



Frequently Asked Questions about Medicare and Medicare Advantage plans.

FAQ Quick Links:

[Enrolling in Medicare](#)

[Medicare Advantage Plans](#)

[The UT CARE Plan](#)

[Providers](#)

[Prescription Drug Coverage](#)

[Supplemental Benefits](#)

[Plan Effective Date and Communications](#)

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Enrolling in Medicare

Q. What is Medicare?

A. Medicare is the Federal government health care program designed for people ages 65 and over. Most U.S. citizens earn the right to enroll in Medicare by working and paying their taxes for a minimum of 10 years. Under certain circumstances, people under 65 may be eligible for Medicare. There are four parts of Medicare related to specific services:

Part A — Hospital coverage.

Part B — Medical coverage.

Part C — Medicare Advantage Plans (private insurers like Blue Cross and Blue Shield of Texas that contract with the government to provide Medicare coverage through a variety of insurance products).

Part D — Prescription drug coverage.

Q. Do I need to enroll in Medicare with the government or just with this plan?

A. Enrollment in Medicare Part A and Part B through the federal government is required for retirees to be eligible for any retiree Medicare plans, including this UT CARE™ Medicare PPO plan. To have full coverage, you must sign up for Medicare Parts A & B and continue to pay your Part B premium. Call UT CARE Customer Service 1-877-842-7562 TTY 711 to learn how your retiree plan will work with Medicare.

Q. I am enrolling in Medicare for the first time. When will coverage be effective?

A. Coverage is effective on the first day of the month following the date the application was processed or the Medicare Parts A & B effective date, whichever is later. When enrolling in the UT CARE plan, you will need to provide your 11-character Medicare Beneficiary Identifier (MBI), located on your red, white and blue Medicare card along with your effective date. The earliest someone who is turning age 65 can sign up for Parts A & B is three months before the month they will turn age 65.

Q. I'm not 65 yet. When do I enroll in Medicare Part A and B?

A. You have an Initial Enrollment Period (IEP) of 7 months to sign up: the 3 months leading up to the month you turn age 65, the month you turn 65, and 3 months following the month you turn 65. We strongly encourage you to start the enrollment process 3 months prior to turning age 65 so that there will be less chance of any gaps in coverage with your UT CARE plan.

Q. How do I enroll in Medicare Part A and B?

A. Enrollment is done through the Social Security Administration (SSA). Most people should enroll in Medicare Part A (hospital coverage) during the Initial Enrollment Period (IEP) and SSA will send you enrollment instructions at the beginning of your IEP. This is the period during which you can enroll in Medicare for the first time. It is a seven-month period that begins three months before the month you turn 65, includes the month you turn 65, and runs for three months after the month you turned 65. For example, if you were born in June, your window to enroll is March 1 through September 30.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

If you're already receiving Social Security benefits, you will be automatically enrolled in Medicare Part A at the start of your Initial Enrollment Period. However, you will need to contact SSA to sign up for Part B.

If you do not receive instructions from the SSA, please call 1-800-772-1213 (TTY 1-800-325-0778) or go to www.ssa.gov to enroll in Medicare. Because enrollment takes time to process, if you plan to retire at 65, we recommend enrolling three months prior to your 65th birthday.

IMPORTANT: If you plan to enroll in an employer-sponsored Medicare plan, you will need to enroll in both Parts A and B. And if you do not enroll in Medicare Parts A, B and D when you are first eligible, you can be subject to late enrollment penalties.

Q. Are there costs to Medicare outside of my plan?

A. Part A will not cost you anything if you or your spouse paid into Social Security for a minimum of 10 years. But signing up for Part A and/or Part B means you can no longer add funds to a health savings account. You pay a premium each month for Part B. Your Part B premium will be automatically deducted from your benefit payment if you get benefits from one of these:

- Social Security.
- Railroad Retirement Board.
- Office of Personnel Management.

If you don't get these benefit payments, you will receive a Part B premium bill. The Part B monthly premium changes each year and can vary according to income through what's known as IRMAA: income-related monthly adjustment amount. Most people will pay the standard premium amount. Medicare uses the modified adjusted gross income reported on your IRS tax return from two years ago to determine your Part B premium. This is the most recent tax return information provided to Social Security by the IRS. A notice from Medicare will be mailed to those who will pay the IRMAA surcharge.

