2022 Summary of Benefits

Jan. 1, 2022 – Dec. 31, 2022

888-645-6025 | 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)

BlueCross RX PLUS℠(PDP)
BlueCross RX VALUE℠(PDP)
BlueCross RX ESSENTIAL℠(PDP)

2022 Summary of Benefits
BlueCross Rx Essential (PDP), BlueCross Rx Value (PDP) and BlueCross Rx Plus (PDP)

January 1, 2022 – December 31, 2022

This booklet gives you a summary of what we cover and what you pay. The information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and copayments/coinsurance may change on January 1 of each year. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage.*

You have choices about how to get your Medicare prescription drug benefits

- One choice is to get your prescription drug coverage through a Medicare Prescription Drug Plan, like Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP).
- Another choice is to get your prescription drug coverage through a Medicare Advantage Plan (like an HMO or PPO) or another Medicare health plan that offers Medicare prescription drug coverage. You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Rx Essential (PDP)**, **Rx Value (PDP)** and **Rx Plus (PDP)** cover and what you pay.

- If you want to compare our plans with other Medicare drug plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your *2022 Medicare & You* handbook. View it online at www.medicare.gov, or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits

This document is available in other formats, such as Braille, large print or audio.

This document may be available in a non-English language. For additional information, call us at 1-800-930-2836. TTY users call 711.

THINGS TO KNOW ABOUT RX ESSENTIAL (PDP), RX VALUE (PDP) AND RX PLUS (PDP)

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time.
- All other times, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP) Phone Numbers and Website

- If you are a member of one of these plans, call toll-free 1-888-645-6025. TTY users call 711.
- If you are not a member of this plan, call toll-free 1-800-930-2836. TTY users call 711. (Calls to this number are answered by a licensed insurance agent.)
- Our website: www.SCBluesMedAdvantage.com/marx22

Who can join?

To join **Rx Essential (PDP)**, **Rx Value (PDP)** or **Rx Plus (PDP)**, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area. Our service area includes the following: South Carolina.

Which drugs are covered?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website (www.SCBluesMedAdvantage.com/marx22). Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate the tier your drug is in to determine how much it will cost. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur (after you meet your deductible – Rx Essential (PDP) and Rx Value (PDP) only): Initial Coverage, Coverage Gap and Catastrophic Coverage.

Which pharmacies can I use?

We have a network of pharmacies. You must generally use these pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our *Pharmacy Directory* at our website (www.SCBluesMedAdvantage.com/marx22). Or, call us and we will send you a copy of the directory.

Summary of Benefits

January 1, 2022 – December 31, 2022

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

Premium and Deductible Details	Rx Essential (PDP)	Rx Value (PDP)	Rx Plus (PDP)
How much is the monthly premium?	$26.10 per month. You must continue to pay your Medicare Part B premium.	$115.90 per month. You must continue to pay your Medicare Part B premium.	$207.20 per month. You must continue to pay your Medicare Part B premium.
How much is the deductible?	$480 per year for Part D prescription drugs, except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	$400 per year for Part D prescription drugs, except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	$0. This plan does not have a deductible.

PRESCRIPITON DRUG BENEFITS

The following section includes information about what we cover and what you pay during the four "drug payment stages" of our plan's benefits. The stages are Yearly Deductible (Rx Essential (PDP) and Rx Value (PDP) only), Initial Coverage, Coverage Gap and Catastrophic Coverage. Your cost-sharing may change as you enter another stage of the Part D benefit. For more details, call us (the number is on the cover of this booklet) or see your *Evidence of Coverage.* The *Evidence of Coverage* is available on our website.

Initial Coverage	Rx Essential (PDP)	Rx Value (PDP)	Rx Plus (PDP)
What You Pay	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.	You pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.

How much you pay for your prescription will depend in part on which cost-sharing tier your drug is in.

Tier Number	Tier Label	General Description
Tier 1	Preferred Generic	The lowest tier and includes preferred generic drugs.
Tier 2	Generic	Includes generic drugs
Tier 3	Preferred Brand	Includes preferred brand drugs and non-preferred generic drugs.
Tier 4	Non-Preferred Drug	Includes non-preferred brand drugs and non-preferred generic drugs.
Tier 5	Specialty Tier	The highest tier. It contains very high-cost brand and generic drugs that may require special handling and/or monitoring.

Your costs will also differ relative to the pharmacy's status as preferred or standard retail, mail-order, Long-Term Care (LTC), or Home Infusion, and whether you receive a one-month (30-day), two-month (60-day), or three-month (90-day) supply.

