HealthSelect of Texas® | CONSUMER DIRECTED HealthSelect℠

2024 Summer Enrollment Guide

The 2025 plan year begins Sept. 1, 2024, and runs through Aug. 31, 2025.

Healthy You, Healthy Texas

healthselectoftexas.com

A Healthier Texas Starts with You

WELCOME TO YOUR PLAN YEAR 2025

In this brochure, you will learn about your health plan options, new benefits, changes coming to the medical plans and how to access important resources. The Employees Retirement System of Texas (ERS) manages the Texas Employees Group Benefits Program (GBP).

HealthSelect of Texas® and Consumer Directed HealthSelect℠ are part of the GBP and are administered by Blue Cross and Blue Shield of Texas (BCBSTX). ERS determines medical coverage for enrolled participants and pays claims. BCBSTX manages the provider network, processes claims and provides customer service.

Stay up to date on the latest Summer Enrollment updates by visiting **healthselectoftexas.com** and clicking on the Summer Enrollment banner.

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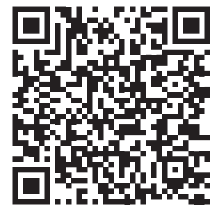
Scan the QR codes in this brochure with your phone's camera app to learn more about each benefit.

Scan to visit the Summer Enrollment webpage.

healthselectoftexas.com/medical-benefits/summer-enrollment-2024



WHAT'S NEW

Benefits Updates

Annual out-of-pocket maximum

Effective January 1, 2025, the total in-network annual out-of-pocket maximum will increase for all HealthSelect[SM] medical plans, including Consumer Directed HealthSelect. The out-of-pocket maximum will increase to $8,050 for employee-only coverage and $16,100 for family coverage. The out-of-pocket maximum includes expenses you pay toward medical and prescription drug copays, coinsurance and deductibles, if your plan has one.

New condition management programs

Your health and wellness are a priority. HealthSelect medical plans will include new programs to help you manage conditions and improve your well-being in plan year 2025.

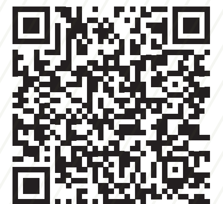
Support for heart health

Improve mobility, reduce pain and improve musculoskeletal health

Digital mental health support

Learn more about the programs available Sept. 1, 2024 and how to use them on the Summer Enrollment page.

healthselectoftexas.com/medical-benefits/summer-enrollment-2024



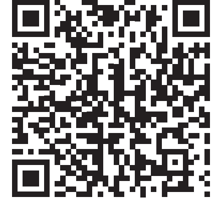
LEARN ABOUT YOUR PLANS

	HealthSelect of Texas®	HealthSelect℠ Out-of-State	Consumer Directed HealthSelect℠
Available to	Active employees, non-Medicare-eligible retirees and their eligible dependents, who live or work in Texas	Active employees, non-Medicare-eligible retirees and their eligible dependents, who live or work outside of Texas	Active employees, non-Medicare-eligible retirees and their eligible dependents
Type of plan	Point-of-service plan (HME on your ID card refers to the ***HealthSelect network***, not HMO)	Preferred provider organization (PPO)	High-deductible health plan paired with a health savings account (HSA)
Health care benefits (in-network)	When you see in-network providers, you pay: • no deductible, • nothing for preventive care and • a copay for primary care provider (PCP) and specialist visits	When you see in-network providers, you pay: • no deductible, • nothing for preventive care and • a copay for PCP and specialist visits	When you see in-network providers, you pay: • nothing for preventive care and • the full cost for most care and prescriptions until you meet your annual deductible
Preventive care services covered at no cost	Yes, for in-network providers	Yes, for in-network providers	Yes, for in-network providers
Medical and mental health Virtual Visits	You pay nothing	You pay nothing	You must meet your annual deductible before visits are covered. You will pay 20% coinsurance after meeting the deductible.
Annual deductible (when you stay in-network)	No	No	Yes
Out-of-network benefits available	Yes, but with higher out-of-pocket costs	Yes, but with higher out-of-pocket costs	Yes, but with higher out-of-pocket costs
Requires a PCP on file to receive in-network benefits	Yes	No	No
Requires referrals to see specialists	Yes	No	No
Includes an HSA	No	No	Yes
Eligible for TexFlex℠ health care flexible spending account (FSA)	Yes	Yes	Limited-Purpose FSA that can only be used for eligible vision and dental expenses

