3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in BlueCross Total Value Upstate.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with BlueCross Total Value Upstate.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Customer Service number at 1-855-204-2744 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm, Eastern Time, Monday through Friday. Our automated phone system handles calls received after 8 pm and on Saturdays, Sundays, and holidays. From October 1 through March 31, we are available 8 am to 8 pm, Eastern Time, seven days a week. This call is free.
- Customer Service has free language interpreter services available for non-English speakers. This information is available in alternate formats, including large print. Please call Customer Service if you need plan information in other formats.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About BlueCross Total Value Upstate

- BlueCross Total Value Upstate is a Medicare Advantage Preferred Provider Organization plan with a Medicare contract. Enrollment in BlueCross Total Value Upstate depends on contract renewal.
- When this document says "we," "us," or "our," it means BlueCross BlueShield of South Carolina. When it says "plan" or "our plan," it means BlueCross Total Value Upstate.

Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for BlueCross Total Value Upstate in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $7,900 From network and out-of-network providers combined: $11,300	From network providers: $9,350 From network and out-of-network providers combined: $14,000
Doctor office visits	Primary care visits from in-network providers: $0 copay per visit Primary care visits from out-of-network providers: $40 copay per visit Specialist visits from in-network providers: $30 copay per visit Specialist visits from out-of-network providers: $55 copay per visit	Primary care visits from in-network providers: $0 copay per visit Primary care visits from out-of-network providers: $40 copay per visit Specialist visits from in-network providers: $17-$47 copay per visit Specialist visits from out-of-network providers: $55 copay per visit

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	**In-Network** You pay $350 per day for days 1 through 4. You pay $0 per day for days 5 through 90. **Out-of-Network** 20% Coinsurance per admission	**In-Network** You pay $465 per day for days 1 through 2. You pay $0 per day for days 3 through 90. **Out-of-Network** 40% Coinsurance per admission
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $95 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance Standard Retail during the Initial Coverage Stage (**30-day** supply): • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 • Drug Tier 5: 31% • Drug Tier 6: $5 Copayment/Coinsurance Preferred Retail during the Initial Coverage Stage (**30-day** supply): • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $42 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 • Drug Tier 5: 31% • Drug Tier 6: $0	Deductible: $200 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance Standard Retail during the Initial Coverage Stage (**30-day** supply): • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: 25% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 42% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 30% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $5 Copayment/Coinsurance Preferred Retail during the Initial Coverage Stage (**30-day** supply): • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: 21%

Cost	2024 (this year)	2025 (next year)
	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 40% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 30% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

Cost	2024 (this year)	2025 (next year)
Comprehensive Dental (Non-Medicare)	**In-Network:** You pay 50% Coinsurance of the total cost.* **Out-Of-Network:** You pay 50% Coinsurance 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 $2,000 preventive/ comprehensive maximum coverage per year.	**In-Network:** You pay 50% Coinsurance of the total cost.* **Out-Of-Network:** You pay 50% Coinsurance 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 maximum coverage per year.
Diagnostic Procedures Tests	**In-Network**: You pay a $0 - $295 copay. Prior Authorization **is not** required.	**In-Network**: You pay a $0 - $150 copay. Prior Authorization **is** required.
Diagnostic Radiological Services	**In-Network**: You pay a $0 - $150 copay.	**In-Network**: You pay a $0 - $300 copay.
Emergency Care	You pay a $100 copay.	You pay a $110 copay.

Cost	2024 (this year)	2025 (next year)
Ground Ambulance Services	**In-Network**: You pay a $295 copay. **Out-of-Network**: You pay a $295 copay.	**In-Network**: You pay a $310 copay. **Out-of-Network**: You pay a $325 copay.
Group Sessions for Mental Health Specialty Services	**In-Network:** You pay a $35 copay.	**In-Network:** You pay a $50 copay.
Group Sessions for Outpatient Substance Abuse	**In-Network**: You pay a $35 copay.	**In-Network**: You pay a $40 copay.
Group Sessions for Psychiatric Services	**In-Network**: You pay a $35 copay.	**In-Network**: You pay a $45 copay.
Individual Sessions for Outpatient Substance Abuse	**In-Network**: You pay a $35 copay.	**In-Network**: You pay a $40 copay.
Individual Sessions for Psychiatric Services	**In-Network**: You pay a $35 copay.	**In-Network**: You pay a $45 copay.
Individual Sessions Mental Health Specialty Services	**In-Network:** You pay a $35 copay.	**In-Network:** You pay a $50 copay.
Inpatient Hospital Acute	**In-Network:** You pay a $350 copay per day for days 1-4. You pay a $0 copay per day for days 5-90. **Out-of-Network:** You pay 20% of the total cost.	**In-Network:** You pay a $465 copay per day for days 1-2. You pay a $0 copay per day for days 3-90. **Out-of-Network:** You pay 40% of the total cost.
Inpatient Hospital Psychiatric	**In-Network:** You pay a $645 copay per day for days 1-3. You pay a $0 copay per day for days 4-90.	**In-Network:** You pay a $675 copay per day for days 1-3. You pay a $0 copay per day for days 4-90.
Intensive Cardiac Rehabilitation Services	**In-Network:** You pay a $55 copay. Prior Authorization **is not** required.	**In-Network:** You pay a $45 copay. Prior Authorization **is** required.
Observation Services	**In-Network**: You pay a $375 copay.	**In-Network**: You pay a $325 copay.

