South Carolina

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

Blue Select Policy Comparison Chart
Effective January 1, 2019
Blue Select®

Part A Hospital Insurance – Covered Services										
SERVICE	**MEDICARE PAYS**	**PLAN A PAYS**	**PLAN B PAYS**	**PLAN C PAYS**	**PLAN D PAYS**	**PLAN F PAYS**	**PLAN F* PAYS**	**PLAN G PAYS**	**PLAN L PAYS**	**PLAN N PAYS**
Hospitalization Semiprivate room and board. General nursing and miscellaneous hospital services and supplies.										
Network Hospital – First 60 days	All but $1,364 (Part A deductible)	$0	$1,364 (Part A deductible)	$1,364 (Part A deductible)	$1,364 (Part A deductible)	$1,364 (Part A deductible)	$1,364 (Part A deductible)	$1,364 (Part A deductible)	$1,023 (75% of the Part A deductible)	$1,364 (Part A deductible)
61st to 90th day	All but $341 a day	$341 a day	$341 a day	$341 a day	$341 a day	$341 a day	$341 a day	$341 a day	$341 a day	$341 a day
91st day and after: – While using 60 lifetime reserve days	All but $682 a day	$682 a day	$682 a day	$682 a day	$682 a day	$682 a day	$682 a day	$682 a day	$682 a day	$682 a day
Once lifetime reserve days are used: – Additional 365 days	$0	100% of Medicare eligible expense	100% of Medicare eligible expense	100% of Medicare eligible expense	100% of Medicare eligible expense	100% of Medicare eligible expense	100% of Medicare eligible expense	100% of Medicare eligible expense	100% of Medicare eligible expense	100% of Medicare eligible expense
– Beyond the additional 365 days	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Skilled Nursing Care Medicare must approve the facility and you must have been in the hospital at least three days.										
First 20 days	All approved amounts	$0	$0	$0	$0	$0	$0	$0	$0	$0
21st through 100th day	All but $170.50 a day	$0	$0	Up to $170.50 a day	Up to $170.50 a day	Up to $170.50 a day	Up to $170.50 a day	Up to $170.50 a day	Up to $127.88 a day	Up to $170.50 a day
101st day and after	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blood First three pints	$0	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints	75% of first three pints	Three pints
Additional amounts	100%	$0	$0	$0	$0	$0	$0	$0	$0	$0
Hospice Care Must be terminally ill	All but very limited copayment/coinsurance for outpatient drugs and respite care	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	Medicare copayment/ coinsurance	75% of the Medicare copayment/ coinsurance	Medicare copayment/ coinsurance

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Part B Medical Insurance – Covered Services										
SERVICE	**MEDICARE PAYS**	**PLAN A PAYS**	**PLAN B PAYS**	**PLAN C PAYS**	**PLAN D PAYS**	**PLAN F PAYS**	**PLAN F* PAYS**	**PLAN G PAYS**	**PLAN L PAYS**	**PLAN N PAYS**
Medical Expenses Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:										
– First $185 of Medicare-approved amounts (Part B deductible)	$0	$0	$0	$185 (Part B deductible)	$0	$185 (Part B deductible)	$185 (Part B deductible)	$0	$0	$0
– Preventive benefits for Medicare-covered services	Generally 80% or more of Medicare-approved amounts	20%	20%	20%	20%	20%	20%	20%	15%	20%
– Remainder of Medicare-approved amounts	Generally 80%	20%	20%	20%	20%	20%	20%	20%	15%	Balance of the Medicare-approved amount after a $20 copayment for office visits. Balance of the Medicare-approved amount after a $50 copayment for emergency room visits. The emergency room copayment is waived if you are admitted to the hospital and the emergency visit is covered as a Medicare Part A expense.

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Part B Medical Insurance – Covered Services										
SERVICE	**MEDICARE PAYS**	**PLAN A PAYS**	**PLAN B PAYS**	**PLAN C PAYS**	**PLAN D PAYS**	**PLAN F PAYS**	**PLAN F* PAYS**	**PLAN G PAYS**	**PLAN L PAYS**	**PLAN N PAYS**
Part B Excess Charges Above Medicare-approved amounts	$0	$0	$0	$0	$0	100%	100%	100%	$0	$0
Blood First three pints	$0	All costs	All costs	All costs	All costs	All costs	All costs	All costs	75% of the first three pints	All costs
Next $185 of Medicare-approved amounts (Part B deductible)	$0	$0	$0	$185 (Part B deductible)	$0	$185 (Part B deductible)	$185 (Part B deductible)	$0	$0	$0
Remainder of Medicare-approved amounts	Generally 80%	20%	20%	20%	20%	20%	20%	20%	15%	20%
Clinical Laboratory Services Tests for diagnostic services	100%	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Healthcare Medicare-Approved Services Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0	$0	$0	$0	$0	$0
Durable medical equipment:										
- First $185 of Medicare-approved amounts (Part B deductible)	$0	$0	$0	$185 (Part B deductible)	$0	$185 (Part B deductible)	$185 (Part B deductible)	$0	$0	$0
- Remainder of Medicare-approved amounts	Generally 80%	20%	20%	20%	20%	20%	20%	20%	15%	20%
Other Services – Not Covered by Medicare										
Foreign Travel Medically necessary emergency services during the first 60 days of each trip outside the USA:										
- First $250 each calendar year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
- Remainder of charges	$0	$0	$0	80% to a lifetime maximum benefit of $50,000	80% to a lifetime maximum benefit of $50,000	80% to a lifetime maximum benefit of $50,000	80% to a lifetime maximum benefit of $50,000	80% to a lifetime maximum benefit of $50,000	$0	80% to a lifetime maximum benefit of $50,000

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Blue Select Policy Comparison Chart
Effective January 1, 2019
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Medicare Part A & B – Covered Services										
SERVICE	**MEDICARE PAYS**	**PLAN A PAYS**	**PLAN B PAYS**	**PLAN C PAYS**	**PLAN D PAYS**	**PLAN F PAYS**	**PLAN F* PAYS**	**PLAN G PAYS**	**PLAN L PAYS**	**PLAN N PAYS**
***Out-of-Pocket Maximum**										
	N/A	N/A	N/A	N/A	N/A	N/A	$2,300*	N/A	$2,780**	N/A

* 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 $2,300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,300. 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.

**For Plan L you will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,780 each calendar year. Once you reach the annual limit, the plan pays 100 percent 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.

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 (TDD: 711).

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 by emailing 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 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 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (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, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 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)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)