

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
 An Independent Licensee of the Blue Cross and Blue Shield Association
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE 1 of 2:

BENEFIT PLANS TRADITIONAL PLAN A, MEDICARE SELECT – PLAN B, MEDICARE SELECT – PLAN D and MEDICARE SELECT – PLAN F

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 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% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: first three pints of blood each year.

Traditional Plan A	Medicare Select Plan B	C	Medicare Select Plan D	E	Medicare Select Plan 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	
		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 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	
			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.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

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OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE 2:

BENEFIT PLANS TRADITIONAL PLAN A, MEDICARE SELECT – PLAN B, MEDICARE SELECT – PLAN D and MEDICARE SELECT – PLAN F

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% 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

Except as stated in the following paragraph, 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 payment is due at the beginning of the period of time you pay for. 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. We, 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.

This policy is subject to nonrenewal by the company if the Secretary of Health and Human Services determines that this Medicare Select policy should be discontinued. In the event of discontinuance, the Continuation of Coverage provision on page 12 would apply.

Age	Traditional Plan A			Medicare Select - Plan B		
	Monthly Bank Draft	Monthly	Quarterly	Monthly Bank Draft	Monthly	Quarterly
65	\$82.25	\$87.50	\$262.50	\$91.76	\$97.62	\$292.86
66	\$85.24	\$90.68	\$272.04	\$95.34	\$101.43	\$304.29
67	\$88.33	\$93.97	\$281.91	\$99.05	\$105.37	\$316.11
68	\$91.53	\$97.37	\$292.11	\$102.91	\$109.48	\$328.44
69	\$94.84	\$100.89	\$302.67	\$106.93	\$113.76	\$341.28
70	\$98.29	\$104.56	\$313.68	\$111.10	\$118.19	\$354.57
71	\$101.85	\$108.35	\$325.05	\$115.43	\$122.80	\$368.40
72	\$105.54	\$112.28	\$336.84	\$119.94	\$127.60	\$382.80
73	\$109.38	\$116.36	\$349.08	\$124.61	\$132.56	\$397.68
74	\$113.35	\$120.59	\$361.77	\$129.47	\$137.73	\$413.19
75	\$117.45	\$124.95	\$374.85	\$134.52	\$143.11	\$429.33
76	\$121.71	\$129.48	\$388.44	\$139.76	\$148.68	\$446.04
77	\$126.13	\$134.18	\$402.54	\$145.21	\$154.48	\$463.44
78	\$130.71	\$139.05	\$417.15	\$150.87	\$160.50	\$481.50
79	\$135.45	\$144.10	\$432.30	\$156.76	\$166.77	\$500.31
80+	\$140.37	\$149.33	\$447.99	\$162.86	\$173.26	\$519.78

PREMIUM AND RENEWABILITY INFORMATION

Continued

Age	Medicare Select - Plan D			Medicare Select - Plan F		
	Monthly Bank Draft	Monthly	Quarterly	Monthly Bank Draft	Monthly	Quarterly
65	\$98.54	\$104.83	\$314.49	\$127.57	\$135.71	\$407.13
66	\$102.96	\$109.53	\$328.59	\$133.22	\$141.72	\$425.16
67	\$107.57	\$114.44	\$343.32	\$139.13	\$148.01	\$444.03
68	\$112.38	\$119.55	\$358.65	\$145.30	\$154.57	\$463.71
69	\$117.42	\$124.91	\$374.73	\$151.75	\$161.44	\$484.32
70	\$122.69	\$130.52	\$391.56	\$158.49	\$168.61	\$505.83
71	\$128.19	\$136.37	\$409.11	\$165.52	\$176.09	\$528.27
72	\$133.93	\$142.48	\$427.44	\$172.86	\$183.89	\$551.67
73	\$139.93	\$148.86	\$446.58	\$180.54	\$192.06	\$576.18
74	\$146.20	\$155.53	\$466.59	\$188.55	\$200.59	\$601.77
75	\$152.75	\$162.50	\$487.50	\$196.92	\$209.49	\$628.47
76	\$159.60	\$169.79	\$509.37	\$205.65	\$218.78	\$656.34
77	\$166.75	\$177.39	\$532.17	\$214.78	\$228.49	\$685.47
78	\$174.22	\$185.34	\$556.02	\$224.30	\$238.62	\$715.86
79	\$182.02	\$193.64	\$580.92	\$234.25	\$249.20	\$747.60
80+	\$190.15	\$202.29	\$606.87	\$244.64	\$260.26	\$780.78

NOTE: Medicare Select contracts include restricted network provisions. You must use providers who participate in a network program to receive full Medicare supplement benefits. You have the right to purchase any Medicare supplement contract, without restricted network provisions, offered by Blue Cross and Blue Shield of South Carolina.

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 29202-3133. 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 *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 — Traditional Plan A
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 consecutive days.

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.

Traditional Plan A
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			
Blood 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 Select - Plan B
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 consecutive days.

