Annual Notice of Changes for 2027

BlueCross Total Value℠ Lowcountry (PPO)

Jan. 1, 2027 – Dec. 31, 2027

855-204-2744 | TTY 711

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

Monday – Friday, 8 a.m. to 8 p.m.
(All Other Times)

South Carolina

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

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BlueCross Total Value Lowcountry (PPO) offered by BlueCross BlueShield of South Carolina

Annual Notice of Change for 2027

You're enrolled as a member of BlueCross Total Value Lowcountry.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in BlueCross Total Value Lowcountry.
- To change to a **different plan**, visit Medicare.gov or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at SCBluesMedAdvantage.com or call Customer Service at 1-855-204-2744 (TTY users call 711) to get a copy by mail.

More Resources

- Call Customer Service number at 1-855-204-2744 (TTY users 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.
- This information is available in alternate formats, including large print. Please call Customer Service if you need plan information in other formats.

About BlueCross Total Value Lowcountry

- BlueCross Total Value Lowcountry is a Medicare Advantage Preferred Provider Organization plan with a Medicare contract. Enrollment in BlueCross Total Value Lowcountry depends on contract renewal.
- When this material says "we," "us," or "our," it means BlueCross BlueShield of South Carolina. When it says "plan" or "our plan," it means BlueCross Total Value Lowcountry.
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in BlueCross Total Value Lowcountry.** Starting January 1, 2027, you'll get your medical

and drug coverage through BlueCross Total Value Lowcountry. Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	$0	**$0**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From in-network providers: $9,250 From in-network and out-of-network providers combined: $13,900	**From in-network providers: $9,850 From in-network and out-of-network providers combined: $13,900**
Primary care office visits	**In-Network:** You pay a $0 copayment per visit. **Out-of-Network:** You pay a $40 copayment per visit.	**In-Network: You pay a $0 copayment per visit. Out-of-Network: You pay a $40 copayment per visit.**
Specialist office visits	**In-Network:** You pay a $45 copayment per visit. **Out-of-Network:** You pay a $55 copayment per visit.	**In-Network: You pay a $45 copayment per visit. Out-of-Network: You pay a $55 copayment per visit.**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**In-Network:** You pay a $425 copayment per day; days 1 through 4. You pay a $0 copayment per day; days 5 through 90. **Out-of-Network:** You pay 40% coinsurance per admission.	**In-Network: You pay a $450 copayment per day; days 1 through 5. You pay a $0 copayment per day; days 6 through 90. Out-of-Network: You pay 40% coinsurance per admission.**

	2026 (this year)	2027 (next year)
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible $615 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: $10 Drug Tier 3: 25% You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 4: 30% You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 5: 25% You pay no more than $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: $5	**Part D drug coverage deductible** **$700** **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: $10** **Drug Tier 3: 25%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 4: 31%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 5: 25%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 6: $0** **Copayment/Coinsurance Preferred Retail during the Initial Coverage Stage (30-day supply):** **Drug Tier 1: $0** **Drug Tier 2: $5**

	2026 (this year)	2027 (next year)
	Drug Tier 3: 20% You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 4: 28% You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 5: 25% You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 6: $0 Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	**Drug Tier 3: 20%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 4: 30%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 5: 25%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 6: $0** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0	**$0**
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	There was no Part B premium reduction.	**$1**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2026 (this year)	2027 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers **count** toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$9,250	**$9,850** **Once you've paid $9,850 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.**
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	$13,900	**$13,900** **Once you've paid $13,900 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider Directory* SCBluesMedAdvantage.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at SCBluesMedAdvantage.com.
- Call Customer Service at 1-855-204-2744 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at 1-855-204-2744 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2027 *Pharmacy Directory* SCBluesMedAdvantage.com to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at SCBluesMedAdvantage.com.
- Call Customer Service at 1-855-204-2744 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-855-204-2744 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2026 (this year)	2027 (next year)
Ambulance Services - Air Ambulance	**In-Network:** You pay a $350 copayment. **Out-of-Network:** You pay a $365 copayment.	**In-Network: You pay a $550 copayment.** **Out-of-Network: You pay a $550 copayment.**
Ambulance Services-Ground Ambulance	**In-Network:** You pay a $350 copayment. **Out-of-Network:** You pay a $365 copayment.	**In-Network: You pay a $525 copayment.** **Out-of-Network: You pay a $525 copayment.**

