

2024 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, 2024 – December 31, 2024.

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 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, 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 a.m. to 8 p.m., 7 days a week. From January 1 to September 30, we’re here 8 a.m. to 8 p.m., Monday through Friday. Calls to this number are answered by a licensed insurance agent.

Premiums and Benefits	BlueCross Total Value (PPO)
Monthly Plan Premium*	*You must continue to pay your Medicare Part B premium.
BlueCross Total Value (PPO) - Upstate (004), Midlands/Coastal (005) and Lowcountry (006)	You pay \$0
Deductible	No Deductible.
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	<p>In-network: You pay no more than \$7,900 annually.</p> <p>In-network and Out-of-network: You pay no more than \$11,300 combined.</p> <p>Includes copays and other costs covered Part A and Part B services.</p>
Inpatient Hospital Coverage*	<p>In-network: You pay a \$350 copay per day for days 1 - 4 (You pay a \$0 copay per day for days 5 - 90).</p> <p>Out-of-network Total Value Upstate and Midlands/Coastal: You pay 20% of the total cost.</p> <p>Out-of-network Total Value Lowcountry: You pay 50% of the total cost.</p> <p>*Prior authorization is required.</p> <p>This benefit will begin on day 1 each time you are admitted to a specific facility type. You pay your cost share per admission.</p>
Outpatient Hospital Coverage*	<p>In-network: You pay a \$0 up to a \$350 copay per visit. You pay a \$0 copay if a polyp is found and removed during colonoscopy. You pay a \$375 copay for each Medicare covered observation service.</p> <p>Out-of-network: You pay 50% of the total cost.</p> <p>*Prior authorization is required.</p>
Ambulatory Surgical Center (ASC) Services*	<p>In-network Total Value Upstate and Lowcountry: You pay a \$0 up to \$310 copay per visit.</p> <p>In-network Total Value Midlands/Coastal: You pay a \$0 up to \$300 copay per visit.</p> <p>Out-of-network: You pay 50% of the total cost.</p> <p>*Prior authorization is required.</p>
Doctor Visits	
Primary Care Providers	<p>In-network: You pay a \$0 copay per visit.</p> <p>Out-of-network: You pay a \$40 copay per visit.</p>
Specialists	<p>In-network: You pay a \$30 copay per visit.</p> <p>Out-of-network: You pay \$55 per visit.</p>

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Telehealth	<p>You pay a \$0 copay for each primary care physician telehealth service.</p> <p>You pay a \$0 copay for each urgent care telehealth service.</p> <p>You pay a \$40 copay for each individual session for psychiatric services.</p> <p>You pay a \$40 copay for each individual session for mental health specialty services.</p>
Preventive Care	<p>In-network: You pay a \$0 copay.</p> <p>Out-of-network: You pay a \$0 copay.</p> <p>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.</p>
Emergency Care	<p>You pay a \$100 copay per visit, waived if admitted within 24 hours.</p> <p>You pay a \$250 service specific deductible and then 20% of the total cost for worldwide emergency care.</p>
Urgently Needed Services	<p>You pay a \$0 copay for primary care visits at urgent care.</p> <p>You pay a \$40 copay for specialist visit at urgent care.</p> <p>You pay a \$55 copay for urgently needed services at urgent care.</p> <p>You pay 0% of the total cost for worldwide urgent care.</p>
Diagnostic Services/Labs/Imaging*	*Prior authorization may be required for these services.
Diagnostic Procedures/Tests	<p>In-network: You pay a \$0 up to \$295 copay per service. You pay a \$0 copay for diagnostic EKG and diagnostic colorectal screening.</p> <p>Out-of-network: You pay 50% of the total cost.</p>
Lab services	<p>In-network: You pay a \$0 copay per lab service.</p> <p>Out-of-network: You pay 50% of the total cost per lab service.</p>
Diagnostic radiology service(e.g., MRI and CT scan)	<p>In-network: You pay a \$0 up to \$150 copay per service. You pay a \$0 copay for diagnostic mammogram and ultrasounds.</p> <p>Out-of-network: You pay 50% of the total cost.</p>
Therapeutic Radiological Services	<p>In-network: You pay 20% of the total cost.</p> <p>Out-of-network: You pay 50% of the total cost.</p>

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Outpatient x-rays	<p>In-network Total Value Upstate and Midlands/Coastal: You pay a \$10 - \$20 copay per x-ray. You pay a \$10 copay for X-rays in a provider's office and a \$20 copay for all other locations.</p> <p>In-network Total Value Lowcountry: You pay 20% of the cost.</p> <p>Out-of-network: You pay 50% of the total cost per x-ray.</p>
Hearing Services	
Medicare-covered hearing exam	<p>In-network: You pay a \$45 copay.</p> <p>Out-of-network: You pay 50% of the total cost.</p>
Routine hearing exam	<p>In-network: You pay a \$45 copay using a TruHearing provider.</p> <p>Out-of-network: You pay a \$45 copay using a TruHearing provider.</p>
Hearing aids	<p>In-network: You pay \$699 - \$999, using TruHearing network for up to 2 hearing aids per year (one per ear, each year).</p> <p>Out-of-network: You pay \$699 - \$999, using TruHearing network for up to 2 hearing aids per year (one per ear, each year).</p> <p>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.</p>
Dental Services	
Preventive Dental	<p>In-network: You pay a \$0 copay.*</p> <p>Out-of-Network: You pay 50% of the total cost.*</p> <p>2 preventive dental visits per year. Oral exam, cleaning, 1 dental bitewing x-ray (fluoride treatment not covered).</p> <p>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.)</p> <p>*Preventive dental services are included in your \$2,000 preventive/comprehensive limit per year. See your EOC for details.</p>

Premiums and Benefits	BlueCross Total Value (PPO)
Comprehensive Dental (Non-Medicare Covered)	<p>In-network: You pay 50% of the total cost.*</p> <p>Out-of-network: You pay 50% of the total cost.*</p> <p>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.</p> <p>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.)</p> <p>*Comprehensive dental services are included in your \$2,000 preventive/comprehensive limit per year. See your EOC for details.</p>
Comprehensive Dental (Medicare Covered)	<p>In-network: You pay a \$50 copay.</p> <p>Out-of-network: You pay a \$50 copay.</p> <p>See your EOC for details.</p>
Vision Services	
Diabetic eye exam	<p>In-network: You pay a \$0 copay.</p> <p>Out-of-network: You pay a \$0 copay.</p>
Glaucoma screening	<p>In-network: You pay a \$0 copay.</p> <p>Out-of-network: You pay a \$0 copay.</p>
Medicare-covered eye exam	<p>In-network: You pay a \$50 copay.</p> <p>Out-of-network: You pay 50% of the total cost.</p>
Routine eye exam	<p>In-network: You pay a \$0 copay using the VSP network. 1 exam per year.</p> <p>Out-of-network: You pay 50% of the total cost. You pay a \$0 copay using the VSP network for 1 exam per year.</p>
Eyeglasses (frames and lenses) and contacts	<p>In-network: You pay a \$0 copay for one pair of glasses to include frames and lenses or one pair of contact lenses every 2 years using the VSP network.</p> <p>Out-of-network: You pay a \$0 copay for one pair of glasses to include frames and lenses or one pair of contact lenses every 2 years using the VSP network.</p>
Eyeglasses or contact lenses after cataract surgery	<p>In-network: You pay a \$0 copay for Medicare-covered eyewear related to cataract surgery.</p> <p>Out-of-network: You pay a \$0 copay for Medicare-covered eyewear related to cataract surgery.</p>

