

# 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 A, B, D, and 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 Outline 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% 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	
		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 A, B, D, and 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

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.

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 31<sup>st</sup> of the prior year.

Age	Plan A			Plan B		
	Monthly Bank Draft	Monthly	Quarterly	Monthly Bank Draft	Monthly	Quarterly
65	\$82.25	\$87.50	\$262.50	\$111.69	\$118.82	\$356.46
66	\$85.24	\$90.68	\$272.04	\$116.59	\$124.03	\$372.09
67	\$88.33	\$93.97	\$281.91	\$121.70	\$129.47	\$388.41
68	\$91.53	\$97.37	\$292.11	\$127.04	\$135.15	\$405.45
69	\$94.84	\$100.89	\$302.67	\$132.62	\$141.09	\$423.27
70	\$98.29	\$104.56	\$313.68	\$138.44	\$147.28	\$441.84
71	\$101.85	\$108.35	\$325.05	\$144.51	\$153.73	\$461.19
72	\$105.54	\$112.28	\$336.84	\$150.86	\$160.49	\$481.47
73	\$109.38	\$116.36	\$349.08	\$157.48	\$167.53	\$502.59
74	\$113.35	\$120.59	\$361.77	\$164.39	\$174.88	\$524.64
75	\$117.45	\$124.95	\$374.85	\$171.61	\$182.56	\$547.68
76	\$121.71	\$129.48	\$388.44	\$179.14	\$190.57	\$571.71
77	\$126.13	\$134.18	\$402.54	\$187.00	\$198.94	\$596.82
78	\$130.71	\$139.05	\$417.15	\$195.21	\$207.67	\$623.01
79	\$135.45	\$144.10	\$432.30	\$203.78	\$216.79	\$650.37
80+	\$140.37	\$149.33	\$447.99	\$212.73	\$226.31	\$678.93

**PREMIUM AND RENEWABILITY INFORMATION**

Continued

Age	Plan D			Plan F		
	Monthly Bank Draft	Monthly	Quarterly	Monthly Bank Draft	Monthly	Quarterly
65	\$116.12	\$123.53	\$370.59	\$138.78	\$147.64	\$442.92
66	\$121.71	\$129.48	\$388.44	\$145.49	\$154.78	\$464.34
67	\$127.58	\$135.72	\$407.16	\$152.51	\$162.24	\$486.72
68	\$133.73	\$142.27	\$426.81	\$159.88	\$170.09	\$510.27
69	\$140.17	\$149.12	\$447.36	\$167.60	\$178.30	\$534.90
70	\$146.92	\$156.30	\$468.90	\$175.70	\$186.91	\$560.73
71	\$154.01	\$163.84	\$491.52	\$184.18	\$195.94	\$587.82
72	\$161.43	\$171.73	\$515.19	\$193.08	\$205.40	\$616.20
73	\$169.21	\$180.01	\$540.03	\$202.42	\$215.34	\$646.02
74	\$177.36	\$188.68	\$566.04	\$212.19	\$225.73	\$677.19
75	\$185.91	\$197.78	\$593.34	\$222.44	\$236.64	\$709.92
76	\$194.88	\$207.32	\$621.96	\$233.18	\$248.06	\$744.18
77	\$204.27	\$217.31	\$651.93	\$244.45	\$260.05	\$780.15
78	\$214.12	\$227.79	\$683.37	\$256.26	\$272.62	\$817.86
79	\$224.44	\$238.77	\$716.31	\$268.64	\$285.79	\$857.37
80+	\$235.27	\$250.29	\$750.87	\$281.63	\$299.61	\$898.83

## 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 *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 consecutive days.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN A PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but <b>\$1,100</b>	<b>\$0</b>	<b>\$1,100</b> (Part A deductible)
61st through 90th day	All but <b>\$275</b> a day	<b>\$275</b> a day	<b>\$0</b>
91st day and after:			
— While using 60 lifetime reserve days	All but <b>\$550</b> a day	<b>\$550</b> a day	<b>\$0</b>
Once lifetime reserve days are used:			
— Additional 365 days	<b>\$0</b>	100% of Medicare-eligible expenses	<b>\$0**</b>
— Beyond the additional 365 days	<b>\$0</b>	<b>\$0</b>	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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	<b>\$0</b>	<b>\$0</b>
21st through 100th day	All but <b>\$137.50</b> a day	<b>\$0</b>	Up to <b>\$137.50</b> a day
101st day and after	<b>\$0</b>	<b>\$0</b>	All costs
<b>BLOOD</b>			
First three pints	<b>\$0</b>	Three pints	<b>\$0</b>
Additional amounts	<b>100%</b>	<b>\$0</b>	<b>\$0</b>
<b>HOSPICE CARE</b>			
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	<b>\$0</b>	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
<b>MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , 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
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES</b>			
Blood tests for diagnostic services	100%	\$0	\$0
<b>MEDICARE (PART A &amp; B)</b>			
<b>HOME HEALTHCARE MEDICARE-APPROVED SERVICES</b>			
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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but <b>\$1,100</b>	<b>\$1,100</b> (Part A deductible)	<b>\$0</b>
61st through 90th day	All but <b>\$275</b> a day	<b>\$275</b> a day	<b>\$0</b>
91st day and after:			
— While using 60 lifetime reserve days	All but <b>\$550</b> a day	<b>\$550</b> a day	<b>\$0</b>
Once lifetime reserve days are used:			
— Additional 365 days	<b>\$0</b>	<b>100%</b> of Medicare-eligible expenses	<b>\$0**</b>
— Beyond the additional 365 days	<b>\$0</b>	<b>\$0</b>	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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	<b>\$0</b>	<b>\$0</b>
21st through 100th day	All but <b>\$137.50</b> a day	<b>\$0</b>	Up to <b>\$137.50</b> a day
101st day and after	<b>\$0</b>	<b>\$0</b>	All costs
<b>BLOOD</b>			
First three pints	<b>\$0</b>	Three pints	<b>\$0</b>
Additional amounts	<b>100%</b>	<b>\$0</b>	<b>\$0</b>
<b>HOSPICE CARE</b>			
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	<b>\$0</b>	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 B PAYS	YOU PAY
<b>MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , 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)	<b>\$0</b>	<b>\$0</b>	<b>\$155</b> (Part B deductible)
— Remainder of Medicare-approved amounts	<b>80%</b>	<b>20%</b>	<b>\$0</b>
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	<b>\$0</b>	<b>\$0</b>	All costs
<b>BLOOD</b>			
First three pints	<b>\$0</b>	<b>All costs</b>	<b>\$0</b>
Next \$155 of Medicare-approved amounts*	<b>\$0</b>	<b>\$0</b>	<b>\$155</b> (Part B deductible)
Remainder of Medicare-approved amounts	<b>80%</b>	<b>20%</b>	<b>\$0</b>
<b>CLINICAL LABORATORY SERVICES</b>			
Blood tests for diagnostic services	<b>100%</b>	<b>\$0</b>	<b>\$0</b>
<b>MEDICARE (PART A &amp; B)</b>			
<b>HOME HEALTHCARE MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	<b>100%</b>	<b>\$0</b>	<b>\$0</b>
Durable medical equipment:			
— First \$155 of Medicare-approved amounts*	<b>\$0</b>	<b>\$0</b>	<b>\$155</b> (Part B deductible)
— Remainder of Medicare-approved amounts	<b>80%</b>	<b>20%</b>	<b>\$0</b>