Standard Retail Cost-Sharing

Tier	Rx Essential (PDP)			Rx Value (PDP)			Rx Plus (PDP)		
Each plan has 5 cost-sharing tiers	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$15 copay	$30 copay	$45 copay	$10 copay	$20 copay	$30 copay	$5 copay	$10 copay	$15 copay
Tier 2 (Generic)	$20 copay	$40 copay	$60 copay	$20 copay	$40 copay	$60 copay	$8 copay	$16 copay	$24 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$27 copay	$54 copay	$81 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	50% of the cost	50% of the cost	50% of the cost	45% of the cost	45% of the cost	45% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost	33% of the cost	33% of the cost	33% of the cost

Preferred Retail Cost-Sharing

Tier	Rx Essential (PDP)			Rx Value (PDP)			Rx Plus (PDP)		
Each plan has 5 cost-sharing tiers	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$5 copay	$10 copay	$15 copay	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$5 copay	$10 copay	$15 copay	$15 copay	$30 copay	$45 copay	$3 copay	$6 copay	$9 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	$120 copay	$40 copay	$80 copay	$120 copay	$20 copay	$40 copay	$60 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	45% of the cost	45% of the cost	45% of the cost	40% of the cost	40% of the cost	40% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost	33% of the cost	33% of the cost	33% of the cost

Standard Mail-Order Cost-Sharing

Tier	Rx Essential (PDP)			Rx Value (PDP)			Rx Plus (PDP)		
Each plan has 5 cost-sharing tiers	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$15 copay	$30 copay	$37.50 copay	$10 copay	$20 copay	$25 copay	$5 copay	$10 copay	$12.50 copay
Tier 2 (Generic)	$20 copay	$40 copay	$50 copay	$20 copay	$40 copay	$50 copay	$8 copay	$16 copay	$20 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$117.50 copay	$27 copay	$54 copay	$67.50 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	50% of the cost	50% of the cost	50% of the cost	45% of the cost	45% of the cost	45% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost	33% of the cost	33% of the cost	33% of the cost

Preferred Mail-Order Cost-Sharing

Tier	Rx Essential (PDP)			Rx Value (PDP)			Rx Plus (PDP)		
Each plan has 5 cost-sharing tiers	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$5 copay	$10 copay	$12.50 copay	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$5 copay	$10 copay	$12.50 copay	$15 copay	$30 copay	$37.50 copay	$3 copay	$6 copay	$7.50 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	$100 copay	$40 copay	$80 copay	$100 copay	$20 copay	$40 copay	$50 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost	45% of the cost	45% of the cost	45% of the cost	40% of the cost	40% of the cost	40% of the cost
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost	33% of the cost	33% of the cost	33% of the cost

Plan	Rx Essential (PDP) and Rx Value (PDP)	Rx Plus (PDP)
Long-Term Care, Out-of-Network and other Limitations	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy in situations where you are not able to use a network pharmacy, but you may pay more than you pay at an in-network pharmacy. For more information on when your drugs can be covered at an out-of-network pharmacy, call us or see your *Evidence of Coverage*. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged. Some drugs have limitations. The limitations are quantity limits, prior authorization, and step therapy.	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy in situations where you are not able to use a network pharmacy, but you may pay more than you pay at an in-network pharmacy. For more information on when your drugs can be covered at an out-of-network pharmacy, call us or see your *Evidence of Coverage*. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged. Some drugs have limitations. The limitations are quantity limits, prior authorization, and step therapy.
Plan	**Rx Essential (PDP) and Rx Value (PDP)**	**Rx Plus (PDP)**
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there is a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there is a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Coverage Gap Standard Retail Cost-Sharing

Tier	Rx Essential (PDP) and Rx Value (PDP)				Rx Plus (PDP)			
	Covered Drugs	One-month supply	Two-month supply	Three-month supply	Covered Drugs	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	No Coverage	No Coverage	No Coverage	No Coverage	Tier 1 (Preferred Generic)	$5 copay	$10 copay	$15 copay
Tier 2 (Generic)	No Coverage	No Coverage	No Coverage	No Coverage	Tier 2 (Generic)	$8 copay	$16 copay	$24 copay

Coverage Gap Preferred Retail Cost-Sharing

Tier	Rx Essential (PDP) and Rx Value (PDP)				Rx Plus (PDP)			
	Covered Drugs	One-month supply	Two-month supply	Three-month supply	Covered Drugs	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	No Coverage	No Coverage	No Coverage	No Coverage	Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	No Coverage	No Coverage	No Coverage	No Coverage	Tier 2 (Generic)	$3 copay	$6 copay	$9 copay

Coverage Gap Standard Mail-Order Cost-Sharing

Tier	Rx Essential (PDP) and Rx Value (PDP)				Rx Plus (PDP)			
	Covered Drugs	One-month supply	Two-month supply	Three-month supply	Covered Drugs	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	No Coverage	No Coverage	No Coverage	No Coverage	Tier 1 (Preferred Generic)	$5 copay	$10 copay	$15 copay
Tier 2 (Generic)	No Coverage	No Coverage	No Coverage	No Coverage	Tier 2 (Generic)	$8 copay	$16 copay	$20 copay

Coverage Gap Preferred Mail-Order Cost-Sharing

Tier	Rx Essential (PDP) and Rx Value (PDP)				Rx Plus (PDP)			
	Covered Drugs	One-month supply	Two-month supply	Three-month supply	Covered Drugs	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	No Coverage	No Coverage	No Coverage	No Coverage	Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	No Coverage	No Coverage	No Coverage	No Coverage	Tier 2 (Generic)	$3 copay	$6 copay	$7.50 copay

Catastrophic Coverage:

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of:

- 5% of the cost, or
- $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.

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

BlueCross BlueShield of South Carolina is a Medicare Advantage PDP organization with a Medicare contract. Enrollment in BlueCross BlueShield of South Carolina depends on contract renewal.

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)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 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)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

South Carolina

BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association