2024 Summary of Benefits

BlueCross Total℠ (PPO)

Jan. 1, 2024 – Dec. 31, 2024

855-204-2744 | TTY 711

Seven Days a Week, 8 a.m. to 8 p.m.
(Oct. 1 to March 31)

Monday – Friday, 8 a.m. to 8 p.m.
(All other times)

H8003_SB2024_M

South Carolina

2024 Summary of Benefits BlueCross Total (PPO)

H8003, Plans 001, 002 and 003

This is a summary of the health and drug service covered by BlueCross Total (PPO): January 1, 2024 – December 31, 2024.

This plan, **BlueCross Total**, is offered by BlueCross BlueShield of South Carolina. **BlueCross Total** is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in BlueCross BlueShield of South Carolina depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover, or list every limitation, or exclusion. To get a complete list of services we cover, please request the *Evidence of Coverage* by calling Customer Service at 1-855-204-2744 (TTY users should call 711). The *Evidence of Coverage* is also available online at www.SCBluesMedAdvantage.com.

To join BlueCross Total (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in South Carolina:

BlueCross Total (PPO) – Upstate (001)	Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, and York
BlueCross Total (PPO) - Midlands/Coastal (002)	Aiken, Calhoun, Chesterfield, Dillon, Fairfield, Florence, Horry, Kershaw, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Saluda,and Sumter
BlueCross Total (PPO) – Lowcountry (003)	Beaufort, Berkeley, Charleston, Dorchester, and Georgetown

BlueCross Total (PPO) has a network of doctors, hospitals, pharmacies, and other providers, as well as access to out-of-network providers. As a member of our plan, you do not need a referral from a Primary Care Provider to see a Specialist or to obtain a service. However, you are required to obtain prior authorization from our plan for some services.

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

Customer Service has free language interpreter services available for non-English speakers. This information is available in other formats. To get this information in other formats, please call Customer Service.

For more information or to enroll, call us at 1-800-930-2836 (TTY users should call 711), or visit us at www.SCBluesMedAdvantage.com. We are available for phone calls from October 1 to March 31; you can call us 8 am to 8 pm, 7 days a week. From January 1 to September 30, we're here 8 am to 8 pm, Monday through Friday. Calls to this number are answered by a licensed insurance agent.

H8003_SB2024_M

Premiums and Benefits	BlueCross Total (PPO)
Monthly Plan Premium*	*You must continue to pay your Medicare Part B premium.
BlueCross Total (PPO) - Upstate (001)	You pay $25
BlueCross Total (PPO) - Midlands/Coastal (002)	You pay $19
BlueCross Total (PPO) - Lowcountry (003)	You pay $25
Deductible	No Deductible
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	**In-network:** You pay no more than $6,900 annually. **In-network and Out-of-network:** You pay no more than $10,000 combined. Includes copays and other costs for covered Part A and Part B services.
Inpatient Hospital Coverage*	**In-network:** You pay a $300 copay per day for days 1 - 4 (You pay a $0 copay per day for days 5 - 90). **Out-of-network:** You pay 40% of the total cost. *Prior authorization is required. This benefit will begin on day 1 each time you are admitted to a specific facility type. You pay your cost share per admission.
Outpatient Hospital Coverage*	**In-network:** You pay a $0 up to $295 copay per visit. You pay a $0 copay if a polyp is found and removed during colonoscopy. You pay a $325 copay for each Medicare covered observation service. **Out-of-network:** You pay 40% of the total cost. *Prior authorization is required.
Ambulatory Surgical Center (ASC) Services*	**In-network:** You pay a $0 up to $250 copay per visit. **Out-of-network:** You pay 40% of the total cost. *Prior authorization is required.
Doctor Visits	
Primary Care Providers	**In-network:** You pay a $0 copay per visit. **Out-of-network:** You pay a $30 copay per visit.
Specialists	**In-network for:** You pay a $25 copay per visit. **Out-of-network:** You pay a $55 copay per visit.
Telehealth	You pay a $0 copay for each primary care physician telehealth service. You pay a $0 copay for each urgent care telehealth service. You pay a $40 copay for each individual session for psychiatric services. You pay a $40 copay for each individual session for mental health specialty services.