Q. What happens if I do not pay my Part B premiums?

A. Non-payment of Part B and/or IRMAA premiums will result in termination of coverage.

Q. Where can I find additional Medicare resources?

A. The following web sites may be helpful:

www.medicare.gov

www.ssa.gov

www.cms.gov

Medicare Advantage Plans

Q. What is a Medicare Advantage Plan? How is it different from my traditional coverage?

A. Medicare Advantage plans are government-authorized plans offered by private health insurance companies like Blue Cross and Blue Shield of Texas that expand upon the benefits offered by Medicare Parts A and B. Also known as 'Medicare Part C' plans, they include some medical benefits not traditionally covered by Original Medicare Parts A and B. For example, the UT CARE plan includes non-Medicare covered benefits

Frequently Asked Questions about Medicare and Medicare Advantage plans.

such as hearing services, including a hearing aid allowance, the SilverSneakers® fitness program, chiropractic services, private duty nursing, a 24-hour nurse line, and virtual visits.

Q. Are Medicare Advantage plans joint? Can my spouse or partner be on a different plan?

A. Retirees and their eligible dependents are enrolled in the UT CARE plan as individuals. Each covered individual will receive their own enrollment kit and ID card.

Q. Can I be refused coverage due to a pre-existing condition? Can my policy be canceled once I am enrolled because of my condition?

A. You cannot be refused coverage because of a pre-existing condition. Your coverage cannot be canceled and your claims for covered services cannot be denied because of a pre-existing condition.

The UT CARE Plan

Q. What are the advantages of a group Medicare plan like UT CARE over an individual Medicare plan?

A. As a rule, group Medicare plans have better benefits than individual plans. And, because many employers or unions offer a defined contribution plan or subsidy (paying part of the cost you would pay wholly on your own with an individual plan), the cost is likely less as well.

Q. Regarding Part C, will coverage through a supplemental plan be included?

A. UT CARE is a Part C Medicare Advantage plan, not to be confused with a Medicare Supplement Insurance plan. Unlike a Medicare Supplement Insurance plan, UT CARE has additional benefits that Medicare does not cover.

UT CARE replaces UT SELECT which also provided coverage beyond Medicare benefits for UTS retirees. This new plan covers all the services that Medicare Parts A and B cover and includes the additional benefits that were included in your previous UT SELECT plan. The UT CARE plan information provided through various channels covers this in more detail, including the chart in the enrollment materials that compares UT SELECT with UT CARE. Please call customer service for help understanding how the plans compare.

Q. Are my dependents eligible?

A. Yes. Dependents are defined as a spouse, a child under the age of 26, or an eligible, incapacitated dependent over the age of 26 who is included under the retiree's medical coverage through UTS. Different plan scenarios apply depending on Medicare eligibility:

- If the retiree and dependents are all eligible for Medicare, then all will be enrolled in the UT CARE.
- If the retiree is eligible for Medicare but dependents are not, then retiree will be enrolled in a UT CARE plan and dependents will be enrolled in UT SELECT™.
- If the retiree is not eligible for Medicare but dependents are, then the retiree will be enrolled in UT SELECT and dependents will be enrolled in UT CARE.
- If neither the retiree nor dependents are eligible for Medicare, then all will be enrolled in UT SELECT.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. Am I covered by UT CARE when I travel outside the U.S.?

A. If you require medical treatment while out of the country, you are only covered in an emergency per [Medicare rules](#). The Blue Cross and Blue Shield Global Core program gives members traveling outside of the United States and its territories access to urgent and emergency medical assistance services and doctors and hospitals in more than 200 countries around the world. If you have questions about what medical care is covered when you travel, please call UT CARE Customer Service or access information at www.bcbsglobalcore.com.

Q. Can I enroll in UT CARE if I live abroad?

A. UT CARE is a Medicare plan available to retirees who live in the United States and its territories. If you reside full time outside the country, you are not eligible for UT CARE. Your coverage may be continued through your current UT System health care plan.

Q. Will UT CARE cover all that UT SELECT covers, regardless of whether Medicare allows the procedure?

A. The UT CARE plan was designed to mirror the benefits of the UT SELECT plan. Based on the specific procedure or service, there could be some differences, but those are rare. In many cases UT CARE has additional benefits outside of what Medicare allows. Please see benefit comparison chart and summary of benefits for coverage details.

