

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

An Independent Licensee of the Blue Cross and Blue Shield Association

OUTLINE OF MEDICARE SELECT COVERAGE — COVER PAGE 1 of 2: BENEFIT PLANS TRADITIONAL PLAN A and MEDICARE SELECT – PLANS C and L

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

BASIC BENEFITS for Plans A – J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20 percent of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: first three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-home Recovery				At-home Recovery		At-home Recovery		At-home Recovery
				Preventive Care NOT Covered by Medicare							Preventive Care NOT Covered by Medicare

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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OUTLINE OF MEDICARE SELECT COVERAGE — COVER PAGE 2: BENEFIT PLANS TRADITIONAL PLAN A and MEDICARE SELECT PLANS – C AND L

Basic Benefits for Plans K and L include similar services as Plans A – J, but cost sharing for basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance Plus Coverage for 365 Days After Medicare Benefits End 50% Hospice Cost Sharing 50% of Medicare-eligible Expenses for the First Three Pints of Blood 50% Part B Coinsurance, Except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance Plus Coverage for 365 Days After Medicare Benefits End 75% Hospice Cost Sharing 75% of Medicare-eligible Expenses for the First Three Pints of Blood 75% Part B Coinsurance, Except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Coinsurance	75% Skilled Nursing Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT Covered by Medicare		
	\$4,620 Out-of-pocket Annual Limit***	\$2,310 Out-of-pocket Annual Limit***

** Plans K and L provide for different cost sharing items and services than Plans A – J. Once you reach the annual limit, the plans pay 100 percent of the Medicare copayments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

PREMIUM AND RENEWABILITY INFORMATION

Your policy will stay in effect as long as you pay your premiums on time. You may choose to pay premiums monthly or every three months. Premium payments are due at the beginning of the period of time for which you are paying. You may always renew your policy at the premium rate in effect at the time of renewal. Your insurance will not lapse as long as you pay your premiums on time.

Blue Cross and Blue Shield of South Carolina can only raise your premium if we raise the premium for all policies like yours in this state. If premiums change, you will be notified at least 31 days before the change, but you will not have to pay more on a premium you have paid in advance. Note that your premium increases as you enter an older attained age group. Premiums are based on your age as of December 31st of the prior year.

Age	Plan A			Plan C			Plan L Standard			Plan L Preferred		
	Monthly Bank Draft	Monthly	Quarterly	Monthly Bank Draft	Monthly	Quarterly	Monthly Bank Draft	Monthly	Quarterly	Monthly Bank Draft	Monthly	Quarterly
65	\$82.25	\$87.50	\$262.50	\$120.06	\$127.72	\$383.16	\$93.55	\$99.52	\$298.56	\$93.55	\$99.52	\$298.56
66	\$85.24	\$90.68	\$272.04	\$125.53	\$133.54	\$400.62	\$95.84	\$101.96	\$305.88	\$95.84	\$101.96	\$305.88
67	\$88.33	\$93.97	\$281.91	\$131.25	\$139.63	\$418.89	\$98.18	\$104.45	\$313.35	\$98.18	\$104.45	\$313.35
68	\$91.53	\$97.37	\$292.11	\$137.23	\$145.99	\$437.97	\$100.58	\$107.00	\$321.00	\$100.58	\$107.00	\$321.00
69	\$94.84	\$100.89	\$302.67	\$143.48	\$152.64	\$457.92	\$103.04	\$109.62	\$328.86	\$103.04	\$109.62	\$328.86
70	\$98.29	\$104.56	\$313.68	\$150.01	\$159.59	\$478.77	\$105.56	\$112.30	\$336.90	\$105.56	\$112.30	\$336.90
71	\$101.85	\$108.35	\$325.05	\$156.85	\$166.86	\$500.58	\$108.14	\$115.04	\$345.12	\$108.14	\$115.04	\$345.12
72	\$105.54	\$112.28	\$336.84	\$164.00	\$174.47	\$523.41	\$110.78	\$117.85	\$353.55	\$110.78	\$117.85	\$353.55
73	\$109.38	\$116.36	\$349.08	\$171.47	\$182.41	\$547.23	\$113.49	\$120.73	\$362.19	\$113.49	\$120.73	\$362.19
74	\$113.35	\$120.59	\$361.77	\$179.28	\$190.72	\$572.16	\$116.26	\$123.68	\$371.04	\$116.26	\$123.68	\$371.04
75	\$117.45	\$124.95	\$374.85	\$187.44	\$199.40	\$598.20	\$119.10	\$126.70	\$380.10	\$119.10	\$126.70	\$380.10
76	\$121.71	\$129.48	\$388.44	\$195.98	\$208.49	\$625.47	\$122.01	\$129.80	\$389.40	\$122.01	\$129.80	\$389.40
77	\$126.13	\$134.18	\$402.54	\$204.91	\$217.99	\$653.97	\$124.99	\$132.97	\$398.91	\$124.99	\$132.97	\$398.91
78	\$130.71	\$139.05	\$417.15	\$214.24	\$227.91	\$683.73	\$128.04	\$136.21	\$408.63	\$128.04	\$136.21	\$408.63
79	\$135.45	\$144.10	\$432.30	\$223.99	\$238.29	\$714.87	\$131.17	\$139.54	\$418.62	\$131.17	\$139.54	\$418.62
80+	\$140.37	\$149.33	\$447.99	\$234.19	\$249.14	\$747.42	\$134.36	\$142.94	\$428.82	\$134.36	\$142.94	\$428.82