Premiums and Benefits	BlueCross Total (PPO)
Preventive Care	**In-network:** You pay a $0 copay. **Out-of-network:** You pay 0% of the total cost. Preventive care includes: Abdominal aortic aneurysm; Alcohol misuse counseling; Bone mass measurement; Breast cancer screening (mammogram); Cardiovascular disease screenings; Colorectal cancer screenings (colonoscopy); Depression screenings; Diabetes Screening and training; Medicare Diabetes Prevention Program; HIV Screening; Obesity screening and counseling; Prostate cancer screenings (PSA); Vaccines, including flu shots and pneumococcal shots; Welcome to Medicare initial visit; Annual Wellness Visit; Annual Physical; and Health Coaching via FitOn.
Emergency Care	You pay a $100 copay per visit, waived if admitted within 24 hours. You pay a $250 service specific deductible and then 20% of the total cost for worldwide emergency care.
Urgently Needed Services	You pay a $0 copay for each PCP visit at urgent care. You pay a $40 copay for each Specialist visit at urgent care. You pay a $55 copay for each urgently needed service at urgent care. You pay 0% of the total cost for worldwide urgent care.
Diagnostic Services/Labs/ Imaging*	*Prior authorization may be required for these services.
Diagnostic tests and procedures	**In-network:** You pay a $0 up to $275 copay per service. You pay a $0 copay for diagnostic EKG and diagnostic colorectal screening. **Out-of-network:** You pay 40% of the total cost.
Lab services	**In-network:** You pay a $0 copay per lab service. **Out-of-network:** You pay 40% of the total cost per lab service.
Diagnostic radiology service (e.g., MRI and CT scan)	**In-network:** You pay a $0 up to $150 copay per service. You pay a $0 copay for diagnostic mammograms and ultrasounds. **Out-of-network:** You pay 40% of the total cost.
Therapeutic Radiological Services	**In-network:** You pay 20% of the total cost. **Out-of-network:** You pay 40% of the total cost.
Outpatient x-rays	**In-network:** You pay a $10 copay per x-ray. **Out-of-network:** You pay 40% of the total cost per x-ray.
Hearing Services	
Medicare-covered hearing exam	**In-network:** You pay a $45 copay. **Out-of-network:** You pay 40% of the total cost.
Routine hearing exam	**In-network:** You pay a $45 copay using a TruHearing provider. **Out-of-network:** You pay a $45 copay using a TruHearing provider.

Premiums and Benefits	BlueCross Total (PPO)
Hearing aids	**In-network:** You pay $699 - $999, using TruHearing network for up to 2 hearing aids per year (one per ear, each year). **Out-of-network:** You pay $699 - $999. A TruHearing provider must be used for this benefit. The copayment range is based on different types and styles of hearing aids. The lower range $699 is for the Advanced hearing aid type and the higher range $999 is for the Premium hearing aid type, a TruHearing provider must be used for in- and out-of-network hearing aid benefit.
Dental Services	
Preventive Dental (non-Medicare covered)	**In-network:** You pay a $0 copay.* **Out-of-Network:** You pay 50% of the total cost.* 2 preventive dental visits per year. Oral exam, cleaning, 1 dental bitewing x-ray (fluoride treatment not covered). **In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)** *Preventive dental services are included in your $3,500 preventive/comprehensive limit per year. See your EOC for details.
Comprehensive Dental (Non-Medicare Covered)	**In-network:** You pay 50% of the total cost.* **Out-of-network:** You pay 50% of the total cost.* Non-routine services, diagnostic services, restorative services, endodontics, extractions, prosthodontics, other oral/maxillofacial surgery, periodontics, and other services (i.e., dentures, root canals). We do not cover implants. **In-network services receive the BCBS discount (Going to an out of network dentist may cost you more than using a contracted in network dentist. We pay up to 50% for reasonable and customary charges for out of network claims.)** *Comprehensive dental services are included in your $3,500 preventive/comprehensive limit per year. See your EOC for details.
Comprehensive Dental (Medicare-Covered)	**In-network:** You pay a $50 copay. **Out-of-network:** You pay 40% of the total cost. See your EOC for details.
Vision Services	
Diabetic eye exam	**In-network:** You pay a $0 copay. **Out-of-network:** You pay a $0 copay.
Glaucoma screening	**In-network:** You pay a $0 copay. **Out-of-network:** You pay a $0 copay.

