



BlueCross BlueShield
of Texas

THE TEXAS A&M
UNIVERSITY SYSTEM

The Texas A&M University SystemSM

2026

Summary

of Benefits

The 65 Plus Medicare Advantage Plan (PPO)SM

January 1, 2026 – December 31, 2026

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage*.

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call the Education Helpline for more information at 1-855-476-4149 (TTY: 711). We are open October 1 – March 31, daily, 8:00 a.m. to 8:00 p.m., local time, Monday through Friday. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Understanding the Benefits

- Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Visit www.bcbstx.com/tamus-retiree-medicare or call 1-855-476-4149 (TTY: 711) to request a copy of the EOC.
- Check with your current providers to confirm that they accept Medicare. Review the *Provider Finder* for a list of doctors in our network.

Understanding Important Rules

- Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.

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SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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, call us and ask for the *Evidence of Coverage*. You can also see the *Evidence of Coverage* on our website, www.bcbstx.com/tamus-retiree-medicare.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as the **65 Plus Medicare Advantage Plan (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what the **65 Plus Medicare Advantage Plan (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the 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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About the **65 Plus Medicare Advantage Plan (PPO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.

This document is available in other formats such as Braille, large print or audio.

This document may be available in a non-English language. For additional information, call us at 1-855-476-4149 (TTY: 711).

Things to Know About the 65 Plus Medicare Advantage Plan (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., local time, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., local time, Monday through Friday. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
- If you are a member of this plan, call us at 1-855-476-4149, (TTY: 711).
- If you are not a member of this plan, call us at 1-855-476-4149, (TTY: 711).
- Our website: www.bcbstx.com/tamus-retiree-medicare.

Who can join?

To join the **65 Plus Medicare Advantage Plan (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and be a retiree, or Medicare-eligible dependent of a retiree of the Texas A&M University System. Our service area includes anywhere in the United States.

Which doctors, hospitals, and pharmacies can I use?

The **65 Plus Medicare Advantage Plan (PPO)** has a network of doctors, hospitals, pharmacies, and other providers.

You can see our plan's *Provider Finder* and *Pharmacy Directory* at our website (www.bcbstx.com/tamus-retiree-medicare).

Or call us at 1-855-476-4149 (TTY: 711) and we will send you a copy of the *Provider Directory* and *Pharmacy Directory*.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more. Some of the extra benefits are outlined in this booklet.

In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

If you have any questions about this plan's benefits or costs, please contact Blue Cross and Blue Shield of Texas

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SECTION II - SUMMARY OF BENEFITS

The 65 Plus Medicare Advantage Plan (PPO)SM

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	For information concerning the actual premiums you will pay, please contact your employer or your employer group benefits plan administrator. In addition, you must keep paying your Medicare Part B premium.
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$750 for services you receive from in- and out-of-network providers combined.

COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital	Our plan covers unlimited number of days for an inpatient hospital stay. <u>In-Network:</u> 5% of the total cost per stay. <u>Out-of-Network:</u> 5% of the total cost per stay. May require prior authorization.
Outpatient Hospital	<u>In-Network:</u> 5% of the total cost. <u>Out-of-Network:</u> 5% of the total cost. May require prior authorization.
Ambulatory Surgical Center	<u>In-Network:</u> 5% of the total cost. <u>Out-of-Network:</u> 5% of the total cost. May require prior authorization.
Doctor's Office Visits	<u>In-Network:</u> Primary care physician visit: \$0 copay. Specialist visit: 5% of the total cost. <u>Out-of-Network:</u> Primary care physician visit: \$0 copay.

	<p>Specialist visit: 5% of the total cost.</p> <p>May require prior authorization.</p>
<p>Preventive Care <i>(e.g., flu vaccine, diabetic screenings)</i></p>	<p><u>In-Network:</u></p> <p>\$0 copay for all preventive services covered under Original Medicare at zero cost sharing.</p> <p><u>Out-of-Network:</u></p> <p>\$0 copay for all preventive services covered under Original Medicare at zero cost sharing.</p> <p>Call Customer Service for more information.</p>
<p>Emergency Care</p>	<p>5% of the total cost per visit.</p> <p>Worldwide Emergency Coverage: 5% of the total cost.</p> <p>Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital" section of this booklet for other costs.</p>
<p>Urgently Needed Services</p>	<p>5% of the total cost per visit.</p> <p>Worldwide Urgent Coverage: 5% of the total cost.</p>
<p>Diagnostic Services / Labs/ Imaging</p>	<p><u>In-Network:</u></p> <p>Diagnostic tests and procedures: 5% of the total cost.</p> <p>Lab services: 5% of the total cost.</p> <p>MRIs, CT scans: 5% of the total cost.</p> <p>X-rays: 5% of the total cost.</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 5% of the total cost.</p> <p><u>Out-of-Network:</u></p> <p>Diagnostic tests and procedures: 5% of the total cost.</p> <p>Lab services: 5% of the total cost.</p> <p>MRIs, CT scans: 5% of the total cost.</p> <p>X-rays: 5% of the total cost.</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 5% of the total cost.</p> <p>May require prior authorization.</p>

