BlueCross BlueShield of Texas

2026 Summary of Benefits

Blue Cross Medicare Advantage Preferred (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 and speak to a Customer Service representative at 1-877-774-8592 (TTY: 711). We are open 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on the 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 getbluetx.com/mapd or 1-877-774-8592 (TTY: 711) to request a copy of the EOC.
- ☐ Review the *Provider Finder* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the *Pharmacy Directory* to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

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.
- ☐ In addition to your monthly plan premium, 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. In addition, you will pay a higher co-pay for services received by non-contracted providers.

1 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, getbluetx.com/mapd.

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 **Blue Cross Medicare Advantage Preferred (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Blue Cross Medicare Advantage Preferred (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 https://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 https://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 **Blue Cross Medicare Advantage Preferred (PPO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug 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 1-877-774-8592 (TTY: 711).

Things to Know About Blue Cross Medicare Advantage Preferred (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, 7 days a week. 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 1-877-774-8592, (TTY: 711).
- If you are not a member of this plan, call us at 1-877-213-1817, (TTY: 711).
- Our website: getbluetx.com/mapd.

Who can join?

To join **Blue Cross Medicare Advantage Preferred (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Texas: Andrews, Austin, Bailey, Bexar, Bowie, Brazoria, Brooks, Cameron, Carson, Cass, Cherokee, Cochran, Coke, Dallam, Denton, Dickens, Donley, El Paso, Ellis, Erath, Falls, Fort Bend, Franklin, Freestone, Galveston, Gillespie, Gregg, Grimes, Hardeman, Harris, Harrison, Hidalgo, Hockley, Hopkins, Irion, Jeff Davis, Jefferson, Karnes, Kaufman, King, Lamar, Lamb, Leon, Liberty, Limestone, Lubbock, Madison, Marion, Mason, McLennan, Midland, Mitchell, Montgomery, Nacogdoches, Nueces, Orange, Palo Pinto, Parker, Pecos, Polk, Presidio, Rains, Reagan, Reeves, Refugio, Robertson, San Saba, Smith, Somervell, Starr, Tarrant, Tom Green, Travis, Upshur, Uvalde, Victoria, Walker, Waller, Washington, Williamson, Winkler, Wise and Wood.

Which doctors, hospitals, and pharmacies can I use?

Blue Cross Medicare Advantage Preferred (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's *Provider Finder* and *Pharmacy Directory* at our website (getbluetx.com/mapd).

Or, call us at 1-877-774-8592 (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.

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

- You can see the complete plan *Formulary* (list of Part D prescription drugs) and any restrictions on our website, getbluetx.com/mapd.
- Or, call us at 1-877-774-8592 (TTY: 711) and we will send you a copy of the *Formulary*.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage and Catastrophic Coverage.

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

2 SECTION II - SUMMARY OF BENEFITS

Blue Cross Medicare Advantage Preferred (PPO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You pay $110 per month. In addition, you must keep paying your Medicare Part B premium.
Part B Premium Buy-down (if applicable)	This plan does not have a Part B Premium Buy-down.
Deductible	$750
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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. Your yearly limit(s) in this plan: • $8,000 for services you receive from in-network providers. • $12,500 for services you receive from out-of-network providers. • $12,500 for services you receive from in- and out-of-network providers combined.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	**In-Network:** Days 1-6: $375 copay per day. Days 7-90: $0 copay per day. $0 copay per day for days 91 and beyond. **Out-of-Network:** 50% of the total cost per stay.

Outpatient Hospital	**In-Network:** $0 - $390 copay. **Out-of-Network:** 50% of the total cost.
Ambulatory Surgical Center	**In-Network:** $0 - $335 copay. **Out-of-Network:** 50% of the total cost.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $7 copay. Specialist visit: $47 copay. **Out-of-Network:** Primary care physician visit: 50% of the total cost. Specialist visit: 50% of the total cost.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. **Out-of-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Other preventive services are available. There are some covered services that have a cost. Please reference the EOC for more details. **Important Message About What You Pay for Vaccines** Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.
Emergency Care	$100 copay per visit. Worldwide Emergency Coverage: $100 copay. 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.
Urgently Needed Services	$40 copay per visit.

