BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

An Independent Licensee of the Blue Cross and Blue Shield Association

OUTLINE OF BLUECARE® COVERAGE — COVER PAGE 1 of 2:
BENEFIT PLANS A, F with High Deductible, L and N

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 copayment.

Blood: first three pints of blood each year.

Hospice: Part A coinsurance

A	B	C	D	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 $2,340 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.

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OUTLINE OF BLUECARE COVERAGE — COVER PAGE 2:
BENEFIT PLANS A, F with High Deductible, L and N

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				Plan F*				Plan L				Plan N			
	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	$59.93	$63.76	$66.59	$70.84	$109.48	$116.47	$121.65	$129.41	$114.71	$122.03	$127.45	$135.59
66	$97.84	$104.09	$108.72	$115.66	$62.63	$66.63	$69.59	$74.03	$114.41	$121.71	$127.12	$135.23	$119.87	$127.52	$133.19	$141.69
67	$102.24	$108.77	$113.61	$120.86	$65.44	$69.62	$72.72	$77.36	$119.56	$127.19	$132.84	$141.32	$125.26	$133.25	$139.18	$148.06
68	$106.86	$113.68	$118.73	$126.31	$68.39	$72.76	$75.99	$80.84	$124.94	$132.91	$138.82	$147.68	$130.91	$139.27	$145.46	$154.74
69	$111.66	$118.79	$124.07	$131.99	$71.47	$76.03	$79.41	$84.48	$130.56	$138.89	$145.06	$154.32	$136.79	$145.52	$151.99	$161.69
70	$116.69	$124.14	$129.65	$137.93	$74.68	$79.45	$82.98	$88.28	$136.43	$145.14	$151.59	$161.27	$142.95	$152.07	$158.83	$168.97
71	$121.95	$129.73	$135.49	$144.14	$78.05	$83.03	$86.72	$92.25	$142.58	$151.68	$158.42	$168.53	$149.38	$158.92	$165.99	$176.58
72	$127.43	$135.56	$141.58	$150.62	$81.56	$86.77	$90.63	$96.41	$148.99	$158.50	$165.54	$176.11	$156.11	$166.07	$173.45	$184.52
73	$133.16	$141.66	$147.96	$157.40	$85.23	$90.67	$94.70	$100.74	$155.69	$165.63	$172.99	$184.03	$163.13	$173.54	$181.25	$192.82
74	$139.15	$148.03	$154.61	$164.48	$89.07	$94.75	$98.96	$105.28	$162.70	$173.09	$180.78	$192.32	$170.47	$181.35	$189.41	$201.50
75	$145.42	$154.70	$161.58	$171.89	$93.07	$99.01	$103.41	$110.01	$170.02	$180.87	$188.91	$200.97	$178.14	$189.51	$197.94	$210.57
76	$151.96	$161.66	$168.84	$179.62	$97.26	$103.47	$108.07	$114.97	$177.68	$189.02	$197.42	$210.02	$186.17	$198.05	$206.85	$220.05
77	$158.79	$168.93	$176.44	$187.70	$101.64	$108.13	$112.93	$120.14	$198.67	$197.52	$206.30	$219.47	$194.54	$206.96	$216.15	$229.95
78	$165.95	$176.54	$184.38	$196.15	$106.21	$112.99	$118.01	$125.54	$194.03	$206.41	$215.58	$229.34	$203.28	$216.26	$225.87	$240.29
79	$173.40	$184.47	$192.67	$204.97	$110.99	$118.07	$123.32	$131.19	$202.75	$215.69	$225.27	$239.65	$212.43	$225.99	$236.03	$251.10
80+	$181.21	$192.78	$201.35	$214.20	$115.99	$123.39	$128.87	$137.10	$211.89	$225.41	$235.42	$250.45	$222.00	$236.17	$246.67	$262.41

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			
Durable medical equipment	100%	$0	$0
– First $198 of Medicare-approved amounts*			
– Remainder of Medicare-approved amounts	$0	$0	$198 (Part B deductible)
	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 days in a row.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from the high deductible Plan F will not begin until the out-of-pocket expenses are $2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE**, PLAN F* PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
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	$0**
– Beyond the additional 365 days	$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

**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.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from the high deductible Plan F will not begin until the out-of-pocket expenses are $2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE**, 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			
Durable medical equipment	100%	$0	$0
– First $198 of Medicare-approved amounts*			
– Remainder of Medicare-approved amounts	$0	$198 (Part B deductible)	$0
	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

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,940 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

SERVICES	MEDICARE PAYS	PLAN L PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,408	$1,056 (75% Part A deductible)	$352 (25% 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 $132 a day	Up to $44 a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	75%	25% ♦
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	75% of Medicare copayment/coinsurance	25% of Medicare copayment/coinsurance ♦

***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 L 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)* ♦
– Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
– Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,940)**
BLOOD			
First three pints	$0	75%	25% ♦
Next $198 of Medicare-approved amounts*	$0	$0	$198 (Part B deductible) ♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	5% ♦
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

**This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,940 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	$0	$0
– First $198 of Medicare-approved amounts***			
– Remainder of Medicare-approved amounts	$0	$0	$198 (Part B deductible) ♦
	80%	15%	5% ♦

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

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 N PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
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

**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 N 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%	Balance other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
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			
Durable medical equipment	100%	$0	$0
– First $198 of Medicare-approved amounts**			
– Remainder of Medicare-approved amounts	$0	$0	$198 (Part B deductible)
	80%	20%	$0

**Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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

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 BlueCare® Coverage

Benefit Plans A, F with High Deductible, L and N

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