<p>Hearing Services</p>	<p><u>In-Network:</u></p> <p><u>Medicare-covered:</u> Exam to diagnose and treat hearing and balance issues: 5% of the total cost.</p> <p><u>Routine Hearing:</u> Routine hearing exam (1 each year): 20% of the total cost.</p> <p><u>Out-of-Network:</u></p> <p><u>Medicare-covered:</u> Exam to diagnose and treat hearing and balance issues: 5% of the total cost.</p> <p><u>Routine Hearing:</u> Routine hearing exam (1 each year): 20% of the total cost.</p> <p><u>In-Network and Out-of-Network:</u></p> <p><u>Hearing Aid:</u> \$2,000 Allowance per ear in-network and out-of-network on hearing aids every three years. May require prior authorization.</p>
<p>Dental Services</p>	<p><u>In-Network:</u> Medicare-covered: 5% of the total cost.</p> <p><u>Out-of-Network:</u> Medicare-covered: 5% of the total cost. May require prior authorization.</p>
<p>Vision Services</p>	<p><u>In-Network:</u></p> <p><u>Medicare-covered:</u></p> <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 5% of the total cost for an eye exam. • Eyeglasses or contact lenses after cataract surgery: 5% of the total cost. <p><u>Routine Vision:</u></p> <ul style="list-style-type: none"> • Routine eye exam (1 every year): \$0 copay. <p><u>Out-of-Network:</u></p> <p><u>Medicare-covered:</u></p> <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 5% of the total cost for an eye exam.

	<ul style="list-style-type: none"> • Eyeglasses or contact lenses after cataract surgery: 5% of the total cost. <p><u>Routine Vision:</u></p> <ul style="list-style-type: none"> • Routine eye exam (1 every year): \$0 copay <p>May require prior authorization.</p>
<p>Mental Health Services</p>	<p>Medicare covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p><u>In-Network:</u></p> <p>Inpatient Mental Health Care: 5% of the total cost per stay.</p> <p>Outpatient group therapy visit: 5% of the total cost.</p> <p>Outpatient Individual therapy visit: 5% of the total cost.</p> <p><u>Out-of-Network:</u></p> <p>Inpatient Mental Health Care: 5% of the total cost per stay.</p> <p>Outpatient group therapy visit: 5% of the total cost.</p> <p>Outpatient Individual therapy visit: 5% of the total cost.</p> <p>May require prior authorization.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p><u>In-Network:</u></p> <p>Days 1-20: \$0 copay per day.</p> <p>Days 21-100: 5% of the total cost per day.</p> <p><u>Out-of-Network:</u></p> <p>Days 1-20: \$0 copay per day.</p> <p>Days 21-100: 5% of the total cost per day.</p> <p>May require prior authorization.</p>
<p>Physical Therapy</p>	<p><u>In-Network:</u></p> <p>5% of the total cost.</p>

	<p><u>Out-of-Network:</u></p> <p>5% of the total cost.</p> <p>May require prior authorization.</p>
Outpatient Rehabilitation	<p><u>In-Network:</u></p> <p>Cardiac rehab services (Maximum of 2 one-hour sessions per day up to 36 sessions in 36 weeks. Limit to 36 per year): 5% of the total cost.</p> <p>Occupational therapy visit: 5% of the total cost.</p> <p><u>Out-of-Network:</u></p> <p>Cardiac rehab services (Maximum of 2 one-hour sessions per day up to 36 sessions in 36 weeks. Limit to 36 per year): 5% of the total cost.</p> <p>Occupational therapy visit: 5% of the total cost.</p> <p>May require prior authorization.</p>
Ambulance	<p>Ground Ambulance: 5% of the total cost for each one-way trip.</p> <p>Air Ambulance: 5% of the total cost for each one-way trip.</p> <p>May require prior authorization.</p>
Transportation	Not Covered
Medicare Part B Drugs	<p><u>In-Network:</u></p> <p>For Part B drugs such as chemotherapy drugs: 5% of the total cost.</p> <p>Other Part B drugs: 5% of the total cost.</p> <p>For Part B Insulin Drugs: 5% of the total cost with a maximum copay amount per month of \$35.</p> <p><u>Out-of-Network:</u></p> <p>For Part B drugs such as chemotherapy drugs: 5% of the total cost.</p> <p>Other Part B drugs: 5% of the total cost.</p> <p>For Part B Insulin Drugs: 5% of the total cost with a maximum copay amount per month of \$35.</p> <p>May require prior authorization.</p>

**Additional
Member
Benefits**

The 65 Plus Medicare Advantage Plan (PPO)SM

**Acupuncture for
Chronic Low Back
Pain**

In-Network:

Medicare-covered:

- 5% of the total cost.