	2026 (this year)	2027 (next year)
Ambulatory Surgical Center (ASC) Services	**In-Network:** You pay a $0 - $195 copayment.	**In-Network: You pay a $0 - $150 copayment.**
Comprehensive Dental (Non-Medicare Covered)	**In-Network:** You pay 50% coinsurance of the total cost.* *Comprehensive Dental services are included in your $1,500 comprehensive limit per year.	**Comprehensive Dental is not covered.**
Contact Lenses (Non-Medicare)	**Out-of-Network:** You pay a $0 copayment.	**Out-of-Network: You pay 90% coinsurance of the total cost.**
Eye Exams - Routine (Non-Medicare)	**Out-of-Network:** You pay a $0 copayment.	**Out-of-Network: You pay 90% coinsurance of the total cost.**
Eyeglass frames - (Non-Medicare)	**In-Network:** You pay a $0 copayment for frames. **Out-of-Network:** You pay a $0 copayment.	**In-Network: You receive a $100 - $150 allowance for frames.** **Out-of-Network: You pay 90% coinsurance of the total cost.**
Eyeglass lenses - (Non-Medicare)	**In-Network:** You pay a $0 copayment for Single, Bifocal, and Trifocal lenses. **Out-of-Network:** You pay a $0 copayment.	**In-Network: You pay a $25 - $135 copayment for Single, Bifocal, Trifocal, and Progressive lenses.** **Out-of-Network: You pay 90% coinsurance of the total cost.**
Fitness Benefit	**In-Network:** You pay a $0 copayment for a gym membership through a	**In-Network: You pay a $0 copayment for a Health participating**

	2026 (this year)	2027 (next year)
Fitness Benefit (continued)	contracted vendor. (Health participating fitness center and/or home fitness options and access to digital workouts). You must use an approved BlueCross contracted vendor for this benefit. **Out-of-Network:** You pay a $0 copayment. You must use an approved BlueCross contracted vendor for this benefit.	**fitness center, home fitness kit (1 per benefit year), and access to digital workouts. Home fitness kit options (1 per benefit year) – Strength Kit (includes resistance tubing), Toning Kit (includes Pilates ball), Yoga Kit (includes yoga mat), Self-Care Kit (includes foam roller), and Walking Kit (includes pedometer).** **Out-of-Network: You pay 90% coinsurance of the total cost.**
Fitting/Evaluation for Hearing Aid	**Out-of-Network**: You pay 50% coinsurance of the total cost.	**Out-of-Network: You pay 90% coinsurance of the total cost.**
Hearing Aids (all types)	**Out-of-Network:** You pay a $0 copayment. You must see a TruHearing provider to use this benefit.	**Out-of-Network: You pay 90% coinsurance of the total cost.**
Inpatient Hospital - Acute	**In-Network:** You pay a $425 copayment per day; days 1-4. You pay a $0 copayment per day; days 5-90.	**In-Network: You pay a $450 copayment per day; days 1-5. You pay a $0 copayment per day; days 6-90.**
Inpatient Hospital Psychiatric	**In-Network:** You pay a $690 copayment per day; days 1-3. You pay a $0 copayment per day; days 4-90.	**In-Network: You pay a $695 copayment per day; days 1-3. You pay a $0 copayment per day; days 4-90.**

