2021 Summary of Benefits

BlueCross Total℠ Value (PPO)

Jan. 1, 2021 – Dec. 31, 2021

855-204-2744 | TTY 711

Seven Days a Week, 8 a.m. to 8 p.m.
(October 1 to March 31)

Monday-Friday, 8 a.m. to 8 p.m.
(All other times)

H8003_VSB2021_M

South Carolina

2021 Summary of Benefits
BlueCross Total Value℠ (PPO)

H8003, Plans 004 and 005

This is a summary of the health and drug services covered by BlueCross Total Value (PPO): January 1, 2021 – December 31, 2021.

This plan, BlueCross Total Value, is offered by BlueCross BlueShield of South Carolina. BlueCross BlueShield of South Carolina 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 available online at www.scbluesmedadvantage.com/marx21.

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 the following 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, Orangeburg, Richland, Saluda and Sumter

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 in order to see a Specialist or to obtain a service. However, you are required to obtain prior authorization from our plan for some services.

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/marx21. We are available for phone calls from October 1 to December 31; you can call us 8 a.m. to 8 p.m., 7 days a week. From January 1 to September 30, we're here 8 a.m. to 6 p.m., Monday through Friday. Calls to this number are answered by a licensed insurance agent.

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.

H8003_VSB2021_M

Premiums and Benefits	BlueCross Total Value (PPO)
Monthly Plan Premium	
BlueCross Total Value (PPO) - Upstate (004)	You pay $0 You must continue to pay your Medicare Part B premium.
BlueCross Total Value (PPO) - Midlands/Coastal (005)	You pay $0 You must continue to pay your Medicare Part B premium.
Deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**In-network:** You pay no more than $7,550 annually. **In-network and Out-of-network:** You pay no more than $11,300 combined. Includes copays and other costs for medical services for the year.
Inpatient Hospital Coverage*	**In-network:** You pay $495 per day for days 1 - 4 (You pay nothing per day for days 5 - 90). **Out-of-network:** You pay 40% of the cost. *Prior authorization may be required. This benefit will begin on day 1 each time you are admitted to a specific facility type. You pay your cost share per admission.
Outpatient Hospital Coverage*	**In-network:** You pay $0 up to $395 per visit. You pay nothing if polyp is found and removed during colonoscopy. **Out-of-network:** You pay 40% of the cost. *Prior authorization may be required.
Doctor Visits	
• Primary Care Providers	**In-network:** You pay $15 per visit. **Out-of-network:** You pay $40 per visit.
• Specialists	**In-network:** You pay $50 per visit. **Out-of-network:** You pay $55 per visit.
• Telehealth	You pay $5 per PCP or urgent care visit. Refer to the EOC for complete details on how to access telehealth providers.

Premiums and Benefits	BlueCross Total Value (PPO)
Preventive Care	**In-network:** You pay $0. **Out-of-network:** You pay $0 - $50 per visit, or 0% - 30% of the cost (depending on the service and where it is performed). 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); EKG; Vaccines, including flu shots and pneumococcal shots; Welcome to Medicare initial visit; Annual Wellness Visit; Annual Physical; and Health Coaching via Silver and Fit. Other preventive services are available. There are some covered services that have a cost, refer to the EOC for complete details.
Emergency Care	You pay $90 per visit, waived if admitted. Emergency care is covered worldwide; refer to the EOC for complete details.
Urgently Needed Services	You pay $65 per visit.
Diagnostic Services/Labs/ Imaging*	*Prior authorization may be required for these services.
• Diagnostic tests and procedures	**In-network:** You pay $0 up to $275 per service. You pay $0 for diagnostic EKG and diagnostic colorectal screening. **Out-of-network:** You pay 40% of the cost.
• Lab services	**In-network:** You pay $10 per lab service. **Out-of-network:** You pay 40% per lab service.
• Diagnostic radiology service (e.g., MRI and CT scan)	**In-network:** You pay $0 up to $150 per service. You pay $0 for diagnostic mammogram and ultrasounds. **Out-of-network:** You pay 40% of the cost.
• Outpatient x-rays	**In-network:** You pay $10 - $20 per x-ray. **Out-of-network:** You pay 40% per x-ray.
Hearing Services	
• Medicare-covered hearing exam	**In-network:** You pay $45. **Out-of-network:** You pay 50% of the cost.
• Routine hearing exam	**In-network:** You pay $45. **Out-of-network:** You pay 50% of the cost.
• Hearing aids	**In-network:** You pay $699 - $999 using TruHearing network for up to 2 hearing aids per year (one per ear, each year). **Out-of-network:** You pay $699 - $999.