Routine Acupuncture:

- Routine acupuncture: 20% of the total cost per visit for up to 30 routine acupuncture visit(s) every year.

Out-of-Network:

Medicare-covered:

- 5% of the total cost.

Routine Acupuncture:

- Routine acupuncture: 20% of the total cost per visit for up to 30 routine acupuncture visit(s) every year.

May require prior authorization.

Chiropractic Care

Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).

In-Network:

Medicare-covered:

- 5% of the total cost.

Routine Chiropractic Care:

- Routine chiropractic: 20% of the total cost per visit for up to 30 routine chiropractic visit(s) every year.

Out-of-Network:

Medicare-covered:

- 5% of the total cost.

Routine Chiropractic Care:

- Routine chiropractic: 20% of the total cost per visit for up to 30 routine chiropractic visit(s) every year.

May require prior authorization.

**Additional
Member
Benefits**

The 65 Plus Medicare Advantage Plan (PPO)SM

<p>Diabetes Supplies and Services</p>	<p><u>In-Network:</u></p> <p>Diabetes monitoring supplies</p> <ul style="list-style-type: none"> • 0% cost sharing is limited to diabetic testing supplies (meters and strips) obtained through the pharmacy to Ascensia and Abbott branded products. All other diabetic testing supplies (meters and strips) and will be subject to 5% cost sharing. <p>Diabetes self-management training</p> <ul style="list-style-type: none"> • \$0 copay. <p>Therapeutic shoes or inserts</p> <ul style="list-style-type: none"> • 5% of the total cost. <p><u>Out-of-Network:</u></p> <p>Diabetes monitoring supplies</p> <ul style="list-style-type: none"> • 0% cost sharing is limited to diabetic testing supplies (meters and strips) obtained through the pharmacy to Ascensia and Abbott branded products. All other diabetic testing supplies (meters and strips) and will be subject to 5% cost sharing. <p>Diabetes self-management training</p> <ul style="list-style-type: none"> • \$0 copay. <p>Therapeutic shoes or inserts</p> <ul style="list-style-type: none"> • 5% of the total cost. <p>May require prior authorization.</p>
<p>Durable Medical Equipment (wheelchairs, oxygen, etc.)</p>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • 5% of the total cost. <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 5% of the total cost. <p>May require prior authorization.</p>
<p>Wellness Programs</p>	<p>\$0 copay for SilverSneakers® Fitness Program</p>

**Additional
Member
Benefits**

The 65 Plus Medicare Advantage Plan (PPO)SM

	<p>SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations.</p> <p>You have access to a nationwide network of participating locations where you can take classes.</p> <p>SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.</p>
<p>Foot Care (Podiatry services)</p>	<p>Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.</p> <p><u>In-Network:</u></p> <p><u>Medicare-covered:</u></p> <ul style="list-style-type: none"> • 5% of the total cost. <p><u>Routine Podiatry:</u></p> <ul style="list-style-type: none"> • Routine podiatry: Not Covered. <p><u>Out-of-Network:</u></p> <p><u>Medicare-covered:</u></p> <ul style="list-style-type: none"> • 5% of the total cost. <p><u>Routine Podiatry:</u></p> <ul style="list-style-type: none"> • Routine podiatry: Not Covered. <p>May require prior authorization.</p>
<p>Private Duty Nursing</p>	<p><u>In-Network and Out-of-Network:</u></p> <p>\$10,000 Allowance per year for Non Medicare-covered services.</p> <p>For more details on benefits and benefit limitations regarding your private duty nursing coverage, please see your <i>Evidence of Coverage</i>.</p>

Additional Member Benefits	The 65 Plus Medicare Advantage Plan (PPO) SM
Home Health Care	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • 5% of the total cost. <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 5% of the total cost. <p>May require prior authorization.</p>
Opioid Treatment Program Services	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • \$0 copay. <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • \$0 copay. <p>May require prior authorization.</p>
Outpatient Substance Abuse Services	<p><u>In-Network:</u></p> <p>Group therapy visit</p> <ul style="list-style-type: none"> • 5% of the total cost. <p>Individual therapy visit</p> <ul style="list-style-type: none"> • 5% of the total cost. <p><u>Out-of-Network:</u></p> <p>Group therapy visit</p> <ul style="list-style-type: none"> • 5% of the total cost. <p>Individual therapy visit</p> <ul style="list-style-type: none"> • 5% of the total cost. <p>May require prior authorization.</p>
Over-the-Counter Items	Not Covered
Prosthetic Devices <i>(braces, artificial limbs, etc.)</i>	<p><u>In-Network:</u></p> <p>Prosthetic devices</p> <ul style="list-style-type: none"> • 5% of the total cost.