	2026 (this year)	2027 (next year)
Meal Benefit	**Out-of-Network:** You pay a $0 copayment.	**Out-of-Network: You pay 90% coinsurance of the total cost.**
Medicare-covered Dental Services	**Out-of-Network:** You pay 50% coinsurance of the total cost.	**Out-of-Network: You pay a $50 copayment.**
Medicare-covered Diabetic Monitors	**In-Network:** You pay 0% coinsurance for BlueCross preferred brand glucose monitors. **Note:** In case of an approved medical exception, other brands may be covered at 20% coinsurance of the total cost.	**In-Network: You pay 0% coinsurance for Preferred brand glucose monitors. You pay 20% coinsurance of the total cost for other brands with approved medical exception.**
Medicare-covered Diagnostic Radiological Services	**In-Network:** You pay a $0 - $300 copayment.	**In-Network: You pay a $0 - $325 copayment.**
Medicare-covered Eye Exams	**Out-of-Network**: You pay 50% coinsurance of the total cost.	**Out-of-Network: You pay a $50 copayment.**
Medicare-covered Eyewear	**Out-of-Network:** You pay a $0 copayment.	**Out-of-Network: You pay a $50 copayment.**
Medicare-covered Hearing Exams	**Out-of-Network:** You pay 50% coinsurance of the total cost.	**Out-of-Network: You pay a $45 copayment.**
Medicare-covered Lab Services	**In-Network:** You pay a $0 - $15 copayment.	**In-Network: You pay $20 copayment.**
Medicare-covered Observation Services	**In-Network:** You pay a $375 copayment.	**In-Network: You pay a $400 copayment.**

	2026 (this year)	2027 (next year)
Medicare-covered Physical Therapy and Speech Pathology Services	**In-Network:** You pay $25 copayment.	**In-Network: You pay $35 copayment.**
Other Health Care Professional Services	**In-Network:** You pay a $10 - $30 copayment.	**In-Network: You pay a $10 - $40 copayment.**
Outpatient Hospital Services	**In-Network:** You pay a $0 - $315 copayment.	**In-Network: You pay a $0 - $450 copayment.**
Over-the-Counter (OTC) Items	**In-Network:** You receive $25 every three months (per quarter) for a total of $100 per year. **Out-of-Network:** You receive $25 every three months (per quarter) for a total of $100 per year.	**In-Network: You receive $5 every three months (per quarter) for a total of $20 per year.** **Out-of-Network: You receive $5 every three months (per quarter) for a total of $20 per year.** **Reimbursement for eligible items will be reimbursed after submitting valid receipts and reimbursement request form.**
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**	**In-Network:** You pay a $105 copayment.	**In-Network: You pay a $115 copayment.**

	2026 (this year)	2027 (next year)
Partial Hospitalization (continued) **day with no overnight stay.**		
Preventive Dental (Non-Medicare Covered)	**In-Network:** You pay a $0 copayment. * 2 preventive dental visits per year. Oral exam, cleaning, 1 dental bitewing x-ray, 2 fillings (fluoride treatment not covered).	**In-Network: You pay a $0 copayment.** *** 2 preventive dental visits per year. Oral exam, cleaning, 1 dental bitewing x-ray, 2 fillings (fluoride treatment not covered).** **Maximum allowable amount is $1,000.**
Psychiatric Services Medicare-covered Group Sessions	**In-Network:** You pay a $45 copayment.	**In-Network: You pay a $50 copayment.**
Psychiatric Services Medicare-covered Individual Sessions	**In-Network:** You pay a $45 copayment.	**In-Network: You pay a $50 copayment.**
Routine Hearing Exams (Non-Medicare)	**Out-of-Network**: You pay a $45 copayment.	**Out-of-Network: You pay 50% coinsurance of the total cost.**
Skilled Nursing Facility (SNF)	**In-Network:** You pay a $0 copayment per day; days 1-20. You pay a $218 copayment per day; days 21-100.	**In-Network: You pay a $0 copayment per day; days 1-20. You pay a $221 copayment per day; days 21-100.**
Transportation Services	**In-Network:** You pay a $0 copayment for 24 one-way trips per year to any health-related location. **Out-of-Network:** You pay a $0 copayment for 24	**In-Network: You pay a $0 copayment for 12 one-way trips per year to any health-related location.**

