareOnDemand℠ Powered by MDLIVE® for the Telehealth services.
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-network:** You pay a $0 copay. **Out-of-network:** You pay a $0 copay. Preventive care includes: Abdominal aortic aneurysm; Alcohol misuse counseling; Bone mass measurement; Breast cancer screening (mammogram); Cardiovascular disease screenings; Colorectal cancer screenings (colonoscopy); Depression screenings; Diabetes Screening and training; Medicare Diabetes Prevention Program; HIV Screening; Obesity screening and counseling; Prostate cancer screenings (PSA); Vaccines, including flu shots and pneumococcal shots; Welcome to Medicare initial visit; Annual Wellness Visit; Annual Physical; and Health Coaching via FitOn Health.
Emergency Care	You pay a $110 copay per visit, waived if admitted within 24 hours. Worldwide Emergency Coverage: You pay a $250 service specific deductible and then 20% of the total cost.

Benefits/Services	BlueCross Total Value (PPO)
Urgently Needed Services	You pay a $10 copay per visit, waived if admitted within 24 hours. Worldwide Urgent Coverage: You pay a $45 copay for urgent care outside of the United States.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: You pay a $0 - $150 copay per service. You pay a $0 copay for diagnostic EKG and diagnostic colorectal screening. Lab services: You pay a $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): You pay a $0 - $300 copay per service. You pay a $0 copay for diagnostic mammograms and ultrasounds. X-rays: You pay a $10 copay. Therapeutic radiology services (such as radiation treatment for cancer): You pay 20% of the total cost. **Out-of-Network:** Diagnostic tests and procedures: You pay 50% of the total cost. Lab services: You pay 50% of the total cost. Diagnostic Radiology Services (such as MRI, CAT Scan): You pay 50% of the total cost. X-rays: You pay 50% of the total cost. Therapeutic radiology services (such as radiation treatment for cancer): You pay 50% of the total cost. **May require prior authorization.**

Benefits/Services	BlueCross Total Value (PPO)
Hearing Services	**In-Network:** Medicare-covered hearing exam: You pay a $45 copay. Routine hearing exam (up to 1 visit every year): You pay a $45 copay using TruHearing providers. **Hearing Aid (up to 2 hearing aids every year)**: You pay $699 - $999 The copayment range is based on different types and styles of hearing aids. The lower range $699 is for the Advanced hearing aid type and the higher range $999 is for the Premium hearing aid type. A TruHearing provider must be used for in- and out-of-network hearing aid benefit. **Out-of-Network:** Medicare-covered hearing exam: You pay 50% of the total cost. Routine hearing exam (up to 1 visit(s) every year): You pay a $45 copay using TruHearing providers. **Hearing Aid (up to 2 hearing aids every year)**: You pay $699 - $999 The copayment range is based on different types and styles of hearing aids. The lower range $699 is for the Advanced hearing aid type and the higher range $999 is for the Premium hearing aid type. A TruHearing provider must be used for in- and out-of-network hearing aid benefit.
Preventive Dental (non-Medicare covered)	**In-Network:** You pay a $0 copay. **Out-of-Network**: You pay 50% of the total cost. 2 preventive dental visits per year. Oral exam, cleaning, 1 dental bitewing x-ray (fluoride treatment not covered). **In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)** *Preventive dental services are included in your $3,000 preventive/ comprehensive limit per year. See your EOC for details.

Benefits/Services	BlueCross Total Value (PPO)
Comprehensive Dental (Non-Medicare Covered)	**In-Network:** You pay 50% of the total cost. **Out-of-Network**: You pay 50% of the total cost. Non-routine services, diagnostic services, restorative services, endodontics, extractions, prosthodontics, other oral/maxillofacial surgery, periodontics, and other services (i.e., dentures, root canals). We do not cover implants. **In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)** *Comprehensive Dental services are included in your $3,000 preventive/ comprehensive limit per year. See your EOC for details
Comprehensive Dental (Medicare Covered)	**In-Network:** You pay a $50 copay. **Out-of-Network**: You pay 50% of the total cost. See your EOC for details.

Benefits/Services	BlueCross Total Value (PPO)
Vision Services	**<u>In-Network:</u>** **Medicare covered:** You pay a $0 - $50 copay. Eyeglasses or contact lenses after cataract surgery - You pay a $0 copay for Medicare-covered eyewear related to cataract surgery. **Non-Medicare Covered:** Routine eye exam - You pay a $0 copay using the Vendor network. 1 exam per year. You pay a $0 copay for one pair of lenses or contact every year. Benefit to include frames every two years using a BlueCross authorized vendor provider. **<u>Out-of-Network:</u>** **Medicare covered:** You pay 50% of the total cost. Eyeglasses or contact lenses after cataract surgery - You pay a $0 copay for Medicare-covered eyewear related to cataract surgery. **Non-Medicare Covered:** Routine eye exam - You pay 50% of the total cost using the Vendor network. 1 exam per year. You pay a $0 copay for one pair of lenses or contact every year. Benefit to include frames every two years using a BlueCross authorized vendor provider.
Mental Health Care Inpatient hospital - psychiatric	**<u>In-Network:</u>** Days 1-3: You pay a $675 copay per day for each admission. Days 4-90: You pay a $0 copay per day. **<u>Out-of-Network:</u>** You pay 50% of the total cost per stay. **May require prior authorization.**
Mental Health Care Outpatient group therapy/ individual therapy	**<u>In-Network:</u>** You pay a $50 copay per Individual or Group Mental Health Visit. You pay a $45 copay per Individual or Group Psychiatric Health Visit. **<u>Out-of-Network:</u>** You pay 50% of the total cost for Mental Health or Psychiatric service visits.

