BlueCross BlueShield of Texas

THE TEXAS A&M UNIVERSITY SYSTEM

Frequently Asked Questions about Medicare and Medicare Advantage plans.

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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 65 Plus Medicare Advantage Plan (PPO). To have full coverage, you must sign up for Medicare Parts A & B and continue to pay your Part B premium. This is no different than in previous years under the A&M Care plan and 65 Plus Plan, which required Medicare eligible retirees and covered dependents to enroll in Medicare Part A and Part B. Call the 65 Plus Medicare Advantage enrollment support at 1-855-476-4149 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 65 Plus Medicare Advantage Plan (PPO), 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 65 Plus Medicare Advantage Plan (PPO).

Q. How do I enroll in Medicare Part A and B?
A. Enrollment is done through the Social Security Administration (SSA). If you are 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. Contact the Social Security Administration:

Visit SSA online at www.ssa.gov, or
Visit in person at your local SSA office, or
Call SSA at 1-800-772-1213 (TTY 1-800-325-0778)

Most people should enroll 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.

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 and B 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 do not 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 is 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

Frequently Asked Questions about Medicare and Medicare Advantage plans.

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 65 Plus Medicare Advantage Plan (PPO) includes non-Medicare covered benefits such as an eye exam, hearing aid allowance, the SilverSneakers® fitness program, routine acupuncture 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 Medicare as individual members; however sponsored plans determine their own eligibility and enrollment policies. See below for enrollment information specific to the 65 Plus Medicare Advantage Plan (PPO).

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 65 Plus Medicare Advantage Plan (PPO)

Q. What are the advantages of a group Medicare plan like the 65 Plus Medicare Advantage Plan 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. The 65 Plus Medicare Advantage Plan (PPO) is a Part C Medicare Advantage plan, not to be confused with a Medicare Supplement Insurance plan. Unlike a Medicare Supplement Insurance plan, the 65 Plus Plan has additional benefits that Medicare does not cover.

This 65 Plus Medicare Advantage Plan (PPO) replaces the A&M Care 65 Plus Plan which also provided coverage beyond Medicare benefits for Texas A&M University System retirees. This new plan covers all the services that Medicare Parts A and B cover and includes additional benefits not covered by Original Medicare (Parts A and B). Plan specifics and details are covered in enrollment materials, including a chart that compares A&M Care 65 Plus Plan with 65 Plus Medicare Advantage (PPO). Please call customer service at 1-855-476-4149 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 Texas A&M University System. Different plan scenarios apply depending on Medicare eligibility:

Frequently Asked Questions about Medicare and Medicare Advantage plans.

- If the retiree and dependents are all eligible for Medicare, then all will be enrolled in the 65 Plus Medicare Advantage Plan (PPO).
- If a spouse or dependent is not eligible for Medicare, then all will remain on the active plan until all are eligible for Medicare.
- If the retiree is not eligible for Medicare but dependents are, then all will remain on the active plan until all are eligible for Medicare.
- If neither the retiree nor dependents are eligible for Medicare, then all will remain on the active plan until all are eligible for Medicare.

Q. What are the dates related to the $750 out-of-pocket maximum? What costs count toward it?
A. Starting January 1, 2024, the plan year will be January 1- December 31. Yearly allowances and out-of-pocket calculations reset to zero each January 1. Any deductibles, copays or coinsurance count toward your out-of-pocket maximum.

Q. So I should have no costs after reaching the $750 out-of-pocket maximum?
A. The only costs to the member after reaching the out-of-pocket maximum would be amounts over the maximum indicated by the plan for supplemental benefits like a hearing aid and any balance billing when a provider doesn't accept the Medicare-allowed amount for compensation.

Q. Please explain "balance billing."
A. Balance billing is when a provider bills you for the difference between what they charge and the amount allowed by Medicare. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30.

Q. Am I covered by 65 Plus Medicare Advantage (PPO) 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 65 Plus Medicare Advantage PPO customer service at 1-855-476-4149 or access information at www.bcbsglobalcore.com.

Q. Can I enroll in 65 Plus Medicare Advantage Plan (PPO) if I live abroad?
A. 65 Plus Medicare Advantage (PPO) is a Medicare plan available to retirees who live in the United States and its territories. If you reside full time outside of the country, you are not eligible for the 65 Plus Medicare Advantage Plan (PPO). Your coverage may be continued through the current Texas A&M University System active health care plan.

Q. Will 65 Plus Medicare Advantage PPO cover all that A&M Care 65 Plus Plan covers, regardless of whether Medicare allows the procedure?
A. The 65 Plus Medicare Advantage Plan (PPO) was designed to mirror the benefits of the A&M Care 65 Plus Plan in a managed care plan. Based on the specific procedure or service, there could be some differences, but those are rare. In many cases, the 65 Plus Medicare Advantage Plan (PPO) has additional benefits outside of

what Medicare allows. Please see benefit comparison chart and summary of benefits for coverage details. You can also call the pre-enrollment help line at 1-855-476-4149.

Q. Which "high-cost medical services" need prior authorization?
A. Some examples of higher cost services are diagnostic procedures such as MRI, MRA, CT scans and PET scans (Advanced Imaging). Prior Authorization (PA) is also needed for:

- ✓ Musculoskeletal – Pain/Joint/Spine
- ✓ Outpatient Medical Oncology
- ✓ Outpatient Radiation Therapy
- ✓ Outpatient Sleep Study
- ✓ Outpatient Specialty Drugs
- ✓ Lab Management Solutions – Molecular and Genomic Lab Testing

Services that are performed as part of an inpatient stay, 23-hour observation or emergency room visit do not need PA.