Q. What are some examples of “high-cost medical services” that require prior authorization? And how are those authorizations obtained?

A. Some examples of higher cost services are diagnostic procedures such as MRI, MRA, CT scans and PET scans. The member should also discuss alternative cost-effective services with their physician. If you have a Prior Authorization (PA) already in place when you enroll in UT CARE, the PA requirement is waived for the first six months of coverage.

Q. Do I have to choose a plan offered by UTS?

A. You may choose not to enroll in the UT CARE Medicare PPO. Opting out of this plan means you will not have medical or prescription coverage through the UT Benefits program or the basic life coverage that is included with the medical plan. You may continue other coverage types and may enroll in UT CARE later during Annual Enrollment or following a qualifying change of status.

Q. How do I enroll in UT CARE?

A. As long as you are enrolled in Medicare Parts A and B you will be automatically enrolled in UT CARE. There is no form to complete or action needed on your part.

Q. How do I opt out of UT CARE?

A: If you prefer to opt out of the UT CARE medical and prescription plan, you must do so between November 1 and November 15, 2022, by declining the coverage through the My UT Benefits online system. To access My UT Benefits, please visit the “Manage Your UT Benefits” page at <http://utbenefits.link/manage>.

IMPORTANT: If you take action to opt out, you will not have any UT medical, prescription or basic retiree life insurance.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

If CMS does not accept your enrollment because a federal requirement was not met for enrollment, then you will still have UT SELECT medical coverage. However, the benefit will be limited to what the plan would pay after Medicare pays. Typically, that means the plan will pay about 20%.

Q. If I decline participation in this Group plan now, can I sign up later?

A. Yes, you can opt in or out of the plan anytime you have a qualified change of status or life event or during annual enrollment.

Q. What if I keep working past age 65?

A. If you're retired and working in a benefits eligible position at a UT institution, you and/or any dependent(s)

will be enrolled in the UT SELECT plan regardless of your Medicare status. If you are retired and working less than 20 hours at a UT institution, you and any Medicare-eligible dependents will be covered by UT CARE.

Below are additional coverage examples for when the retiree is working less than 20 hours at a UT institution:

- If the retiree is eligible for Medicare but dependents are not, the retiree will be enrolled in UT CARE and dependents will be enrolled in UT SELECT.
- If the retiree is not eligible for Medicare but dependents are, then the retiree will be enrolled in UT SELECT and dependents will be enrolled in UT CARE.
- If neither the retiree nor dependents are eligible for Medicare, then all will be enrolled in UT SELECT.

Q. When will my UT CARE coverage be effective?

A. Coverage for this plan is effective January 1, 2023. Or, if newly eligible for the plan after January 1, 2023, due to age or retirement, UT CARE is effective once CMS approves your coverage. Until that time, your coverage will continue to be in place with UT SELECT.

Q. How often will I be billed? By whom?

A. Discuss premium payments with the benefit office at your institution. Remember, you are still required to pay your Medicare Part B premium.

Providers

Q. Will I be able to see my current providers?

A. Yes. Under the UT CARE plan, which is an 'open access' or 'passive' PPO, you can go to any providers who: 1) accept Medicare; 2) agree to see you as a patient; and 3) agree to submit claims to Blue Cross and Blue Shield of Texas. They do not need to be part of any Blue Cross and Blue Shield network.

Q. How will my provider know my plan has changed?

A. Please inform your providers that your plan has changed when you call for an appointment and when you arrive for your visit. As a UT CARE member, you have a new member number and ID card. Be sure to show your new card to your providers or their office staff. Remind them that your old ID is no longer valid. If the provider does not use your new number, your benefits cannot be confirmed and there may be delays processing your claims. Your welcome kit will also have a notice to bring with you when you see your provider.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. Will my provider be able to submit claims easily to UT CARE?

A. Yes. In fact, we simplified the UT CARE claims process for providers. Instead of submitting claims to Medicare, providers can now submit directly to Blue Cross and Blue Shield of Texas. We take care of any interactions with Medicare on behalf of the provider and you. In addition, we offer providers education and dedicated online resources about UT CARE that can be quickly accessed. And we make it easy for them to reach customer service any time they have questions.