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

Read Your Policy Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all the rights and duties of both you and your insurance company.

Right To Return Your Policy

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of South Carolina, Individual Products, Post Office Box 61153, Columbia, SC 29260-1153. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments, provided you have not filed any claims.

Policy Replacement

If you are replacing another health insurance policy, DO NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

- This policy may not fully cover all of your medical costs.
- Neither Blue Cross and Blue Shield of South Carolina nor its agents are connected with Medicare.
- This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the *Medicare and You* Guide for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history (if applicable). The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**Blue Cross and Blue Shield of South Carolina
Medicare (Part A) — Hospital Services — Per Benefit Period**

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,100	\$0	\$1,100 (Part A deductible)
61st through 90th day	All but \$275 a day	\$275 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$550 a day	\$550 a day	\$0
Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days, and enter a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$137.50 a day	\$0	Up to \$137.50 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and in-patient respite care	\$0	Balance of charges

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
— First \$155 of Medicare-approved amounts* (the Part B deductible)	\$0	\$0	\$155 (Part B deductible)
— Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD			
First three pints	\$0	All costs	\$0
Next \$155 of Medicare-approved amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0
MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
— First \$155 of Medicare-approved amounts*	\$0	\$0	\$155 (Part B deductible)
— Remainder of Medicare-approved amounts	80%	20%	\$0

**Blue Cross and Blue Shield of South Carolina
Medicare (Part A) — Hospital Services — Per Benefit Period**

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
Network Hospital – First 60 days	All but \$1,100	\$1,100 (Part A deductible)	\$0
Non-Network Hospital – First 60 days	All but \$1,100	\$0	\$1,000 (Part A deductible)
61st through 90th day	All but \$275 a day	\$275 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$550 a day	\$550 a day	\$0
Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare’s requirements, including having been in a hospital for at least three days, and enter a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$137.50 a day	Up to \$137.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and in-patient respite care	\$0	Balance of charges

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
— First \$155 of Medicare-approved amounts* (the Part B deductible)	\$0	\$155 (Part B deductible)	\$0
— Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD			
First three pints	\$0	First three pints	\$0
Next \$155 of Medicare-approved amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0
MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
— First \$155 of Medicare-approved amounts*	\$0	\$155 (Part B deductible)	\$0
— Remainder of Medicare-approved amounts	80%	20%	\$0
OTHER BENEFITS — Not Covered By Medicare			
FOREIGN TRAVEL — NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the first 60 days of each trip outside the USA:			
— First \$250 each calendar year	\$0	\$0	\$250
— Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**Blue Cross and Blue Shield of South Carolina
Medicare (Part A) — Hospital Services — Per Benefit Period**

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$2,310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100 percent of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN L PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
Network Hospital – First 60 days	All but \$1,100	\$825 (75% of Part A deductible)	\$275 (25% of Part A deductible)♦
Non-Network Hospital – First 60 days	All but \$1,100	\$0	\$1,100 (Part A Deductible)
61st through 90th day	All but \$275 a day	\$275 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$550 a day	\$550 a day	\$0
Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
— Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare’s requirements, including having been in a hospital for at least three days, and enter a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$137.50 a day	Up to \$103.13 a day	Up to \$34.37 a day♦
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments♦

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Medicare (Part B) — Medical Services — Per Calendar Year

**** Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN L PAYS	YOU PAY*
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as: physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
— First \$155 of Medicare-approved amounts**** (the Part B deductible)	\$0	\$0	\$155 (Part B deductible)****♦
— Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
— Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,310])*
BLOOD			
First three pints	\$0	75%	25% ♦
Next \$155 of Medicare-approved amounts****	\$0	\$0	\$155 (Part B deductible)♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0
MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
— First \$155 of Medicare-approved amounts****	\$0	\$0	\$155 (Part B deductible)♦
— Remainder of Medicare-approved amounts	80%	15%	5% ♦

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$2,310 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.



South Carolina

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Blue Cross® and Blue Shield® of South Carolina

Outline of Medicare Select Coverage

Benefit Plans A, C and L