Cost	2024 (this year)	2025 (next year)
Occupational Therapy Services	**In-Network:** You pay a $25 copay.	**In-Network:** You pay a $35 copay.
Opioid Treatment Program Service	Prior authorization **is not** required.	Prior authorization **is** required.
Other Health Care Professional Services	**In-Network:** You pay a $10 - $35 copay.	**In-Network:** You pay a $10 - $30 copay.
Outpatient Hospital Services	**In-Network:** You pay a $0 - $350 copay.	**In-network:** You pay a $0 - $295 copay.
Outpatient X-Ray Services	**In-Network:** You pay a $10 - $20 copay.	**In-Network:** You pay a $10 copay.
Over-the-Counter (OTC) Items	The benefit is $30 every 3 months (per quarter) for a total of $120 per year.	The benefit is $54 every 3 months (per quarter) for a total of $216 per year.
Partial Hospitalization **Partial hospitalization provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care. Your care plan must state that you require at least 20 hours of therapeutic services per week. You get treatment during the day with no overnight stay.**	**In-Network:** You pay a $55 copay. Prior Authorization **is not** required.	**In-Network:** You pay a $80 copay. Prior Authorization **is** required.
Physical Therapy and Speech Language Pathology Services	**In-Network**: You pay a $25 copay.	**In-Network**: You pay a $15 copay.
Physician Specialist Services	**In-Network:** You pay a $30 copay.	**In-Network:** You pay a $17 - $47 copay.
Podiatry Services	**In-Network:** You pay a $35 copay.	**In-Network:** You pay a $40 copay.

Cost	2024 (this year)	2025 (next year)
Preventive Dental (Non-Medicare)	**In-Network:** You pay $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 $2,000 preventive/ comprehensive maximum coverage per year.**	**In-Network:** You pay $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 maximum coverage per year.**
Pulmonary Rehabilitation Services	**In-Network:** You pay a $15 copay. Prior Authorization **is not** required.	**In-Network:** You pay a $25 copay. Prior Authorization **is** required.
Skilled Nursing Facility (SNF)	**In-Network:** You pay a $0 per day for days 1-20. You pay a $203 per day for days 21-100.	**In-Network:** You pay a $0 per day for days 1-20. You pay a $214 per day for days 21-100.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	**In-Network:** You pay a $25 copay. Prior Authorization **is not** required.	**In-Network:** You pay a $20 copay. Prior Authorization **is** required.

drugs on this tier. For 2024 you paid a $100 copayment (standard), $100 copayment (preferred), and $100 (mail-order) for drugs on Tier 4. For 2025 you will pay 42% coinsurance (standard), 40% coinsurance (preferred), and 40% coinsurance (mail-order) for drugs on this tier. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you.	*Preferred cost sharing:* You pay $10 per prescription Your cost for a one-month mail-order prescription is $10 **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $47 per prescription *Preferred cost sharing:* You pay $42 per prescription You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $42 **Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay $100 per prescription *Preferred cost sharing:* You pay $100 per prescription Your cost for a one-month mail-order prescription is $100 **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 31% of the total cost *Preferred cost sharing:* You pay 31% of the total cost Your cost for a one-month mail-order prescription is 31% of the total cost **Tier 6 (Select Care Drugs):** *Standard cost sharing:* You pay $5 per prescription *Preferred cost sharing:* You pay $0 per prescription Your cost for a one-month mail-order prescription is $0	*Preferred cost sharing:* You pay $10 per prescription Your cost for a one-month mail-order prescription is $10 **Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay 25% of the total cost *Preferred cost sharing:* You pay 21% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 21% of the total cost **Tier 4 (Non-Preferred Drug):** *Standard cost sharing:* You pay 42% of the total cost *Preferred cost sharing:* You pay 40% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 40% of the total cost **Tier 5 (Specialty Tier):** *Standard cost sharing:* You pay 30% of the total cost *Preferred cost sharing:* You pay 30% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 30% of the total cost

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
    - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS**. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the South Carolina AIDS Drug Assistance Program (administered by the South Carolina Department of Public Health). For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call the South Carolina AIDS Drug Assistance Program at 1-800-856-9954. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 833-730-1719 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from BlueCross Total Value Upstate

Questions? We're here to help. Please call Customer Service at 1-855-204-2744. (TTY only, call 711.) We are available for phone calls 8 am to 8 pm, Eastern Time, Monday through Friday. Our automated phone system handles calls received after 8 pm and on Saturdays, Sundays and holidays. From October 1 through March 31, we are available 8 am to 8 pm, Eastern Time, seven days a week. Calls to these numbers are free.

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for BlueCross Total Value Upstate. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.SCBluesMedAdvantage.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.SCBluesMedAdvantage.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/Drug List)*.

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-

you.pdf) or 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.

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。