**Additional
Member
Benefits**

The 65 Plus Medicare Advantage Plan (PPO)SM

	<p>Related medical supplies</p> <ul style="list-style-type: none"> • 5% of the total cost. <p><u>Out-of-Network:</u></p> <p>Prosthetic devices</p> <ul style="list-style-type: none"> • 5% of the total cost. <p>Related medical supplies</p> <ul style="list-style-type: none"> • 5% of the total cost. <p>May require prior authorization.</p>
<p>Renal Dialysis</p>	<p><u>In-Network:</u></p> <ul style="list-style-type: none"> • 5% of the total cost. <p><u>Out-of-Network:</u></p> <ul style="list-style-type: none"> • 5% of the total cost. <p>May require prior authorization.</p>
<p>Telehealth Services</p>	<ul style="list-style-type: none"> • Virtual Urgent Care - \$10 copay (through MDLive only), Virtual Mental Health Specialty Services - \$0 copay (through MDLive only), Virtual Psychiatric Services - \$0 copay (through MDLive only)
<p>Hospice</p>	<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.</p>

DISCLAIMERS

This document is available in other alternate formats.

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 1-855-476-4149 (TTY: 711). Someone who speaks English can help you. This is a free service.

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 1-855-476-4149 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Texas 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 or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.



Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 1-855-476-4149 (TTY: 711).

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	1-855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	1-855-661-6965
300 E. Randolph St., 35th Floor	Fax:	1-855-661-6960
Chicago, IL 60601	Email:	civilrightscordinator@bcbsil.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	1-800-368-1019
200 Independence Avenue SW	TTY/TDD:	1-800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice.

Blue Cross Blue Shield of Texas, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-476-4149 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-476-4149 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-476-4149 (TTY: 711) أو تحدث إلى مقدم الخدمة.
中文 Chinese	注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-855-476-4149 文本电话: 711) 或咨询您的服务提供者。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-476-4149 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-476-4149 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય આક્રમક સહાય અને અસરકારક ફોન માટેની પૂરી પાડવા માટેની સેવાઓ પણ સવના મૂલ્યે ઉપલબ્ધ છે. 1-855-476-4149 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयोगी सामाजिक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-476-4149 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-855-476-4149 (TTY: 711) o parla con il tuo fornitore.
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-476-4149 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yánití'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jii'eh ná hóló. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóo bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jii'eh hóló. Kohjí' 1-855-476-4149 (TTY: 711) hodiilnih doodago nika'análwo'í bich'í' hanidziih.
فارس Farsi	توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-855-476-4149 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود

Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-855-476-4149 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
Русский Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-476-4149 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-476-4149 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: 711) 1-855-476-4149 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
فارسی Persian	ما در راستای پاسخگویی به سوالات شما در مورد طرح سلامت یا دارویی خود، دارای خدمات مترجم رایگان هستیم برای داشتن یک مترجم، کافیست از طریق شماره 1-855-476-4149 (TTY: 711) با ما تماس بگیرید. یک شخص فارسی زبان می تواند به شما کمک کند. این یک سرویس رایگان است
ລາວລາວ Laotian	ພວກເຮົາ ມີ ບໍລິ ການຜູ້ ແປພາສາ ບໍ່ ເສຍຄ່າໃຫ້ເພື່ອ ອອອຍຕອບ ອໍາຖາມທີ່ ທ່ານອາດມີ ກ່ຽວກັບ ບໍາເລງບໍາເລງ ນສຸ ຂະພາບ ແລະ ຢາຂອງພວກເຮົາ າ. ເພື່ອ ອຮົ າຜູ້ ແປພາສາ, ພຽງແຕ່ໃຫ້ພວກເຮົາ າທີ່ ເບີ 1-855-476-4149 (TTY: 711). ຈະມີ ຄື ນທີ່ ເວົ້າ ພາສາລາວສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ ແມ່ນ ນການບໍລິ ການບໍ່ ເສຍຄ່າ.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-476-4149 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.



Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-855-476-4149 (TTY: 711) for more information.

Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

PPO plan provided by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC is an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment depends on contract renewal.

THANK YOU

Connect with us

Contact Information: 1-855-476-4149, TTY: 711

Organization Name: Blue Cross and Blue Shield of Texas

Organization website: www.bcbstx.com