Q. Will most providers agree to bill the new program?

A. 98% of providers across the country accept Medicare. Open Access PPO plans like UT CARE, which cover everything covered by Medicare Part A and B and more, are new to some providers. Many are accustomed to submitting claims directly to Medicare rather than to an insurer like BCBSTX. For most UT CARE patients, providers will file claims with their local BCBS plan and are familiar with this process. If your providers accept Medicare, we've made it easy for them to submit claims for your care.

Q. Help me understand how the provider network works if I don't need to see a network provider.

A. This is an Open Access PPO plan. Any provider who accepts Medicare assignment and agrees to bill BCBS, will be paid. Providers who have contracted to be in the BCBS network will be paid their contracted rate. Providers who are not in the BCBS network will be paid the Medicare allowable rate for your care. You can see providers inside and outside of the BCBS network who agree to the rules stated above. Providers outside of Texas can file claims with their local BCBS plan and are familiar with this process.

Q. The new UT CARE Medicare PPO plan requires that providers accept Medicare patients and must also "agree to submit claims to BCBSTX." What does this claims process entail? Does it differ the current billing procedures?

A. There is no difference in the submission of claims for providers accepting assignment and willing to submit claims to BCBS. With this process there will be no member intervention needed. Providers will not need to submit claims directly to Medicare. The claims will process seamlessly according to benefits allowed and based on medical necessity. Providers outside of Texas can file claims with their local BCBS plan and should be familiar with this process.

Q. If a provider is not on the PPO list, is it possible to continue to be treated by this healthcare provider without incurring significant copays and/or deductibles?

A. This is an Open Access PPO plan. Any provider who accepts Medicare assignment and agrees to bill BCBS will be paid. Providers who have contracted to be in the BCBS network will be paid their contracted rate. Providers who are not in the BCBS network will be paid the Medicare allowable rate for your care. Providers outside of Texas can file claims with their local BCBS plan and are familiar with this process.

Q. We live outside of Texas and our providers are not part of the BCBS network. Will they know what UT CARE is? What documents will we have to share with the provider to explain how to submit claims?

A. This is an Open Access PPO plan. Any provider who accepts Medicare assignment and agrees to bill BCBS will be paid. Providers who are not in the BCBS network will be paid the Medicare allowable rate for your care.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

You will receive a notice in your welcome kit to share with your provider. Providers outside of Texas can file claims with their local BCBS plan and are familiar with this process. The customer service number listed on the back of your member ID card is for you or your provider to call with any questions.

Q. One of the joys of retirement is that retirees can travel to visit family and places outside of their home bases. If we become ill or are involved in an accident while traveling, will we be able to find care and how will the provider submit the claim?

A. This is an Open Access PPO plan. You can see any out-of-state provider who accepts Medicare assignment and agrees to bill BCBS.

If you require medical treatment while out of the country, you are only covered in an emergency or urgent situation. Like the UT SELECT plan, the Blue Cross and Blue Shield Global Core program gives members traveling outside of the United States and its territories access to urgent and emergency medical assistance services and doctors and hospitals in more than 200 countries around the world. If you have questions about what medical care is covered when you travel, please call customer service or access information at www.bcbsglobalcore.com.

Claim Forms for care received abroad can be obtained at www.bcbsglobalcore.com or by calling 800-810-BLUE.

Submit claims to:

**BCBS Global Core Service Center
P.O Box 2048
Southeastern, PA 19399**

Q. What is the appeal process?

A. To request an appeal, you, your representative, or your doctor can mail or fax a written request as well as contact customer service. Appeals must be submitted within 60 days of receiving your Explanation of Benefits (EOB) for the visit in question.

If you submit a written request for appeal, you must include the following information:

Your name, member number, address, reasons for appealing, and any evidence you want us to review such as medical records, doctor's letters or other information that explains why you need the item or service.

Requests can be mailed to:

**Blue Cross Medicare Advantage
Attention: Appeals Department
P.O. Box 663099
Dallas, TX 75266**

For a standard appeal we will provide a written decision within 60 days.

Q. Can I see a provider who doesn't accept Medicare assignment?

A. Yes. If a member goes to a provider who does NOT accept Medicare assignment and is not in the national BCBS Medicare Advantage PPO network, the member may be expected to pay the billed amount directly to the

Frequently Asked Questions about Medicare and Medicare Advantage plans.

provider at the time of service. The member can submit the claim to BCBSTX. We would then pay the claim to the member at the Medicare limiting charge of 115% of the Medicare fee schedule for professional providers. If the provider has charged more than the 115% limiting charge, the member would not be reimbursed the difference of the billed amount they paid to the provider for services and 115% Medicare rates paid. The member would need to pursue a refund from the provider directly.