SERVICES	MEDICARE PAYS	MEDICARE SELECT PLAN B 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	\$1,100 (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	First 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

**Medicare Select - Plan B will pay the Part A deductible or its contractually agreed upon amount. No benefits for the Medicare Part A deductible will be paid when hospitalized in a non-network hospital unless the hospitalization was for emergency treatment as defined by Medicare (Title XVIII of the Social Security Act as amended) or when the services are not available at a network hospital.

Medicare Select - Plan B
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	MEDICARE SELECT PLAN B 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	First three pints	\$0
Next \$155 of Medicare-approved amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Blood 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 Select - Plan D
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 consecutive days.

SERVICES	MEDICARE PAYS	MEDICARE SELECT PLAN D 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	\$1,100 (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 \$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

** Medicare Select - Plan D will pay the Medicare Part A deductible or its contractually agreed upon amount. No benefits for the Medicare Part A deductible will be paid when hospitalized in a non-network hospital unless the hospitalization was for emergency treatment as defined by Medicare (Title XVIII of the Social Security Act as amended) or when the services are not available at a network hospital.

*****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 Select - Plan D
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	MEDICARE SELECT PLAN D 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 test, durable medical equipment: — First \$155 of Medicare-approved amounts* (the Part B deductible) — Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES Blood tests for diagnostic services	100%	\$0	\$0
MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment: — First \$155 of Medicare-approved amounts* — Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B deductible) \$0
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan — Benefit for each visit — Number of visits covered (must be within eight weeks of last Medicare-approved visit) — Calendar year maximum	\$0 \$0 \$0	Actual charges up to \$40 a visit Up to the number of Medicare-approved visits not to exceed seven each week \$1600	Balance of charges
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 — Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

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

* A benefit period begins on the first day you receive services 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 consecutive days.

SERVICES	MEDICARE PAYS	MEDICARE SELECT PLAN F 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	\$1,100 (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 \$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

** Medicare Select - Plan F will pay the Medicare Part A deductible or its contractually agreed upon amount. No benefits for the Medicare Part A deductible will be paid when hospitalized in a non-network hospital unless the hospitalization was for emergency treatment as defined by Medicare (Title XVIII of the Social Security Act as amended) or when the services are not available at a network hospital.

*****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 Select - Plan F
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	MEDICARE SELECT PLAN F 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	100%	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$155 of Medicare-approved amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Blood 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

HOSPITALS THAT ARE NOT CERTIFIED BY THE MEDICARE PROGRAM

Some hospitals are not certified by the Medicare program. The Medicare Select Plans B, D and F will pay the Medicare Part A deductible for a noncertified Medicare hospital when services are recognized by the Medicare program as an emergency.

Emergency treatment or care means treatment or care for patients with unforeseen severe or life-threatening illness, injury or conditions that require immediate intervention to prevent death or serious impairment of your health or bodily function.

CONTINUATION OF COVERAGE

The Medicare Select Plans B, D and F provide for continuation of coverage. If the Medicare Select policy is discontinued, you may purchase, without evidence of insurability, any Medicare supplement contract offered by Blue Cross and Blue Shield of South Carolina which has comparable or lesser benefits and which does not contain a restricted network provision. A Medicare supplement contract is considered to have comparable or lesser benefits unless it has one or more significant benefits not included in the contract being offered.

GRIEVANCE PROCEDURES

To file a formal grievance, concerning denied benefits or any aspect of Blue Cross and Blue Shield of South Carolina's administration of the Medicare Select Plan or the provision of services by a network hospital, you must write to the Director of Individual Products, Blue Cross and Blue Shield of South Carolina, Post Office Box 61153, Columbia, South Carolina 29260-1153. You should complete the "Request for Review," and attach pertinent medical records or other information that you have to support your grievance.

You may also request a description of any pertinent records that Blue Cross and Blue Shield of South Carolina used to make its original decision to deny the claim in whole or in part. The Director of Individual Products will have the grievance researched and prepare a comprehensive problem statement. This statement will be presented to the Appeals Review Committee (or its designee) that will conduct a thorough investigation. The Appeals Review Committee is composed of the Medical Director of Blue Cross and Blue Shield of South Carolina, the Vice President of Group and Individual Operations and the Claims Supervisor for Individual Products. Formal notification of the findings of the investigation will be made in writing to all parties involved. You will receive a response within 30 days of the filing.

For grievances relating to quality of care or service concerns, you will be notified that action is being taken. You may contact the Director of Individual Products for information regarding disposition.

If medical records or other essential information is not received by Blue Cross and Blue Shield of South Carolina within 30 days, the grievance will be considered closed until the requested information is received. You will be notified that the grievance has been closed.

If there are special circumstances that require an extensive review, the final response will be made within 60 days of receipt of the grievance. You will be notified if additional time is needed to complete the response.



South Carolina

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

Blue Cross® and Blue Shield® of South Carolina

Outline of Medicare Select Coverage

Benefit Plans A, B, D, and F

13154M

Ord. # 13154M (Rev. 12/09)

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Association, an association of independent
Blue Cross and Blue Shield plans