LEARN ABOUT YOUR BENEFITS

CHOOSE A PRIMARY CARE PROVIDER (PCP)

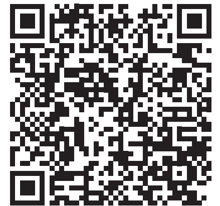
healthselectoftexas.com/find-a-doctor-hospital/choose-a-primary-care-provider



Your PCP serves as your primary point of contact when you need non-emergency medical care. To choose a PCP, call **(800) 252-8039 (TTY: 711)** to speak with a BCBSTX Personal Health Assistant or log in to Blue Access for Members℠.

REFERRALS

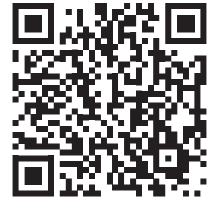
healthselectoftexas.com/find-a-doctor-hospital/referrals-and-prior-authorizations



To receive the highest level of benefits, HealthSelect of Texas participants must get referrals before seeing most specialists.

VIRTUAL VISITS

healthselectoftexas.com/medical-benefits/virtual-visits

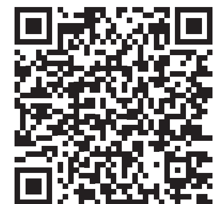


HealthSelect of Texas and HealthSelect℠ Out-of-State participants get medical and mental health Virtual Visits at no cost through **Doctor On Demand**® and **MDLIVE**®.

Consumer Directed HealthSelect participants must meet the annual deductible before visits are covered, and then pay 20% coinsurance.

HEALTHSELECTSHOPPERS

healthselectoftexas.com/medical-benefits/healthselectshoppers



HealthSelectShoppERS℠ allows eligible HealthSelect participants to save money and earn rewards for certain medical services and procedures by using the Provider Finder® to choose a lower-cost, quality provider with an associated reward.

CARE MANAGEMENT

healthselectoftexas.com/medical-benefits/care-management-programs

The care management program is a team of dedicated Texas-based clinicians using a personal approach for addressing health-related questions. Clinicians help with all types of health questions about many topics including asthma, cancer, diabetes, heart disease, high blood pressure, musculoskeletal conditions and pregnancy. Dedicated mental health clinicians are available for concerns including substance use issues, anxiety, depression, domestic violence, grief, post-traumatic stress disorder and stress.

PLAN COMPARISON CHARTS

	HealthSelect of Texas®		CONSUMER DIRECTED HealthSelect℠	
	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	**HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network**	**Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network**	**Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network**
Administrator	**Blue Cross and Blue Shield of Texas (BCBSTX)**			
Annual deductible	None	$500 per individual $1,500 per family	$2,100 per individual, $4,200 per family To help cover part of the deductible, the State contributes to an eligible participant's health savings account: $540/year for an individual, $1,080/year for a family	$4,200 per individual, $8,400 per family To help cover part of the deductible, the State contributes to an eligible participant's health savings account: $540/year for an individual, $1,080/year for a family
Out-of-network benefits?		Yes. See next page for details.		Yes. See next page for details.
Balance billing? (Balance billing is when an out-of-network provider charges you the difference between their billed charges and the plan's allowed amount.)		Yes. Balance billing may apply to certain out-of-network services. For more information, see the plan's Master Benefit Plan Document.		Yes. Balance billing may apply to certain out-of-network services. For more information, see the plan's Master Benefit Plan Document.
Total in-network out-of-pocket maximum (including deductibles, coinsurance and copays)[1]	Jan. 1 – Dec. 31, 2024: $7,500 per person; $15,000 per family Jan. 1 – Dec. 31, 2025: $8,050 per person; $16,100 per family		Jan. 1 – Dec. 31, 2024: $7,500 per person; $15,000 per family Jan. 1 – Dec. 31, 2025: $8,050 per person; $16,100 per family	
Out-of-pocket coinsurance maximum	$2,000 per person	$7,000 per person	None	None
Inpatient copay maximum	$750 copay max, up to 5 days per hospital stay $2,250 copay max per calendar year per person		None	None
Primary care provider (PCP) required?	Participants who live and work in Texas: Yes Out-of-state participants: No	No	No	No
Referrals required?	Participants who live and work in Texas: Yes Out-of-state participants: No	No	No	No

