



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/tx/documents/group/benefit-booklets/2026/bb\\_spsk01bcastx\\_tx\\_2026.pdf](http://www.bcbstx.com/tx/documents/group/benefit-booklets/2026/bb_spsk01bcastx_tx_2026.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/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	Network: \$5,100 Individual/\$15,300 Family Out-of-Network: \$10,200 Individual/\$30,600 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> 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 <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. In-Network Preventive Health Care services, certain services with a <u>copayment</u> , and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Network: \$9,100 Individual/\$18,200 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.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance billing</u> 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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See <a href="http://www.bcbstx.com/go/bcpo">www.bcbstx.com/go/bcpo</a> or call 1-800-521-2227 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 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 charge</u> 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.
<u>Do you need a referral to see a specialist?</u>	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 Providers (You will pay the least)	Out-of-Network Providers (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	\$45 <u>copayment</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual Visits are available. See your benefit booklet* (Your PCP) for details.
	Specialist visit	\$90 <u>copayment</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No Charge; <u>deductible</u> does not apply	50% <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)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. See your benefit booklet* (Outpatient Lab and X-Ray services) for details.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbstx.com/rx26/6T">www.bcbstx.com/rx26/6T</a>	Generic drugs (Preferred)	Retail - Preferred Participating - No Charge Participating - \$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 Out-of-Network charge will not apply to any <u>deductible</u> or out-of-pocket amounts. Certain drugs require approval before 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.
	Generic drugs (Non-preferred)	Retail - Preferred Participating - \$10 <u>copayment</u> /prescription Participating - \$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	
	Brand drugs (Preferred)	Retail - Preferred Participating - \$50 <u>copayment</u> /prescription Participating - \$70 <u>copayment</u> /prescription Mail - \$150 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Retail - \$70 <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/tx/documents/group/benefit-booklets/2026/bb\\_spsk01bcastxo\\_tx\\_2026.pdf](http://www.bcbstx.com/tx/documents/group/benefit-booklets/2026/bb_spsk01bcastxo_tx_2026.pdf).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
	Brand drugs (Non-preferred)	Retail - Preferred Participating - \$100 <u>copayment/prescription</u> Participating - \$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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 <u>copayment/visit</u> plus 30% <u>coinsurance</u>	\$300 <u>copayment/visit</u> plus 50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	Emergency room care	\$500 <u>copayment/visit</u> plus 30% <u>coinsurance</u>	\$500 <u>copayment/visit</u> plus 30% <u>coinsurance</u>	<u>Copayment</u> waived if admitted. Out-of-Network <u>cost share</u> is subject to <u>Network deductible</u> .
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* (Ambulance Services) for details.
	Urgent care	\$75 <u>copayment/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copayment/visit</u> plus 30% <u>coinsurance</u>	\$350 <u>copayment/visit</u> plus 50% <u>coinsurance</u>	<u>Preauthorization</u> required. <u>Preauthorization</u> penalty: \$250 Out-of-Network. See your benefit booklet* (Inpatient Hospital Services) for details.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. See your benefit booklet* (Inpatient Professional Services) for details.

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/tx/documents/group/benefit-booklets/2026/bb\\_spsk01bcastxo\\_tx\\_2026.pdf](http://www.bcbstx.com/tx/documents/group/benefit-booklets/2026/bb_spsk01bcastxo_tx_2026.pdf).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$45 <u>copayment</u> /office visit; <u>deductible</u> does not apply; 30% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Preauthorization may be required; see your benefit booklet* (Behavioral Health Services) for details.
	Inpatient services	\$250 <u>copayment</u> /visit plus 30% <u>coinsurance</u>	\$350 <u>copayment</u> /visit plus 50% <u>coinsurance</u>	Preauthorization required. Preauthorization penalty: \$250 Out-of-Network. See your benefit booklet* (Behavioral Health Services) for details.
If you are pregnant	Office visits	Primary Care: \$45 <u>copayment</u> /initial visit; <u>deductible</u> does not apply Specialist: \$90 <u>copayment</u> /initial visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copayment</u> /visit plus 30% <u>coinsurance</u>	\$350 <u>copayment</u> /visit plus 50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visits/year. Preauthorization may be required; see your benefit booklet* (Extended Care Services) for details.
	Rehabilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Separate 35-visit maximum per benefit period for Habilitation and <u>Rehabilitation services</u> , including chiropractic care. Preauthorization may be required; see your benefit booklet* (Rehabilitation Services and Habilitation Services) for details.
	Habilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Durable medical equipment	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization may be required. See your benefit booklet* (Durable Medical Equipment) for details.