Premiums and Benefits	BlueCross Total (PPO)
Medicare-covered eye exam	**In-network:** You pay a $50 copay. **Out-of-network:** You pay a $50 copay.
Routine eye exam	**In-network:** You pay a $0 copay using the VSP network. 1 exam per year. **Out-of-network:** You pay a $0 copay using the VSP network. 1 exam per year.
Eyeglasses (frames and lenses) and contacts	**In-network**: You pay a $0 copay for one pair of glasses to include frames and lenses or one pair of contact lenses every 2 years using the VSP network. **Out-of-network:** You pay a $0 copay for one pair of glasses to include frames and lenses or one pair of contact lenses every 2 years using the VSP network.
Eyeglasses or contact lenses after cataract surgery	**In-network:** You pay a $0 copay for Medicare-covered eyewear related to cataract surgery. **Out-of-network:** You pay a $0 copay for Medicare-covered eyewear related to cataract surgery.
Mental Health Services	
Inpatient visit*	**In-network:** You pay a $645 copay per day, days 1 - 3. You pay a $0 copay per day, days 4 - 90. **Out-of-network:** You pay 40% of the total cost. *Prior authorization is required.
Outpatient group therapy/ individual therapy	**In-network:** You pay a $40 copay per visit. **Out-of-network:** You pay 40% of the total cost per visit.
Skilled Nursing Facility (SNF)*	**In-network:** You pay a $0 copay per day for days 1 – 20. You pay a $203 copay per day for days 21 - 100. **Out-of-network:** You pay 40% of total the cost. Our plan covers up to 100 days in a SNF. *Prior authorization is required.
Physical Therapy*	**In-network Total Upstate:** You pay a $30 copay per visit. **In-network Total Lowcountry and Midlands/Coastal:** You pay a $35 copay. **Out-of-network:** You pay a $55 copay per visit. *Prior authorization is required.
Ambulance*	**In-network:** You pay a $295 copay per one-way trip for ground ambulance.You pay a $295 copay for a one-way trip for air ambulance. **Out-of-network:** You pay a $295 copay per one-way trip for ground ambulance.You pay a $295 copay for a one-way trip for air ambulance. *Prior authorization may be required for non-emergency transportation.

Premiums and Benefits	BlueCross Total (PPO)
Transportation	You receive 24 one-way trips per year to any health-related location. See your EOC for details.
Medicare Part B Drugs*	*Prior authorization is required.
Medicare Part B Insulin Drugs	**In-network:** You pay a $35 copay for a 1-month supply of Medicare covered Part B insulins. **Out-of-network:** You pay a $35 copay for a 1-month supply of Medicare covered Part B insulins. See EOC for details.
Medicare Part B Chemotherapy/Radiation Drugs	**In-network:** You pay 0% - 20% of the total cost. **Out-of-network:** You pay 40% of the cost. See EOC for details.
Other Medicare Part B Drugs	**In-network:** You pay 0% - 20% of the total cost. **Out-of-network:** You pay 40% of the cost. See EOC for details.
Chiropractic Care (Medicare-covered)	**In-network:** You pay a $15 copay per visit. **Out-of-network:** You pay 40% of the total cost.
Dialysis*	**In-network:** You pay 20% of the total cost. **Out-of-network:** You pay 40% of the total cost. *Prior authorization is required.
Foot Care (podiatry services)	
Medicare-covered foot exams and treatment	**In-network:** You pay a $50 copay per visit. **Out-of-network:** You pay 40% of the total cost.
Routine foot care	Not covered.
Home Health Care*	**In-network:** You pay 0% of the total cost. **Out-of-network:** You pay 40% of the total cost. *Prior authorization is required.
Meal Program	You pay a $0 copay for meals upon discharge from Hospital, Skilled Nursing or Rehab facility. Two meals per day for 5 days. See EOC for details.
Medical Equipment/Supplies*	*Prior authorization is required.
Durable Medical Equipment	**In-network:** You pay 20% of the total cost. **Out-of-network:** You pay 40% of the total cost.
Home Infusion Services	**In-network:** You pay 15% of the total cost. **Out-of-network:** You pay 40% of the total cost.
Other Part B Services	**In-network:** You pay 20% of the total cost. **Out-of-network:** You pay 40% of the total cost.