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Dental Services	
• Preventive dental	2 preventive dental visits per year. Oral exam, cleaning, dental bitewing x-rays (fluoride treatment not covered). **In-network:** You pay $0 for dental services **Out-of-network:** You pay 50% of the cost.
Vision Services	
• Diabetic eye exam	You pay $0.
• Glaucoma screening	You pay $0.
• Medicare-covered eye exam	You pay $50.
• Routine eye exam	You pay $0 using the VSP network. 1 exam per year.
• Eyeglasses (frames and lenses) and contacts	You pay $0 for one pair of glasses to include frames and lenses or one pair of contact lenses every 2 years using the VSP network.
• Eyeglasses or contact lenses after cataract surgery	You pay $0 copay for Medicare-covered eyewear related to cataract surgery.
Mental Health Services	
• Inpatient visit*	**In-network:** You pay $620 per day, days 1 - 3, $0 per day, days 4 - 90. **Out-of-network:** You pay 50% of the cost. *Prior authorization may be required.
• Outpatient group therapy/ individual therapy	**In-network:** You pay $40 per visit. **Out-of-network:** You pay 40% per visit.
Skilled Nursing Facility*	**In-network:** You pay nothing per day for days 1 - 20. You pay $184 per day for days 21 - 100. **Out-of-network:** You pay 40% of the cost. Our plan covers up to 100 days in a SNF. *Prior authorization may be required.
Physical Therapy*	**In-network:** You pay $40 per visit. **Out-of-network:** You pay $55 per visit. *Prior authorization may be required.
Ambulance*	**In-network:** You pay $310 per one-way trip for ground ambulance. You pay 20% of the cost of air ambulance. **Out-of-network:** You pay $310 per one-way trip for ground ambulance. You pay 20% of the cost of air ambulance. *Prior authorization may be required for non-emergency transportation.
Transportation	Not covered

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Medicare Part B Drugs*	**In-network:** You pay 20% of the cost of chemotherapy drugs. **Out-of-network:** You pay 40% of the cost of chemotherapy drugs. **In-network:** You pay 20% of the cost for other Part B drugs. **Out-of-network:** You pay 40% of the cost for other Part B drugs. *Prior authorization may be required.
Ambulatory Surgical Center Services*	**In-network:** You pay $0 up to $395 per visit. **Out-of-network:** You pay 40% of the cost. *Prior authorization may be required.
Chiropractic Care (Medicare-covered)	**In-network:** You pay $20 per visit. **Out-of-network:** You pay $55.
Dialysis*	**In-network:**You pay 20% of the cost. **Out-of-network:** You pay 40% of the cost. *Prior authorization may be required.
Foot Care (podiatry services)	
• Medicare-covered foot exams and treatment	**In-network:** You pay $50 per visit. **Out-of-network:** You pay 40% of the cost.
• Routine foot care	Not covered
Home Health Care*	**In-network:** You pay nothing. **Out-of-network:** You pay 40% of the cost. *Prior authorization may be required.
Meal Program	$0 copay for meals upon discharge from Hospital, Skilled Nursing or Rehab facility. Two meals per day for 5 days. See EOC for details.
Medical Equipment/Supplies	
• Durable Medical Equipment (e.g., wheelchairs, oxygen)*	**In-network:** You pay 20% of the cost. **Out-of-network:** You pay 40% of the cost. *Prior authorization may be required.
• Prosthetics (e.g., braces, artificial limbs)*	**In-network:** You pay 20% of the cost. **Out-of-network:** You pay 40% of the cost. *Prior authorization may be required.
• Diabetic supplies	**In-network:** You pay 0% (preferred vendor One Touch/network pharmacy). **In-network:** You pay 20% of the cost (non-preferred vendor/ non-network pharmacy). **Out-of-network:** You pay 40% of the cost.
Occupational Therapy*	**In-network:** You pay $40 per visit. **Out-of-network:** You pay $55 per visit. *Prior authorization may be required.