	2026 (this year)	2027 (next year)
Transportation Services (continued)	one-way trips per year to any health-related location.	**Out-of-Network: You pay 90% coinsurance of the total cost for 12 one-way trips per year to any health-related location.**
X-Ray Services	**In-Network:** You pay a $10 copayment.	**In-Network: You pay a $0 copayment.**

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically and posted online at SCBluesMedAdvantage.com.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Service at 1-855-204-2744 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you**. We sent you a separate material, called

the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2026, call Customer Service at 1-855-204-2744 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs until you reach the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach $2,400.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage

	2026 (this year)	2027 (next year)
Yearly Deductible	$615 During this stage (for a 30-day supply), you pay $5 standard cost-sharing for drugs on Tier 1 and $0 preferred cost-sharing for drugs on Tier 1. You pay $10 standard cost-sharing for drugs on Tier 2 and $5 preferred cost-sharing for drugs on Tier 2. You pay $5 standard cost-sharing for drugs on Tier 6 and $0 preferred cost-sharing for drugs on Tier 6 and the full cost of drugs on Tiers 3, 4, and 5 until you've reached the yearly deductible.	**$700** **During this stage (for a 30-day supply), you pay $5 standard cost-sharing for drugs on Tier 1 and $0 preferred cost-sharing for drugs on Tier 1. You pay $10 standard cost-sharing for drugs on Tier 2 and $5 preferred cost-sharing for drugs on Tier 2. You pay $0 standard cost-sharing for drugs on Tier 6 and $0 preferred cost-sharing for drugs on Tier 6 and the full cost of drugs on Tiers 3, 4, and 5 until you've reached the yearly deductible.**

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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. For more information about the costs of vaccines, or information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (next year)
Tier 1 (Preferred Generic):	*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.	***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.**
Tier 2 (Generic):	*Standard cost sharing:* You pay $10 per prescription. *Preferred cost sharing:* You pay $5 per prescription. Your cost for a one-month mail-order prescription is $5.	***Standard cost sharing:* You pay $10 per prescription.** ***Preferred cost sharing:* You pay $5 per prescription.** **Your cost for a one-month mail-order prescription is $5.**
Tier 3 (Preferred Brand):	*Standard cost sharing:* You pay 25% of the total cost. *Preferred cost sharing:* You pay 20% 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 20% of the total cost.	***Standard cost sharing:* You pay 25% of the total cost.** ***Preferred cost sharing:* You pay 20% 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 20% of the total cost.**

	2026 (this year)	2027 (next year)
Tier 4 (Non-Preferred Drug):	*Standard cost sharing:* You pay 30% of the total cost. *Preferred cost sharing:* You pay 28% 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 28% of the total cost.	***Standard cost sharing:* You pay 31% 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.**
Tier 5 (Specialty Tier):	*Standard cost sharing:* You pay 25% of the total cost. *Preferred cost sharing:* You pay 25% 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 25% of the total cost.	***Standard cost sharing:* You pay 25% of the total cost.** ***Preferred cost sharing:* You pay 25% 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 25% 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.	***Standard cost sharing:* You pay $0 per prescription.** ***Preferred cost sharing:* You pay $0 per prescription.** **Your cost for a one-month mail-order prescription is $0.**

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Service Area	Service area consists of: Beaufort, Berkeley, Charleston, Dorchester, Georgetown, Jasper counties.	**Service area consists of: Beaufort, Berkeley, Charleston, Colleton, Dorchester, Georgetown, Jasper counties.**

SECTION 3 How to Change Plans

To stay in BlueCross Total Value Lowcountry, you don't need to do anything. Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our BlueCross Total Value Lowcountry.

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from BlueCross Total Value Lowcountry. Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.