	Worldwide Urgent Coverage: $100 copay.
Diagnostic Services /Labs/Imaging	**In-Network:** Diagnostic tests and procedures: $0 - $100 copay. Lab services: $0 - $50 copay. Diagnostic Radiology Services (such as MRIs, CT scans): $0 - $300 copay. X-rays: $0 - $100 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost. **Out-of-Network:** Diagnostic tests and procedures: 50% of the total cost. Lab services: 50% of the total cost. Diagnostic Radiology Services (such as MRIs, CT scans): 50% of the total cost. X-rays: 50% of the total cost. Therapeutic radiology services (such as radiation treatment for cancer): 50% of the total cost.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $45 copay. Routine hearing exam (1 every year): $0 copay. Hearing aid fitting/evaluation: $0 copay. Purchase includes unlimited provider visits for fitting and adjustments within 12 months of purchase of hearing aids. Hearing Aids: Benefit is limited to the TruHearing branded hearing aids. $699 copay per Advanced Aid or $999 copay per Premium Aid (1 per ear per year). **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: 50% of the total cost.
Dental Services	**In-Network:** Medicare-covered: $45 copay. **Out-of-Network:** Medicare-covered: 50% of the total cost. **In-Network and Out-of-Network:** **Preventive Dental Services:**

	• Oral exam (2 every year): $0 copay • Cleaning (2 every year): $0 copay • Dental X-ray (1 every year): $0 copay **Comprehensive Dental Services:** • See OSB Package. For more details on benefits and benefit limitations regarding your dental coverage, please see your *Evidence of Coverage*.
Vision Services	**In-Network:** **Medicare-covered:** • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay for an eye exam; $0 copay for one vision specialist exam • Eyeglasses or contact lenses after cataract surgery: $40 copay **Routine Vision:** • Routine eye exam (1 every year): $0 copay • Eyewear: $0 copay • $100 Annual eyewear allowance maximum (Eyewear includes: frames, lenses, and contact lenses) **Out-of-Network:** **Medicare-covered:** • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 50% of the total cost for an eye exam; 50% of the total cost for one vision specialist exam • Eyeglasses or contact lenses after cataract surgery: 50% of the total cost **Routine Vision:** • $40 Annual allowance maximum for 1 routine eye exam • Eyewear: $0 copay • $100 Annual eyewear allowance maximum (Eyewear includes: frames, lenses, and contact lenses)

Mental Health Services	**In-Network:** Our plan 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. 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. Inpatient Mental Health Care: Days 1-6: $270 copay per day. Days 7-90: $0 copay per day. Outpatient group therapy visit: $30 copay. Outpatient individual therapy visit: $30 copay. **Out-of-Network:** Inpatient Mental Health Care: 50% of the total cost per stay. Outpatient group therapy visit: 50% of the total cost. Outpatient individual therapy visit: 50% of the total cost.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-59: $218 copay per day. Days 60-100: $0 copay per day. **Out-of-Network:** 50% of the total cost per stay.
Physical Therapy	**In-Network:** $50 copay. **Out-of-Network:** 50% of the total cost.
Outpatient Rehabilitation	**In-Network:** Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $30 copay.

	Occupational therapy visit: $35 copay. **Out-of-Network:** Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 50% of the total cost. Occupational therapy visit: 50% of the total cost.
Ambulance	Ground Ambulance: $275 copay for each one-way trip. Air Ambulance: 20% of the total cost for each one-way trip.
Transportation	Not Covered
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% of the total cost. Other Part B drugs: 20% of the total cost. For Part B Insulin Drugs: 20% of the total cost with a maximum copay amount per month of $35. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 50% of the total cost. Other Part B drugs: 50% of the total cost. For Part B Insulin Drugs: 50% of the total cost with a maximum copay amount per month of $35.

PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: $450 for Tiers 3, 4 and 5. Once you have paid $450 for your Tiers 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage. **Important Message About What You Pay for Insulin** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Initial Coverage

You pay the following until your yearly out-of-pocket drug costs reach $2,100.

Standard Retail Cost-Sharing		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$5 copay	$15 copay
Tier 2 (Generic)	$6 copay	$18 copay
Tier 3 (Preferred Brand)	21% coinsurance	21% coinsurance
Tier 4 (Non-Preferred Drug)	40% coinsurance	40% coinsurance
Tier 5 (Specialty Tier)	27% coinsurance	Not Applicable

Preferred Retail Cost-Sharing		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay
Tier 2 (Generic)	$1 copay	$3 copay
Tier 3 (Preferred Brand)	17% coinsurance	17% coinsurance
Tier 4 (Non-Preferred Drug)	37% coinsurance	37% coinsurance
Tier 5 (Specialty Tier)	27% coinsurance	Not Applicable

Standard Mail Order		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$5 copay	$10 copay
Tier 2 (Generic)	$6 copay	$12 copay
Tier 3 (Preferred Brand)	21% coinsurance	21% coinsurance
Tier 4 (Non-Preferred Drug)	40% coinsurance	40% coinsurance
Tier 5 (Specialty Tier)	27% coinsurance	Not Applicable

Preferred Mail Order		
Tier	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay
Tier 2 (Generic)	$1 copay	$2 copay
Tier 3 (Preferred Brand)	17% coinsurance	17% coinsurance
Tier 4 (Non-Preferred Drug)	37% coinsurance	37% coinsurance
Tier 5 (Specialty Tier)	27% coinsurance	Not Applicable

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. We cover prescriptions filled at out-of-network pharmacies in only limited situations.

	Please call us or see the plan's *Evidence of Coverage* on our website (getbluetx.com/mapd) for complete information about your costs for covered drugs.
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $2,100, you pay nothing for covered Part D drugs.

Additional Member Benefits	Blue Cross Medicare Advantage Preferred (PPO)[SM]
Acupuncture for Chronic Low Back Pain	**In-Network:** • $47 copay **Out-of-Network:** • 50% of the total cost
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:** • $15 copay **Out-of-Network:** • 50% of the total cost
Diabetes Supplies and Services - Diabetes Monitoring Supplies - Diabetes self-management training - Therapeutic shoes or inserts	**In-Network:** **Diabetes monitoring supplies** • 0% or 20% of the total cost **Diabetes self-management training** • $0 copay **Therapeutic shoes or inserts** • 20% of the total cost **Out-of-Network:** **Diabetes monitoring supplies** • 50% of the total cost **Diabetes self-management training** • $0 copay **Therapeutic shoes or inserts** • 50% of the total cost

Additional Member Benefits	Blue Cross Medicare Advantage Preferred (PPO)[SM]
Durable Medical Equipment ***(wheelchairs, oxygen, etc.)***	**In-Network:** • 20% of the total cost **Out-of-Network:** • 50% of the total cost
Wellness Programs	$0 copay for SilverSneakers® Fitness Program 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. You have access to a nationwide network of participating locations where you can take classes. SilverSneakers is a registered trademark of Tivity Health, Inc.© 2025 Tivity Health, Inc. All rights reserved.
Foot Care ***(podiatry services)***	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.** **In-Network:** • $45 copay **Out-of-Network:** • 50% of the total cost
Home Health Care	**In-Network:** • $0 copay **Out-of-Network:** • 50% of the total cost
Opioid Treatment Program Services	**In-Network:** • $35 copay **Out-of-Network:** • 50% of the total cost