**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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but <b>\$1,100</b>	<b>\$1,100</b> (Part A deductible)	<b>\$0</b>
61st through 90th day	All but <b>\$275</b> a day	<b>\$275</b> a day	<b>\$0</b>
91st day and after:			
— While using 60 lifetime reserve days	All but <b>\$550</b> a day	<b>\$550</b> a day	<b>\$0</b>
Once lifetime reserve days are used:			
— Additional 365 days	<b>\$0</b>	<b>100%</b> of Medicare-eligible expenses	<b>\$0**</b>
— Beyond the additional 365 days	<b>\$0</b>	<b>\$0</b>	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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	<b>\$0</b>	<b>\$0</b>
21st through 100th day	All but <b>\$137.50</b> a day	Up to <b>\$137.50</b> a day	<b>\$0</b>
101st day and after	<b>\$0</b>	<b>\$0</b>	All costs
<b>BLOOD</b>			
First three pints	<b>\$0</b>	Three pints	<b>\$0</b>
Additional amounts	<b>100%</b>	<b>\$0</b>	<b>\$0</b>
<b>HOSPICE CARE</b>			
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	<b>\$0</b>	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 D PAYS	YOU PAY
<b>MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as: physician's services, in-patient 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
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES</b>			
Blood tests for diagnostic services	100%	\$0	\$0
<b>MEDICARE (PART A &amp; B)</b>			
<b>HOME HEALTHCARE MEDICARE-APPROVED SERVICES</b>			
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
<b>AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE</b>			
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	\$0	Actual charges up to \$40 a visit	Balance
— Number of visits covered (must be within eight weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits not to exceed seven each week.	
— Calendar year maximum	\$0	\$1600	
<b>OTHER BENEFITS — Not Covered By Medicare</b>			
<b>FOREIGN TRAVEL — NOT COVERED BY MEDICARE</b>			
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

**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 F PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but <b>\$1,100</b>	<b>\$1,100</b> (Part A deductible)	<b>\$0</b>
61st through 90th day	All but <b>\$275</b> a day	<b>\$275</b> a day	<b>\$0</b>
91st day and after:			
— While using 60 lifetime reserve days	All but <b>\$550</b> a day	<b>\$550</b> a day	<b>\$0</b>
Once lifetime reserve days are used:			
— Additional 365 days	<b>\$0</b>	100% of Medicare-eligible expenses	<b>\$0**</b>
— Beyond the additional 365 days	<b>\$0</b>	<b>\$0</b>	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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	<b>\$0</b>	<b>\$0</b>
21st through 100th day	All but <b>\$137.50</b> a day	Up to <b>\$137.50</b> a day	<b>\$0</b>
101st day and after	<b>\$0</b>	<b>\$0</b>	All costs
<b>BLOOD</b>			
First three pints	<b>\$0</b>	Three pints	<b>\$0</b>
Additional amounts	<b>100%</b>	<b>\$0</b>	<b>\$0</b>
<b>HOSPICE CARE</b>			
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	<b>\$0</b>	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 F PAYS	YOU PAY
<b>MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , 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
<b>Part B excess charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES</b>			
Blood tests for diagnostic services	100%	\$0	\$0
<b>MEDICARE (PART A &amp; B)</b>			
<b>HOME HEALTHCARE MEDICARE-APPROVED SERVICES</b>			
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
<b>OTHER BENEFITS — Not Covered By Medicare</b>			
<b>FOREIGN TRAVEL — NOT COVERED BY MEDICARE</b>			
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



# 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 Supplement Coverage**

#### **Benefit Plans A, B, D and F**

13141M

Ord. # 13141M (Rev. 12/09)

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