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 – B, G 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	D	Select F	F*	Select 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 $2,340 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,340. 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

An Independent Licensee of the Blue Cross and Blue Shield Association

OUTLINE OF BLUE SELECT COVERAGE — COVER PAGE 2:
BENEFIT PLANS TRADITIONAL A and BLUE SELECT PLANS – B, G 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 $5,880; paid at 100% after limit reached	Out-of-pocket limit $2,940; 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 B				Select Plan G				Select Plan F			
	Female Monthly Bank Draft	Female Monthly	Male Monthly Bank Draft	Male Monthly	Female Monthly Bank Draft	Female Monthly	Male Monthly Bank Draft	Male Monthly	Female Monthly Bank Draft	Female Monthly	Male Monthly Bank Draft	Male Monthly	Female Monthly Bank Draft	Female Monthly	Male Monthly Bank Draft	Male Monthly
Age																
65	$93.63	$99.61	$104.04	$110.68	$104.44	$111.11	$116.05	$123.46	$127.53	$135.67	$141.70	$150.74	$145.21	$154.48	$161.34	$171.64
66	$97.84	$104.09	$108.72	$115.66	$109.15	$116.12	$121.28	$129.02	$133.26	$141.77	$148.07	$157.52	$151.73	$161.42	$168.60	$179.36
67	$102.24	$108.77	$113.61	$120.86	$114.06	$121.34	$126.73	$134.82	$139.26	$148.15	$154.73	$164.61	$158.57	$168.69	$176.18	$187.43
68	$106.86	$113.68	$118.73	$126.31	$119.19	$126.80	$132.44	$140.89	$145.53	$154.82	$161.70	$172.02	$165.71	$176.29	$184.13	$195.88
69	$111.66	$118.79	$124.07	$131.99	$124.56	$132.51	$138.40	$147.23	$152.07	$161.78	$168.97	$179.76	$173.16	$184.21	$192.40	$204.68
70	$116.69	$124.14	$129.65	$137.93	$130.16	$138.47	$144.63	$153.86	$158.93	$169.07	$176.58	$187.85	$180.96	$192.51	$201.07	$213.90
71	$121.95	$129.73	$135.49	$144.14	$136.02	$144.70	$151.13	$160.78	$166.08	$176.68	$184.53	$196.31	$189.11	$201.18	$210.12	$223.53
72	$127.43	$135.56	$141.58	$150.62	$142.15	$151.22	$157.94	$168.02	$173.55	$184.63	$192.83	$205.14	$197.61	$210.22	$219.57	$233.58
73	$133.16	$141.66	$147.96	$157.40	$148.53	$158.01	$165.04	$175.57	$181.35	$192.93	$201.51	$214.37	$206.50	$219.68	$229.44	$244.09
74	$139.15	$148.03	$154.61	$164.48	$155.21	$165.12	$172.46	$185.47	$189.51	$201.61	$210.57	$224.01	$215.79	$229.56	$239.77	$255.07
75	$145.42	$154.70	$161.58	$171.89	$162.21	$172.56	$180.23	$191.73	$198.05	$210.69	$220.05	$234.10	$225.51	$239.90	$250.57	$266.56
76	$151.96	$161.66	$168.84	$179.62	$169.50	$180.32	$188.34	$200.36	$206.97	$220.18	$229.96	$244.64	$235.66	$250.70	$261.84	$278.55
77	$158.79	$168.93	$176.44	$187.70	$177.13	$188.44	$196.82	$209.38	$216.28	$230.08	$240.30	$255.64	$246.25	$261.97	$273.62	$291.08
78	$165.95	$176.54	$184.38	$196.15	$185.10	$196.92	$205.67	$218.80	$226.00	$240.43	$251.11	$267.14	$257.33	$273.76	$285.93	$304.18
79	$173.40	$184.47	$192.67	$204.97	$193.43	$205.78	$214.92	$228.64	$236.17	$251.24	$262.41	$279.16	$268.91	$286.07	$298.79	$317.86
80+	$181.21	$192.78	$201.35	$214.20	$202.14	$215.04	$224.59	$238.93	$246.81	$262.56	$274.23	$291.73	$281.01	$298.95	$312.24	$332.17

Rates may be reduced based on many factors that include, but are not limited to, Medigap Open Enrollment Period eligibility or guaranteed issue rights eligibility and underwriting considerations. Your rate may be higher or lower depending on these relevant factors. Until a policy is approved and issued your actual rates may be subject to change.

An additional 5% discount may apply 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 $1,408	$0	$1,408 (Part A deductible)
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 B PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
Network Hospital – First 60 days	All but $1,408	$1,408 (Part A deductible)**	$0
Non-Network Hospital – First 60 days	All but $1,408	$0	$1,408 (Part A deductible)
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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

**Blue Select – Plan B 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 $198 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 B 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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 G PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
Network Hospital – First 60 days	All but $1,408	$1,408 (Part A deductible)**	$0
Non-Network Hospital – First 60 days	All but $1,408	$0	$1,408 (Part A deductible)
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 G 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 $198 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 G PAYS	YOU PAY
MEDICARE 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 $198 of Medicare-approved amounts*	$0	$0	$198 (Part B deductible)
– 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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 $1,408	$1,408 (Part A deductible)**	$0
Non-Network Hospital – First 60 days	All but $1,408	$0	$1,408 (Part A deductible)
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare-approved amounts*	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$198 (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 B, G 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 B, G and F

13078M (Rev. 1/18) Ord. # 13078M