Example: Robert sees Dr. Smith, a non-participating provider and pays him \$200 after the visit. The Medicare allowed amount for the visit is \$80. Because Medicare limits what the provider can charge for covered services to 115% of the allowed amount for the service, Robert will be reimbursed \$92. The remaining \$108 will not be reimbursed.

\$ 80 Medicare allowed amount for the service

\$ 92 115% of the allowed amount

\$200 Robert pays Dr. Smith

\$ 92 Robert is reimbursed this amount by BCBS

\$108 Robert would need to seek this refund from the provider on his own

Q: Can I see a provider who has opted out of Medicare?

A. Less than 2% of providers opt out of Medicare. Providers who have opted out are unable to be reimbursed for services rendered. A member may see a provider who has opted out of Medicare; however, the visit will not be paid for by the plan or Medicare. A listing of providers that have opted out of Medicare can be found [here on the CMS website](#).

Q: How do I file a claim after seeing a provider who doesn't accept Medicare assignment?

A. If the provider does not accept Medicare assignment and refuses to bill BCBS, the member may need to pay the billed amount of the services directly to the provider at the time of service and submit the bill to BCBSTX for reimbursement. There is no reimbursement form to complete, however you can submit a claim for reimbursement in writing to:

Blue Cross Medicare Advantage (Claims)

PO Box 4195

Scranton, PA 18505

Please include the following documentation:

- Copy of receipt showing payment was made
- Member name and ID number including the alpha prefix listed on ID card
- An invoice showing services rendered OR another form of documentation that includes
 - Diagnosis (or DX codes if available)
 - Procedure (or CPT codes if available)
 - Name and address of servicing provider

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Prescription Drug Coverage

Q. Does my plan cover any prescription drugs?

A. Your plan includes everything covered by Medicare Part B, including some drugs and services. To learn more about drugs covered under Medicare Part B, visit www.medicare.gov/coverage/prescription-drugs-outpatient. You also have Part D prescription drug coverage through a separate carrier for medications not covered under Part B.

Q. What are my other options for prescription drug coverage?

A. Part D prescription drug coverage for UTS retirees is available through a separate carrier and included when you enroll in UT CARE.

Q. How do I know if a drug is covered under my Part D prescription drug plan or the UT CARE Medicare PPO plan?

A. How you access your UT Part D prescription drug benefit has not changed. Part D covers common outpatient medications you get from the pharmacy, like those used to treat high blood pressure, high cholesterol, depression, and osteoporosis. These types of prescription drugs are not covered under Medicare Part A or Part B. If you have questions about your pharmacy benefits, call Part D customer service at 1-800-860-7849 TTY 711.

UT CARE Medicare PPO covers some drugs and services normally covered by Medicare Part B. These can include:

- Drugs that you don't administer yourself. These drugs can be given in a doctor's office as part of their service. Coverage may be limited to drugs that are given by infusion or injection in a hospital or outpatient facility.
- Diabetic supplies as detailed in your evidence of coverage.
- Certain shots (vaccinations):
 - COVID-19 vaccine.
 - Flu shots.
 - Pneumococcal shots.
 - Hepatitis B shots.
 - Other vaccines that are directly related to the treatment of an injury or illness (like a tetanus shot).
- Drugs infused through durable medical equipment, like an infusion pump or a nebulizer. Medicare may cover insulin and insulin pumps worn outside the body.
- Injectable and infused drugs; some antigens; erythropoiesis stimulating agents to treat anemia; blood clotting factors; some immunosuppressive, oral cancer and anti-nausea drugs used as part of chemotherapy treatment; intravenous and tube feeding, and Immune Globulin (IVIG) provided in the home; some oral and intravenous drugs for those with end stage renal disease.

If you need to know if a drug you are prescribed is covered under Part B or Part D, please call UT CARE Medicare PPO Customer Service.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Supplemental Benefits

Q. Will I have access to dental, vision or hearing benefits?

A. The UT CARE plan includes a \$0 copay for one hearing exam annually plus a hearing aid allowance of \$1,000 per ear, over 36 months. While dental and vision services are not covered as part of UT CARE, you will continue to enjoy these benefits through UT group plans, as you do now.