Premiums and Benefits	BlueCross Total (PPO)
Prosthetics/Medical Supplies	**In-network:** You pay 20% of the total cost. **Out-of-network:** You pay 40% of the total cost.
Diabetic supplies	**In-network:** We only cover OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices for $0. Note: In case of an approved medical exception, other brands may be covered, and you pay 20% of the total cost. **Out-of-network:** You pay 40% of the total cost.
Occupational Therapy*	**In-network Total Upstate:** You pay a $30 copay per visit. **In-network Total Lowcountry and Midlands/Coastal:** You pay a $35 copay. **Out-of-network:** You pay a $55 copay per visit. *Prior authorization is required.
Outpatient Substance Abuse	**In-network:** Individual and group therapy visits – You pay a $40 copay. **Out-of-network:** Individual and group therapy visits – You pay 40% of the total cost.
Over-the-Counter Service	You receive $70 per quarter for a total of $280 per year in Over-the-Counter items with free shipping. Order placed once per quarter via phone, catalog, or vendor website. You can use an OTC Benefits Card to purchase food in addition to OTC products. See EOC for details.
Physical Exam - Annual	**In-network:** You pay a $0 copay for one physical exam per year. **Out-of-network:** You pay 40% of the total cost for one physical exam peryear.
Speech and Language Therapy*	**In-network Total Upstate:** You pay a $30 copay per visit. **In-network Total Lowcountry and Midlands/Coastal:** You pay a $35 copay. **Out-of-network:** You pay a $55 copay per visit. *Prior authorization is required.
Visitor Travel	The Visitor/Travel Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state. These areas are subject to change, see EOC for details.

Premiums and Benefits	BlueCross Total (PPO)
Wellness Programs (e.g., fitness)	You pay $0 for basic membership to a FitOn participating fitness center and a home fitness kit.

Prescription Drug Coverage

Yearly Deductible Stage: There is no deductible stage with BlueCross Total.

Initial Coverage Stage: During this stage, the plan pays its share of the cost of your Tier 1, Tier 2, Tier 3, Tier 4, Tier 5 and Tier 6 drugs and you pay your share. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $5,030.

Coverage Gap Stage: BlueCross Total offers additional Gap Coverage; you also receive some coverage for generic drugs. For drugs on Tier 1 and Tier 6 you pay the same share of the cost that you normally pay while in the Initial Coverage Stage, or 25% of the costs, whichever is lower. For all other generic drugs besides those on Tier 1 and Tier 6, you pay 25% of the costs. During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee). For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Cost-Sharing may change depending on the pharmacy you choose (preferred or non-preferred, mail-order, Long-Term Care (LTC) or home infusion, and 30 or 90-day supply) and when you enter another of the four stages of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our *Evidence of Coverage* online at www.SCBluesMedAdvantage.com.

Catastrophic Coverage: Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

Part D Prescription Drug Benefit						
Deductible Stage	You pay $0					
Initial Coverage Stage	Preferred Retail (In-Network)			Standard Retail (In-Network)		
	30-day Supply	60-day Supply	90-day Supply	30-day Supply	60-day Supply	90-day Supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay	$5 copay	$10 copay	$15 copay
Tier 2: Generic	$10 copay	$20 copay	$30 copay	$15 copay	$30 copay	$45 copay
Tier 3: Preferred Brand	$42 copay	$84 copay	$126 copay	$47 copay	$94 copay	$141 copay
Tier 3: Covered Insulin	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay

Tier 4: Non-Preferred	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
Tier 5: Specialty	33% coinsurance	Not Covered	Not Covered	33% coinsurance	Not Covered	Not Covered
Tier 6: Select Care Drugs	$0 copay	$0 copay	$0 copay	$5 copay	$10 copay	$15 copay

Mail Order and Long-Term Care (LTC)				
Initial Coverage Stage	Mail Order			Long-Term Care
	30-day Supply	60-day Supply	90-day Supply	31-day Supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$10 copay	$20 copay	$0 copay	$10 copay
Tier 3: Preferred Brand	$42 copay	$84 copay	$105 copay	$42 copay
Tier 3: Covered Insulin	$35 copay	$70 copay	$105 copay	$35 copay
Tier 4: Non-Preferred	$100 copay	$200 copay	$250 copay	$100 copay
Tier 5: Specialty	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Tier 6: Select Care Drugs	$0 copay	$0 copay	$0 copay	$0 copay

Limitations, copayments, and restrictions may apply. Benefits, premiums, copayments, or coinsurance may change on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat BlueCross Total members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number, (855) 204-2744 (TTY users should call 711), or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-204-2744. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-396-0183. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-396-0188。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-725-1516。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-389-4839. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-396-0190. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-389-4838 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-396-0191. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-396-0187 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-389-4840. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-396-0189. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-725-1519 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-396-0184. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-396-0182. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-398-6232. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-396-0186. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-396-0185 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

South Carolina

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