Benefits/Services	BlueCross Total Value (PPO)
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: You pay a $0 copay per day. Days 21-100: You pay a $214 copay per day. **Out-of-Network:** You pay 50% of the total cost per stay. **May require prior authorization.**
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: You pay a $35 copay. Physical therapy and Speech-Language therapy visit: You pay a $15 copay. **Out-of-Network:** Occupational therapy visit: You pay a $55 copay. Physical therapy and Speech-Language therapy visit: You pay a $55 copay. **May require prior authorization.**
Ambulance	**In-Network:** Ground Ambulance: You pay a $310 copay. Air Ambulance: You pay a $310 copay. **Out-of-Network:** Ground Ambulance: You pay a $325 copay. Air Ambulance: You pay a $325 copay. **May require prior authorization.**
Medicare Part B Drugs	**In-Network:** Medicare Part B Insulin drugs: You pay a $35 copay. Other Part B drugs to include chemotherapy drugs: You pay 0% - 20% of the total cost. **Out-of-Network:** Medicare Part B Insulin drugs: You pay a $35 copay. Other Part B Drugs including chemotherapy drugs: You pay 50% of the total cost. **May require prior authorization.**

Additional Benefits/Services	BlueCross Total Value (PPO)
Chiropractic Office Visits	**In-Network:** You pay a $15 copay per visit. **Out-of-Network:** You pay 50% of the total cost.
Fitness Benefit – FitOn Health	You pay $0 for basic membership to a FitOn Health participating fitness center and/or home fitness kit option.
Foot Care Podiatry services	**In-Network:** You pay a $40 copay per visit. **Out-of-Network:** You pay 50% of the total cost.
Medical Equipment/Supplies*	**In-Network:** Home Infusion: You pay 15% of the total cost. Durable medical, prosthetics, and other Part B services: You pay 20% of the total cost. **Out-of-Network:** You pay 50% of the total cost.
Diabetic supplies and Services	**In-Network:** We only cover OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets, and lancing devices for $0. Note: In case of an approved medical exception, other brands may be covered, and you pay 20% of the total cost. **Out-of-Network:** You pay 50% of the total cost.
Home Health Care	**In-Network:** You pay 0% of the total cost. **Out-of-network:** You pay 50% of the total cost. **Prior authorization is required**

Meal Program	You pay a $0 copay for meals upon discharge from Hospital or Rehab facility. Two meals per day for 5 days.

Over the Counter OTC

BlueCross Total – Value Upstate (004): - You receive $54 per quarter for a total of $216 per year in Over-the-Counter items with free shipping.

BlueCross Total – Value Midlands/Coastal (005): You receive $53 per quarter for a total of $212 per year in Over-the-Counter items with free shipping.

BlueCross Total – Value Lowcountry (006): You receive $60 per quarter for a total of $240 per year in Over-the-Counter items with free shipping.

Order placed once per quarter via phone, catalog, or vendor website. You can use an OTC Benefits Card to purchase food in addition to OTC products. See EOC for details.

Visitor Travel

The Visitor/Travel Program will include BlueCross Total Value network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state. These areas are subject to change, see EOC for details.

Prescription Drug Coverage

Yearly Deductible: During this stage, you pay the full cost of your Tier 3, 4 and 5 drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

Initial Coverage Stage: During this stage, the plan pays its share of the cost of your drugs, and you pay your share. You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.

Catastrophic Coverage: The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs. If you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

Deductible Stage: $200 for Tiers 3, 4 and 5.

Initial Coverage Stage: You pay the following until your total yearly drug costs reach $2000. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$5 copay	$10 copay	$15 copay
Tier 2 (Generic)	$15 copay	$30 copay	$45 copay
Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drug)	42% coinsurance	42% coinsurance	42% coinsurance
Tier 5 (Specialty Tier)	30% coinsurance	Not Applicable	Not Applicable
Tier 6 (Specialty Tier)	$5 copay	$10 copay	$15 copay

Preferred Retail Cost-Sharing			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$20 copay	$30 copay
Tier 3 (Preferred Brand)	21% coinsurance	21% coinsurance	21% coinsurance
Tier 4 (Non-Preferred Drug)	40% coinsurance	40% coinsurance	40% coinsurance
Tier 5 (Specialty Tier)	30% coinsurance	Not Applicable	Not Applicable
Tier 6 (Specialty Tier)	$0 copay	$0 copay	$0 copay

Standard Mail Order			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$20 copay	$0 copay
Tier 3 (Preferred Brand)	21% coinsurance	21% coinsurance	$0 copay, 21% coinsurance
Tier 4 (Non-Preferred Drug)	40% coinsurance	40% coinsurance	$0 copay, 40% coinsurance
Tier 5 (Specialty Tier)	30% coinsurance	Not Applicable	Not Applicable
Tier 6 (Specialty Tier)	$0 copay	$0 copay	$0 copay

Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Please call us or see the plan's **"Evidence of Coverage"** on our website (www.SCBluesMedAdvantage.com) for complete information about your costs for covered drugs.

Limitations, copayments, and restrictions may apply. Benefits, premiums, copayments, or coinsurance may change on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat BlueCross Total Value members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number, 1-855-204-2744 (TTY users should call 711), or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-204-2744. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-396-0183. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-396-0188。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-725-1516。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-389-4839. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-396-0190. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-389-4838 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-396-0191. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-396-0187번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-389-4840. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-396-0189. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-725-1519 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-396-0184. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-396-0182. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-398-6232. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-396-0186. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-396-0185にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。