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/tx/documents/group/benefit-booklets/2026/bb\\_spsk01bcastxo\\_tx\\_2026.pdf](http://www.bcbstx.com/tx/documents/group/benefit-booklets/2026/bb_spsk01bcastxo_tx_2026.pdf).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. See your benefit booklet* (Extended Care Services) for details.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Up to a \$30 reimbursement is available; <u>deductible</u> does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge; <u>deductible</u> does not apply	Up to a \$75 reimbursement is available; <u>deductible</u> does not apply	One pair of glasses every 12 months. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's dental check-up	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Oral exams are limited to two every benefit period. Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months. See your benefit booklet* (Pediatric Dental Benefits Rider) for details.

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/tx/documents/group/benefit-booklets/2026/bb\\_spsk01bcastxo\\_tx\\_2026.pdf](http://www.bcbstx.com/tx/documents/group/benefit-booklets/2026/bb_spsk01bcastxo_tx_2026.pdf).

## 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.)

<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Weight loss programs</li></ul>
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"><li>• Abortion (Only for a pregnancy that, as certified by a physician, places the individual in danger of death)</li><li>• Bariatric surgery</li><li>• Chiropractic care (35 visits/year combined with habilitation and rehabilitation services)</li></ul>	<ul style="list-style-type: none"><li>• Cosmetic surgery (Only for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases when <u>medically necessary</u>)</li><li>• Hearing aids (Limited to 1 hearing aid per ear every 36 months)</li><li>• Infertility treatment (Diagnosis and treatment covered; in vitro not covered)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (Only for extended care)</li><li>• Routine foot care (Only when <u>medically necessary</u>)</li></ul>
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**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: the plan at Blue Cross and Blue Shield of Texas at 1-888-697-0683 or visit [www.bcbstx.com](http://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](http://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](http://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](http://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 on how 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 or visit [www.bcbstx.com](http://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](http://www.dol.gov/ebsa/healthreform), and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://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](http://www.bcbstx.com) or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://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](http://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): Dinek'ehgo shika a'ohwol ninisingo, kwijjigo 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 <u>plan's overall deductible</u>	\$5,100
■ <u>Specialist copayment</u>	\$90
■ <u>Hospital (facility) copayment/coinsurance</u>	\$250+30%
■ <u>Other coinsurance</u>	30%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

Cost sharing	
<u>Deductibles</u>	\$5,100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$2,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,660</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$5,100
■ <u>Specialist copayment</u>	\$90
■ <u>Hospital (facility) copayment/coinsurance</u>	\$250+30%
■ <u>Other coinsurance</u>	30%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

Cost sharing	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$5,100
■ <u>Specialist copayment</u>	\$90
■ <u>Hospital (facility) copayment/coinsurance</u>	\$250+30%
■ <u>Other coinsurance</u>	30%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

Cost sharing	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,700</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.



**BlueCross BlueShield** of Texas

### **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      Phone: 855-664-7270 (voicemail)  
Attn: Office of Civil Rights Coordinator      TTY/TDD: 855-661-6965  
300 E. Randolph St., 35th Floor      Fax: 855-661-6960  
Chicago, IL 60601      Email: [civilrightscoordinator@bcbsil.com](mailto: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](http://ocrportal.hhs.gov/ocr/smartscreen/main.jsf)

Complaint Forms:  
[hhs.gov/civil-rights/filing-a-complaint/index.html](http://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](http://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.
Arabic العربية	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية، كما تتوفر وسائل مساعدة وخدمات مناسبة لتقدير المعلومات وتقنيات يمكن الوصول إليها محلًا. احصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

[www.bcbstx.com](http://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 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	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મકત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. થોરય ઓક્સિલરી સહાય અને એક્સેસિબલ ફોર્મેટ્માં માહિતી પરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिन्दी Hindi	ध્યાન દें: યदि આપ હિન્દી બોલતે હો, તો આપને લિએ નિઃશુલ્ક ભાષા સહાયતા સેવા અને ઉપલબ્ધ હોતી હૈ। સુલભ પ્રારૂપો મેં જાનકારી પ્રદાન કરને કે લિએ ઉપયુક્ત સહાયક સાધન ઔર સેવાએં ભી નિઃશુલ્ક ઉપલબ્ધ હૈન। 855-710-6984 (TTY: 711) પર કોલ કરો યા અપને પ્રદાતા સે બાત કરો।
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: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáñilti'gogo, saad bee ana'awo' bee áka'anída'awo'ít'aá jiik'eh ná hóló. Bee ahíi hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'i'ígií éí t'áá jiik'eh hóló. Kohji' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í' hanidzíih.
فارسی Farsi	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین تکنیک ها و خدمات پشتیبانی مناسب برای افراد امراضی از قبیل دسترسی به طور رایگان موجود می باشند. با شماره 855-710-6984 (TTY: 711) تماس بگیرید با این اندیشه 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 русский, 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 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 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجه دین: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسانی فارمیٹس میں معلومات قرائیم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ فون کار گرین بے اپنے فرائیم کنندہ سے بات کریں۔
Việt Vietnamese	LUU Y: 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.

[www.bcbstx.com](http://www.bcbstx.com)

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