- **To change to Original Medicare with separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from BlueCross Total Value Lowcountry.

- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at 1-855-204-2744 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 1.1).

- **To learn more about Original Medicare and the different types of Medicare plans,** visit Medicare.gov, check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, BlueCross BlueShield of SC offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
    - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
    - Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help 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're currently enrolled, how to continue getting help, 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 payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **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 SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-833-730-1719 (TTY users should call 711) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from BlueCross Total Value Lowcountry

- **Call Customer Service at 1-855-204-2744. (TTY users call 711.)**

  We're 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 2027 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for BlueCross Total Value Lowcountry. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at SCBluesMedAdvantage.com or call Customer Service at 1-855-204-2744 (TTY users call 711) to ask us to mail you a copy.

- **Visit** SCBluesMedAdvantage.com

  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In South Carolina, the SHIP is called Insurance Counseling Assistance and Referrals for Elders (I-CARE).

Call I-CARE to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call I-CARE at 1-(803)-734-9900 or 1-800-868-9095. Learn more about I-CARE by visiting (aging.sc.gov).

Get Help 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 can call 1-877-486-2048.

- **Chat live with** Medicare.gov

  You can chat live at Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit** Medicare.gov

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2027**

  The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-204-2744 (TTY: 711) or speak to your provider.

Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

中文: 注意：如果您說[中文]，我們可以為您提供免費語言援助服務，也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-844-396-0188（TTY：711）或與您的提供者討論。(Chinese)

Tiếng Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ bổ sung phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi 1-844-389-4838 (TTY: 711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị. (Vietnamese)

РУССКИЙ: ВНИМАНИЕ! Если вы говорите на русском языке, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-844-389-4840 (TTY: 711) или обратитесь к своему поставщику услуг. (Russian)

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

Português do Brasil: ATENÇÃO: Se você fala português, há serviços gratuitos de assistência linguística disponíveis para você. Assistência e serviços auxiliares próprios para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-844-396-0182 (TTY: 711) ou fale com seu provedor. (Portuguese)

Français : NOTE : Si vous parlez français, des services gratuits d'assistance linguistique sont à votre disposition. Des aides et des services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-396-0190 (TTY : 711) ou adressez-vous à votre prestataire. (French)

ગુજરાતી: ધ્યાન આપો૭જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે- યોગ્ય ઓિકઝલરી સહાય અને ઍકસેિસબલ ફોમ□ટમાં માિહતી પૂરી પાડવા માટેની સેવાઓ પણ િવના મૂલ્યે ઉપલબ્ધ છે- 1-844-641-2898 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો- (Gujarati)

Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie unter 1-844-396-0191 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter. (German)

한국어: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-844-396-0187(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. (Korean)

العربية: تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-844-396-0189 (خدمة الهاتف النصّي: 711) أو تحدث إلى مقدم الخدمة". (Arabic)

Українська мова: УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні

допоміжні засоби й послуги для надання інформації в доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1- 844-641-2897 (TTY: 711) або зверніться до свого постачальника. (Ukrainian)

日本語: 注 : 日本語を希望する場合、無料の言語支援サービスをご利用いただけます。アクセシブル (誰でも利用できるよう配慮された) な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-844-396-0191 (TTY: 711) までお電話ください。または、ご利用の事業者にお問い合わせください。(Japanese)

ไทย: โปรดทราบ: หากคุณพูดภาษา ไทย เรามีบริการความช่วยเหลือด้านแปลภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อที่ 1-844-641-2896 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ (Thai)

ລາວ: ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-844-641-2895 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. (Lao)

िहंदी : ◻ान दें9 यिद आप िहंदी बोलते हैं, तो आपके िलए िनः शु◻ भाषा सहायता सेवाएं उपल◻ होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के िलए उपयु◻ सहायक साधन और सेवाएँ भी िनः शु◻ उपल◻ हैं। 1-844-641-2894 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। (Hindi)