BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

An Independent Licensee of the Blue Cross and Blue Shield Association

OUTLINE OF BLUE SELECT® COVERAGE — COVER PAGE 1 of 2:
BENEFIT PLANS TRADITIONAL A and BLUE SELECT PLANS – C, D and F

This 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. Plans E, H, I and J are no longer available for sale after June 1, 2011.

BASIC BENEFITS:

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require you to pay a portion of Part B coinsurance or copayments.

Blood: first three pints of blood each year.

Hospice: Part A coinsurance

A	Select B	C	Select D	Select F F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,200. 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 BLUE SELECT COVERAGE — COVER PAGE 2:
BENEFIT PLANS TRADITIONAL A and BLUE SELECT PLANS – C, D and F

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit and up to $50 copayment for emergency room
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $5,120; paid at 100% after limit reached	Out-of-pocket limit $2,560; paid at 100% after limit reached		

PREMIUM AND RENEWABILITY INFORMATION

Your policy will stay in effect as long as you pay your premiums on time. You can 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 can 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.

	Plan A		Select Plan C		Select Plan D		Select Plan F	
Age	Monthly Bank Draft	Monthly	Monthly Bank Draft	Monthly	Monthly Bank Draft	Monthly	Monthly Bank Draft	Monthly
65	$81.59	$86.80	$119.08	$126.68	$97.75	$103.99	$126.54	$134.62
66	$84.85	$90.27	$124.96	$132.94	$102.50	$109.04	$132.62	$141.09
67	$88.24	$93.87	$131.13	$139.50	$107.47	$114.33	$139.01	$147.88
68	$91.77	$97.63	$137.59	$146.37	$112.69	$119.88	$145.69	$154.99
69	$95.44	$101.53	$144.38	$153.60	$118.17	$125.71	$152.72	$162.47
70	$99.26	$105.60	$151.49	$161.16	$123.90	$131.81	$160.07	$170.29
71	$103.24	$109.83	$158.97	$169.12	$129.91	$138.20	$167.78	$178.49
72	$107.37	$114.22	$166.82	$177.47	$136.23	$144.93	$175.85	$187.07
73	$111.66	$118.79	$175.04	$186.21	$142.84	$151.96	$184.32	$196.09
74	$116.14	$123.55	$183.68	$195.40	$149.78	$159.34	$193.19	$205.52
75	$120.78	$128.49	$192.73	$205.03	$157.06	$167.09	$202.49	$215.41
76	$125.62	$133.64	$202.25	$215.16	$164.69	$175.20	$212.23	$225.78
77	$130.65	$138.99	$212.22	$225.77	$172.69	$183.71	$222.45	$236.65
78	$135.87	$144.54	$222.68	$236.89	$181.07	$192.63	$233.16	$248.04
79	$141.32	$150.34	$233.67	$248.59	$189.87	$201.99	$244.38	$259.98
80+	$146.96	$156.34	$245.19	$260.84	$199.10	$211.81	$256.15	$272.50

Rates may be reduced by 5% when at least two or more members of the same household purchase qualifying Medicare Supplement coverage through Blue Cross Blue Shield of South Carolina.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for an effective date on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale after June 1, 2011.

Read Your Policy Very 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 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.

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 **$1,316**	**$0**	**$1,316** (Part A deductible)
61st through 90th day	All but **$329** a day	**$329** a day	**$0**
91st day and after:			
– While using 60 lifetime reserve days	All but **$658** a day	**$658** 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 entered 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 **$164.50** a day	**$0**	Up to **$164.50** 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	**$0**

****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 $183 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
MEDICARE EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREAMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
– First $183 of Medicare-approved amounts*	$0	$0	**$183** (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 $183 of Medicare-approved amounts*	$0	$0	**$183** (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 $183 of Medicare-approved amounts*	$0	$0	**$183** (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

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 in a row days.

SERVICES	MEDICARE PAYS	SELECT PLAN C PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
Network Hospital – First 60 days	All but **$1,316**	**$1,316** (Part A deductible)**	**$0**
Non-Network Hospital – First 60 days	All but **$1,316**	**$0**	**$1,316** (Part A deductible)
61st through 90th day	All but **$329** a day	**$329** a day	**$0**
91st day and after:			
– While using 60 lifetime reserve days	All but **$658** a day	**$658** 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 entered 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 **$164.50** a day	Up to **$164.50** 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	**$0**

**Blue Select – Plan C 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 (Part B) — Medical Services — Per Calendar Year

* Once you have been billed $183 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	SELECT PLAN C PAYS	YOU PAY
MEDICARE EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREAMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
– First $183 of Medicare-approved amounts*	$0	**$183** (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	**All costs**	$0
Next $183 of Medicare-approved amounts*	$0	**$183** (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 $183 of Medicare-approved amounts*	$0	**$183** (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 beginning 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

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 in a row days.

SERVICES	MEDICARE PAYS	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 **$1,316**	**$1,316** (Part A deductible)**	**$0**
Non-Network Hospital – First 60 days	All but **$1,316**	**$0**	**$1,316** (Part A deductible)
61st through 90th day	All but **$329** a day	**$329** a day	**$0**
91st day and after:			
– While using 60 lifetime reserve days	All but **$658** a day	**$658** 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 entered 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 **$164.50** a day	Up to **$164.50** 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	**$0**

**Blue 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 (Part B) — Medical Services — Per Calendar Year
* Once you have been billed $183 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	SELECT PLAN D PAYS	YOU PAY
MEDICARE EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREAMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
– First $183 of Medicare-approved amounts*	$0	$0	**$183** (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 $183 of Medicare-approved amounts*	$0	$0	**$183** (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 $183 of Medicare-approved amounts*	$0	$0	**$183** (Part B deductible)
– 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 beginning 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

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	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 **$1,316**	**$1,316** (Part A deductible)**	**$0**
Non-Network Hospital – First 60 days	All but **$1,316**	**$0**	**$1,316** (Part A deductible)
61st through 90th day	All but **$329** a day	**$329** a day	**$0**
91st day and after:			
– While using 60 lifetime reserve days	All but **$658** a day	**$658** 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 entered 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 **$164.50** a day	Up to **$164.50** 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	**$0**

**Blue 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 (Part B) — Medical Services — Per Calendar Year

* Once you have been billed $183 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	SELECT PLAN F PAYS	YOU PAY
MEDICARE EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREAMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
– First $183 of Medicare-approved amounts*	$0	**$183** (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 $183 of Medicare-approved amounts*	$0	**$183** (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 $183 of Medicare-approved amounts*	$0	**$183** (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 beginning 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 WHICH ARE NOT CERTIFIED BY THE MEDICARE PROGRAM

Some hospitals are not certified by the Medicare program. The Blue Select – Plans C, 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

Blue Select policies provide for continuation of coverage. If a Blue Select policy is discontinued, you can 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 a Blue 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 can 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 can 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 Blue Select® Coverage

Benefit Plans – Traditional Plan A and Select Plans C, D and F

13079M (Rev. 1/17) Ord.# 13079M

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در بارهی این برنامهی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شمارهی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)