Your provider will work with 65 Plus Medicare Advantage Plan (PPO) to get any PA you may need and may talk with you about other options if necessary. If you have a PA in place when you enroll in A&M Medicare PPO, that PA continues for the first six months of coverage.

Q. Do I have to choose a plan offered by Texas A&M University System?
A. No, but if you opt out of the 65 Plus Medicare Advantage Plan (PPO), you will no longer have medical coverage through The Texas A&M University System. If you take action to opt out, you will not have any medical, prescription or basic retiree life insurance through The Texas A&M University System.

Q. How do I enroll in the 65 Plus Medicare Advantage Plan (PPO)?
A. As long as you are enrolled in Medicare Parts A and B, you will be automatically enrolled in 65 Plus Medicare Advantage Plan (PPO). There is no form to complete, or action needed on your part.

Q. How do I opt out of the 65 Plus Medicare Advantage Plan (PPO)?
A. You must complete a form—available through your benefits office—to opt out of this plan.
If you take action to opt out, you will not have any medical, prescription or basic retiree life insurance through Texas A&M University System.

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 qualifying life event or during Open Enrollment.

Q. When will my 65 Plus Medicare Advantage Plan (PPO) coverage be effective?
A. Coverage for this plan is effective January 1, 2024. Or, if newly eligible for the plan after January 1, 2024, due to age or retirement, 65 Plus Medicare Advantage Plan (PPO) is effective once CMS approves your coverage. Until that time, your coverage will continue to be in place with A&M Care Plan.

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Q. How often will I be billed? By whom?
A. The billing process through the A&M System will not change. For questions regarding your premium payments for the 65 Plus Medicare Advantage Plan (PPO), contact System Insurance Billing at (979) 845-0015. Remember, you are still required to pay your Medicare Part B premium.

Providers

Q. Will I be able to see my current providers?
A. Most likely, yes. Under the 65 Plus Medicare Advantage Plan (PPO), 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 65 Plus Medicare Advantage Plan (PPO) 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 your provider does not use your new number, care may be delayed. Your enrollment and welcome kits will also have a notice to bring with you when you see your provider.

Q. Will my provider be able to submit claims easily to 65 Plus Medicare Advantage Plan (PPO)?
A. Yes. In fact, we simplified the 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.

Q. Will most providers agree to bill the new program?
A. 98% of providers across the country accept Medicare. Open Access PPO plans like **65 Plus Medicare Advantage Plan (PPO)** cover everything covered by Medicare Part A and B. For most 65 Plus Medicare Advantage PPO 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 do not 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.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. The new 65 Plus Medicare Advantage Plan (PPO) requires that providers accept Medicare patients and must also "agree to submit claims to BCBSTX." What does this claim process entail? Does it differ from 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 this plan 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. You will receive a notice in both your enrollment and welcome kits 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 A&M Care 65 Plus 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 two hundred 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.

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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 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.

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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, and
- 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, Express Scripts, for medications not covered under Part B. You can refer to the A&M System website for retiree benefits for questions regarding your Medicare Part D coverage with Express Scripts https://www.tamus.edu/benefits/retiree-benefits/.

Q. What are my other options for prescription drug coverage?
A. Part D prescription drug coverage for the A&M System retirees is available through a separate carrier, Express Scripts, and included when you enroll in the 65 Plus Medicare Advantage Plan (PPO).

Q. How do I know if a drug is covered under my Part D prescription drug plan or the 65 Plus Medicare Advantage Plan (PPO)?
A. How you access your A&M System 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 Express Scripts Medicare customer service at 1-855-895-4647. TTY 1-800-716-3231.

The 65 Plus Medicare Advantage Plan (PPO) covers some drugs and services normally covered by Medicare Part B. These can include:

- Drugs that you do not 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 65 Plus Medicare Advantage Plan (PPO) customer service at 1-855-476-4149.

Supplemental Benefits

Q. Will I have access to vision, hearing or other benefits?
A. The 65 Plus Medicare Advantage Plan (PPO) covers a routine eye exam, routine hearing exam, a hearing aid allowance of $2,000 per ear over 36 months, and routine acupuncture.

Q. Are chiropractic services covered?
A. Routine chiropractic visits are covered with 20% coinsurance for 30 visits per year.

Q. Can I use private duty nursing with this plan?
A. Private duty nursing is covered with 20% coinsurance 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 the A&M Care 65 PLUS Plan?
A. Yes. You may continue to use all these health and wellness tools:

- Blue365℠
- Hinge Health
- Learn to Live
- Livongo

- Nurseline
- Omada
- SilverSneakers® Fitness Program
- Wondr Health™
- MDLive

Plan Effective Date and Communications

Q. When will my 65 Plus Medicare Advantage Plan (PPO) ID card arrive?
A. ID cards for effective date 1/1/2024 will be 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 (mid-December for 1/1/2024 effective date). You may use your confirmation letter as proof of insurance until your card arrives. Your 65 Plus Medicare Advantage Plan (PPO) 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 65 Plus Medicare Advantage Plan (PPO) 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 65 Plus Medicare Advantage, 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 have used.

65 Plus Medicare plan (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)℠.' This plan name also refers to 65 Plus Medicare plan (PPO).

BlueCross BlueShield of Texas

THE TEXAS A&M UNIVERSITY SYSTEM

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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 Vision℠, EyeMed Vision Care, Glasses.com, Jonathan Paul Fitovers and LasikPlus ®.

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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.

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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.