Premiums and Benefits	BlueCross Total Value (PPO)
Outpatient Substance Abuse*	**In-network:** Individual and group therapy visits – You pay $40. **Out-of-network:** Individual and group therapy visits – You pay 40% of the cost. *Prior authorization may be required.
Over-the-Counter Service	You receive $25 per quarter for a total of up to $100 per year in Over-the-Counter items with free shipping. Order placed once per quarter via phone, catalog or vendor website. Details provided in new member welcome kit.
Physical Exam - Annual	**In-network:** You pay $0 for one physical exam per year. **Out-of-network:** You pay 40% of the cost for one physical exam per year.
Speech and Language Therapy*	**In-network:** You pay $40 per visit. **Out-of-network:** You pay $55 per visit. *Prior authorization may be required.
Visitor Travel	The Visitor/Travel Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 43 states and 1 territory: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, 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, 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.
Wellness Programs (e.g., fitness)	You pay nothing for basic membership to a Silver & Fit participating fitness center.

Outpatient Prescription Drugs

Deductible – You pay $200 deductible on Tiers 3, 4, and 5 only.	Standard Retail Rx 30-day supply	Standard Mail Order Rx 90-day supply
Tier 1: Preferred Generic	You pay $5	You pay $0 (Mail order and/or standard retail)
Tier 2: Generic	You pay $15	You pay $37.50
Tier 3: Preferred Brand	You pay $47	You pay $117.50
Tier 4: Non-Preferred Drug	You pay 45%	You pay 45%
Tier 5: Specialty	You pay 29%	You pay 29%

Yearly deductible stage: During this stage, you pay the full cost of your Tier 3, Tier 4 and Tier 5 drugs. You stay in this stage until you have paid your Part D deductible for your Tier 3, Tier 4 and Tier 5 drugs.

Initial coverage stage: During this stage, the plan pays its share of the cost of your Tier 1 and Tier 2 drugs and you pay your share of the cost. After you (or others on your behalf) have met your Tier 3, Tier 4 and Tier 5 deductible, the plan pays its share of the costs of your Tier 3, Tier 4 and Tier 5 drugs and you pay your share. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $**4,130**.

Additional Gap Coverage: You also receive some coverage for generic drugs. For drugs on Tier 1 you pay the same share of the cost that you normally pay while in the Initial Coverage Stage, or 25% of the costs, whichever is lower. For all other generic drugs besides those on Tier 1, you pay 25% of the costs. During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee). For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

Cost-Sharing may change depending on the pharmacy you choose (mail order, Long Term Care (LTC) or home infusion, and 30 or 90-day supply) and when you enter another of the four phases of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online at www.scbluesmedadvantage.com/marx21.

Catastrophic Coverage: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay the greater of:

- **5%** of the cost, or
- **$3.70** copay for generic (including brand drugs treated as generic) and **$9.20** copay for all other drugs.

For coverage and cost 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). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

You must continue to pay your Part B premium.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

داشتھ باشید، حق این را دارید کھ کمک و اطلاعات بھ زبان خود را بھ طور رایگان ااگر شما یا فردی کھ بھ او کمک می کنید سؤالاتی در بارھی این برنامھی بھداشتی دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شمارھی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

South Carolina