Additional Member Benefits	Blue Cross Medicare Advantage Preferred (PPO)[SM]
Outpatient Substance Abuse Services	**In-Network:** **Group therapy visit** • $75 copay **Individual therapy visit** • $75 copay **Out-of-Network:** **Group therapy visit** • 50% of the total cost **Individual therapy visit** • 50% of the total cost
Over-the-Counter Items	Not Covered
Prosthetic Devices ***(braces, artificial limbs, etc.)***	**In-Network:** **Prosthetic devices** • 20% of the total cost **Related medical supplies** • 20% of the total cost **Out-of-Network:** **Prosthetic devices** • 50% of the total cost **Related medical supplies** • 50% of the total cost
Meals	Not Covered
Renal Dialysis	**In-Network:** • 20% of the total cost

Additional Member Benefits	Blue Cross Medicare Advantage Preferred (PPO)[SM]
	Out-of-Network: • 50% of the total cost
Telehealth Services	• $0 copay for urgent care visits through MDLive
Hospice	You pay nothing for hospice care from a Medicare-certified hospice provider. You may have to pay part of the total costs for drugs and respite care. Hospice care is covered outside of our plan. Please contact us for more details.

Optional Supplemental Benefits	Blue Cross Medicare Advantage Preferred (PPO)[SM]
OSB Package ○ Monthly Premium	• You pay additional $34.30 per month If package is purchased: ○ Dental: Comprehensive Basic and Major Restorative services with an additional dental allowance are available if package is purchased. Please see your *Evidence of Coverage* for details.

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 1-877-774-8592 (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 1-877-774-8592 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Blue Cross Medicare Advantage Preferred is a local PPO plan with a Medicare contract. Enrollment in **Blue Cross Medicare Advantage Preferred** depends on contract renewal.

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.

Health coverage is offered by Health Care Service Corporation.

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 1-877-774-8592 (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:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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	

If you are a Medicare member, access your Non-Discrimination Notice at https://www.bcbstx.com/tx/documents/medicare/mapd/2026/mapd-mli-tx-2026.pdf

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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 文本电话：711）或咨询您的服务提供商。
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 1-877-774-8592 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-774-8592 (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 ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ સવના મૂલ્યે ઉપલબ્ધ છે. 1-877-774-8592 (TTY: 711) પર કૉલ 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। 1-877-774-8592 (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'1-877-774-8592 (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. 1-877-774-8592 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yánilti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-877-774-8592 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسی 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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 (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 1-877-774-8592 (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 ،1-877-774-8592) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
فارسی Persian	ما در راستای پاسخگویی به سؤالات شما در مورد طرح سلامت یا دارویی خود، دارای خدمات مترجم رایگان هستیم. برای داشتن یک مترجم، کافیست از طریق شماره 1-877-774-8592 (TTY: 711) با ما تماس بگیرید. یک شخص فارسی زبان می‌تواند به شما کمک کند. این یک سرویس رایگان است
ລາວລາວເວີ້ າ Laotian	ພວກເຮົ າມີ ບໍ ລິ ການຜູ້ ແປພາສາບໍ່ ເສຍຄ່າໃຫ້ ເພື່ ອຄອຍຕອບ ່ຄຳຖາມທີ່ ທ່ານອາດມີ ກ່ ຽວກັ ບແຜນປະກັ ນສຸ ຂະພາບ ແລະ ຢາຂອງພວກເຮົ າ. ເພື່ ອເອົ າຜູ້ ແປພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົ າທີ່ ເບີ 1-877-774-8592 (TTY: 711). ຈະມີ ຄົ ນທີ່ ເວົ້ າພາສາລາວສາມາດຊ່ ວຍທ່ ານໄດ້. ນີ້ ແມ່ ນການບໍ ລິ ການບໍ່ ເສຍຄ່ າ.
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 1-877-774-8592 (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 Blue Cross Medicare 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 1-877-774-8592 (TTY: 711) for more information.

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

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

THANK YOU

Connect with us

Contact Information: 1-877-774-8592, TTY: 711

Organization Name: Blue Cross and Blue Shield of Texas

Organization website: getbluetx.com/mapd