

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbstx.com/bb/mm/bb_mtbcop528_tx_2025.pdf or by calling 1-800-521-2227. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$3,000 Individual/\$9,000 Family Out-of-Network: \$10,000 Individual/\$20,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the deductible amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. <u>Network</u> office visits, <u>prescription</u> drugs, <u>preventive</u> care services, <u>Hospice</u> services, <u>Urgent</u> care services and <u>Diagnostic</u> services are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$9,000 Individual/\$18,000 Family Out-of-Network: Unlimited Individual/Unlimited Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance</u> billing charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com/go/bcoppo or call 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Virtual visits are available. See your benefit booklet* for details.
	Specialist visit	\$80 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Inpatient: Certain services may require <u>preauthorization</u> for out-of-network; failure to <u>preauthorize</u> may result in \$250 reduction in benefits. Outpatient: Certain services may require <u>preauthorization</u> for out-of-network; failure to <u>preauthorize</u> may result in 50% reduction in benefits not to exceed \$500; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbstx.com/rx-drugs/drug-lists/drug-lists	Generic drugs (Preferred)	Retail - Preferred - No Charge Non-Preferred - \$10 <u>copayment</u> /prescription Mail - No Charge; <u>deductible</u> does not apply	Retail - \$10 <u>copayment</u> /prescription; <u>deductible</u> does not apply plus 50% additional charge	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Additional charge will not apply to any <u>deductible</u> or out-of-pocket amounts. Certain drugs require approval before
	Generic drugs (Non-preferred)	Retail - Preferred – \$10 <u>copayment</u> /prescription Non-Preferred – \$20 <u>copayment</u> /prescription Mail – \$30 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Retail - \$20 <u>copayment</u> /prescription; <u>deductible</u> does not apply plus 50% additional charge	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/mm/bb_mtbcp528_tx_2025.pdf

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Brand drugs (Preferred)	Retail - Preferred – \$50 <u>copayment/prescription</u> Non-Preferred - \$70 <u>copayment/prescription</u> Mail - \$150 <u>copayment/prescription</u> ; <u>deductible</u> does not apply	Retail – \$70 <u>copayment/prescription</u> ; <u>deductible</u> does not apply plus 50% additional charge	they will be covered. <u>Cost sharing</u> for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Brand drugs (Non-preferred)	Retail - Preferred – \$100 <u>copayment/prescription</u> Non-Preferred - \$120 <u>copayment/prescription</u> Mail - \$300 <u>copayment/prescription</u> ; <u>deductible</u> does not apply	Retail - \$120 <u>copayment/prescription</u> ; <u>deductible</u> does not apply plus 50% additional charge	
	Specialty drugs (Preferred)	\$150 <u>copayment/prescription</u> ; <u>deductible</u> does not apply	\$150 <u>copayment/prescription</u> ; <u>deductible</u> does not apply plus 50% additional charge	
	Specialty drugs (Non-preferred)	\$250 <u>copayment/prescription</u> ; <u>deductible</u> does not apply	\$250 <u>copayment/prescription</u> ; <u>deductible</u> does not apply plus 50% additional charge	
	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certain services may require <u>preauthorization</u> for out-of-network; failure to <u>preauthorize</u> may result in 50% reduction in benefits not to exceed \$500. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	<u>Emergency room care</u>	\$500 <u>copayment/visit</u> plus 20% <u>coinsurance</u>	\$500 <u>copayment/visit</u> plus 20% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$75 <u>copayment/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. <u>Preauthorization</u> penalty: \$250 out-of-network. See your benefit booklet* for details.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copayment</u> /office visit; deductible does not apply or 20% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	Certain services must be preauthorized, failure to preauthorize at least two business days prior to service will result in 50% reduction in benefits (not to exceed \$500). See your benefit booklet* for details.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits	Primary Care: \$40 <u>copayment</u> /initial visit Specialist: \$80 <u>copayment</u> /initial visit; deductible does not apply	40% <u>coinsurance</u>	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply to preventive services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/year. <u>Preauthorization</u> may be required for out-of-network. Failure to preauthorize may result in 50% reduction in benefits not to exceed \$500. See your benefit booklet* for details.
	Habilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

*For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbstx.com/bb/rmm/bb_mtbcp528_tx_2025.pdf

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Inpatient: <u>Preauthorization</u> may be required for out-of-network; failure to preauthorize may result in a \$250 reduction in benefits. Outpatient: <u>Preauthorization</u> may be required for out-of-network; failure to preauthorize may result in 50% reduction in benefits not to exceed \$500. See your benefit booklet* for details.
	Children's eye exam	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Abortion (Except for a pregnancy that, as certified by a physician, places the individual in danger of death)	• Dental care (Adult and Child)	• Private-duty nursing	
• Acupuncture	• Long-term care	• Routine eye care (Child)	
• Bariatric surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss programs	
• Cosmetic surgery			
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Chiropractic care (Outpatient - Max.35 visits/year combined with habilitation and rehabilitation services)	• Infertility treatment (In vitro and artificial insemination are not covered unless shown in your plan document)	• Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)	
• Hearing aids (Limited to one hearing aid per ear every 36 months)	• Routine eye care (Adult)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the [plan](#), Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.

Navajo (Dine): Dineke'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$3,000
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$3,000
Copayments	\$40
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,800

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,000
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$800
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,000
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$2,100
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,700

The plan would be responsible for the other costs of these EXAMPLE covered 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 855-710-6984.

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
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601
Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
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
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal:
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.

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 855-710-6984 (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 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فيستوفّر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات متشابهة لتوفير المعلومات بنسبقات يمكن الوصول إليها مجانًا. اتصل على الرقم (TTY: 711) أو تحدث إلى مقدم الخدمة.

www.bcbstx.com

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BlueCross BlueShield of Texas

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 855-710-6984（文本电话：711）或寄信索取的服务提供商。
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 855-710-6984 (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 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ટિપ્પણ આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓડિયો સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नि:शुल्क उपलब्ध हैं। 855-710-6984 (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'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáanii't'gogo, saad bee ná'á'awo' bee áka'anida'awo't'áá jik'eh ná hólí. Bee ahil hane'go bee nida'anishí t'áá ákodaat'áhiit' dóó bee áka'anida'wo't' ako bee baa hane'í bee hadadil'yaá bich'í' ahoot'í'gíil éí t'áá jik'eh hólí. Koh'í' 855-710-6984 (TTY: 711) hodilnih doodago nika'anáwo'í bich'í' hanidzilíh.
فارسی Farsi	توجه: اگر فارسی صحبت می کنید، 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 می باشند. با شماره 855-710-6984 (تلفن فوری: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.
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 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
Русский Russian	ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo ng tulong sa wika. Magagamit din nang libre ang mga nasaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دہی: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارسیں میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (711 پر کال کریں) یا اپنے فراہم کنندہ سے بات کریں۔
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 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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