Q. Are chiropractic services covered?

A. Routine chiropractic visits are covered with a \$0 copay for 35 visits per year.

Q. Can I use private duty nursing with this plan?

A. Private duty nursing is covered with a \$0 copay for 90 visits per year for medically necessary, temporary private duty nursing.

Q. What are all my supplemental benefits?

A. Your supplemental benefits include:

- Hearing Care
- Private Duty Nursing
- Wellness Solutions
- SilverSneakers® Fitness Program*
- 24/7 Nurseline
- Virtual Visits
- Chronic Disease Prevention and Support
- Hypertension and Diabetes Programs
- Musculoskeletal and Chronic Pain Programs
- Weight Management Program

* Classes and amenities vary by location.

Q. Will I have access to the same health and wellness benefits I had under UT SELECT?

A. Yes. You may continue to use all these health and wellness tools:

- Airrosti
- Blue365SM
- Catapult
- Hinge Health
- Learn to Live
- Livongo
- Nurseline
- Omada
- SilverSneakers® Fitness Program
- Wondr HealthTM

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Plan Effective Date and Communications

Q. When will my UT CARE ID card arrive?

A. ID cards for effective date 1/1/2023 were mailed in December. Retirees who enroll throughout the year receive their cards 10-14 days after Medicare confirms their enrollment.

Here are the items you can expect, in order. You will receive an acknowledgment letter, followed by a confirmation letter and then your new member ID card. You may use your confirmation letter as proof of insurance until your card arrives. Your UT CARE plan card is for use with hospital and medical providers, and for Medicare Part B drugs ordered by your provider. You will need to use your Medicare Part D membership card for prescriptions covered by your Part D plan.

As a UT CARE member, you have a new member number and ID card. Be sure to show your new card to your providers or their office staff. Remind them that your old ID is no longer valid. If the provider does not use your new number, your benefits cannot be confirmed and there may be delays processing your claims.

Q. Will I receive a periodic Medicare statement based on the plan I select?

A. If you enroll in UT CARE, you will receive your Explanation of Benefits (EOB) from Blue Cross and Blue Shield of Texas. How often you receive it depends on how often you see your provider. This statement is not a bill. It simply details what you have paid and indicates the level of benefits you've used.

UT CARE™ Medicare PPO is an open access Medicare Advantage PPO plan. On occasion, members may receive automated communications that reference plan name 'Blue Cross Group Medicare Advantage Open Access (PPO)SM .' This plan name also refers to UT CARE™ Medicare PPO.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

The relationship between these vendors and Blue Cross and Blue Shield of Texas (BCBSTX) is that of independent contractors. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by the above-mentioned vendors.

Blue365 is a discount program only for BCBSTX members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Employees should check their benefit booklet or call the Customer Service number on the back of their ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors that take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice. Hearing services are provided by American Hearing Benefits, Beltone™, HearUSA and TruHearing®. Vision services are provided by ContactsDirect®, Croakies, Davis VisionSM, EyeMed Vision Care, Glasses.com, Jonathan Paul Fitovers and LasikPlus®.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

TruHearing® is a registered trademark of TruHearing, Inc., which is an independent company providing discounts on hearing aids. The relationship between TruHearing and Blue Cross and Blue Shield of Texas is that of independent contractors.

SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company. Tivity Health and SilverSneakers® are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.

Livongo, Omada, and Hinge Health are independent companies that have contracted with Blue Cross and Blue Shield of Texas to provide health management solutions for members with coverage through BCBSTX.

Learn to Live (L2L) offers customized, user-paced, online programs based on the proven principles of Cognitive Behavioral Therapy (CBT). The programs are confidential, accessible anywhere and based on years of research showing online CBT programs to be as effective as face-to-face therapy. L2L coaches are not providing services as licensed therapists, social workers or doctors and do not offer services requiring professional licensure such as psychotherapy. Coaches do not provide crisis support or emergency behavioral health services. Learn to Live, Inc. is an independent company that provides online behavioral health programs and tools for members with coverage through Blue Cross and Blue Shield of Texas.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

PPO plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC) and GHS Insurance Company (GHSIC). PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC, HISC, and GHSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC, HISC, and GHSIC are Medicare Advantage organizations with a Medicare contract. Enrollment in these plans depends on contract renewal.