2023 Summary of Benefits

Jan. 1, 2023 – Dec. 31, 2023

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)

2023 Summary of Benefits
BlueCross Rx Essential (PDP), BlueCross Rx Value (PDP) and BlueCross Rx Plus (PDP)

January 1, 2023 – December 31, 2023

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 *2023 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

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) or call Customer Service, 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.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

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). Or call Customer Service, and we will send you a copy of the directory.

Summary of Benefits

January 1, 2023 – December 31, 2023

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?	$29.80 per month. You must continue to pay your Medicare Part B premium.	$118.60 per month. You must continue to pay your Medicare Part B premium.	$201.10 per month. You must continue to pay your Medicare Part B premium.
How much is the deductible?	$505 per year for Part D prescription drugs, except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	$450 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.

PRESCRIPTION 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 also 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 **$4,660**. 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 **$4,660**. 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 **$4,660**. 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
Select Insulins	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 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	25% of the cost	25% of the cost	25% 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	$7 copay	$14 copay	$21 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
Select Insulins	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 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	25% of the cost	25% of the cost	25% 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)	$0 copay	$0 copay	$0 copay	$7 copay	$14 copay	$17.50 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
Select Insulin	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 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	25% of the cost	25% of the cost	25% 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	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 $4,660. After you enter the Coverage Gap, you pay 25% of the cost for covered brand name drugs and 25% of the cost for covered generic drugs until your costs total $7,400, which is the end of the Coverage Gap. Not everyone will enter the Coverage Gap.	plan has paid and what you have paid) reaches $4,660. After you enter the Coverage Gap, you pay 25% of the cost for covered generic drugs until your costs total $7,400, 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)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 1 (Preferred Generic)	$5 copay	$10 copay	$15 copay
Tier 2 (Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 2 (Generic)	$8 copay	$16 copay	$24 copay
Select Insulins	$35 copay	$70 copay	$105 copay	Select Insulins	$35 copay	$70 copay	$105 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)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 2 (Generic)	$3 copay	$6 copay	$9 copay
Select Insulins	$35 copay	$70 copay	$105 copay	Select Insulins	$35 copay	$70 copay	$105 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)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	You pay 25% of the cost	You pay 25% of the cost	You pay 25% of the cost	Tier 2 (Generic)	$3 copay	$6 copay	$7.50 copay
Select Insulins	$35 copay	$70 copay	$105 copay	Select Insulins	$35 copay	$70 copay	$105 copay

Catastrophic Coverage:

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of:

- **5%** of the cost, or
- **$4.15** copay for generic (including brand drugs treated as generic) and **$10.35** copay for all other drugs.

You will pay a maximum of $35 for a 1-month supply of covered insulin during the deductible, initial coverage, coverage gap or "donut hole" and catastrophic stages of your benefit. Your cost maybe less if you receive “Extra Help” from Medicare.

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.

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 [1-888-645-6025]. 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 1-844-396-0187 번으로 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.

Portugués: 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。

South Carolina

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