[1]Includes medical and prescription drug copays, coinsurance and deductibles. Excludes out-of-network and bariatric services.

All Texas Employees Group Benefits Program (GBP) benefits could change without notice. The Texas Legislature decides the level of funding for such benefits and has no continuing obligation to provide those benefits beyond each fiscal year.

PLAN COMPARISON CHARTS

Medical Benefits

Service	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Allergy treatment	Covered at 100% if administered in a physician's office; 20% coinsurance in any other outpatient location	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Ambulance services (for emergencies)	20% coinsurance	20% coinsurance; annual deductible does not apply	20% coinsurance after annual deductible is met	20% coinsurance after annual in-network deductible is met
Bariatric surgery Additional eligibility requirements apply.	• Deductible: $5,000 • Coinsurance: 20% • Lifetime max: $13,000	Not covered	Not covered	Not covered
Chiropractic care	• Without office visit: 20% coinsurance • With office visit: $40 copay plus 20% coinsurance • Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	40% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	20% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	40% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year
Cranial hair prosthetics (wigs)	20% coinsurance; limited to lifetime benefit max of $1,000. Out-of-network deductible does not apply.		20% coinsurance after annual deductible is met; limited to lifetime benefit max of $1,000.	
Diagnostic A1c testing (for participants diagnosed with diabetes)	20% coinsurance; see page 10 for details	40% coinsurance after annual deductible is met; see page 10 for details	20% coinsurance after annual deductible is met; see page 10 for details	40% coinsurance after annual deductible is met; see page 10 for details
Diabetes equipment	20% coinsurance; see page 10 for details.	40% coinsurance after annual deductible is met; see page 10 for details.	20% coinsurance after annual deductible is met; see page 10 for details.	40% coinsurance after annual deductible is met; see page 10 for details.
Diabetes supplies	See page 10 for details.			
Diagnostic X-rays and lab tests	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Diagnostic mammography	Covered at 100%	40% coinsurance after annual deductible is met	Covered at 100%	40% coinsurance after annual deductible is met
Durable medical equipment	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Facility-based providers (radiologists, pathologists and labs, anesthesiologists, emergency room physicians, etc.)	20% coinsurance	Emergencies: 20% coinsurance; annual deductible does not apply. Non-emergencies: 40% coinsurance after annual deductible is met (Network benefits apply to services rendered by an out-of-network provider in a network facility.)	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met. (Network benefits apply to services rendered by an out-of-network provider in a network facility.)
Facility emergency care (non-FSER) and hospital-affiliated freestanding emergency departments	$150 copay plus 20% coinsurance (If admitted, copay will apply to hospital copay.)	Emergencies: $150 copay plus 20% coinsurance (If admitted, copay will apply to hospital copay.) Annual deductible does not apply. Non-emergencies: $150 copay plus 40% coinsurance after annual out-of-network deductible is met.	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met.
Freestanding emergency room (FSER) facility	$150 copay plus 20% coinsurance	Emergencies: $300 copay plus 20% coinsurance; annual deductible does not apply. Non-emergencies: $300 copay plus 40% coinsurance after annual out-of-network deductible is met.	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met.

PLAN COMPARISON CHARTS

Service	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Habilitation and rehabilitation services - outpatient therapy (including physical therapy, occupational therapy and speech therapy)	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Hearing aids (for covered participants over age 18)	Plan pays up to $1,000 per ear for any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered at the same benefit level.		Plan pays up to $1,000 per ear every three years after deductible is met.	
Hearing aids (for participants 18 years of age and younger)	Plan pays 100%; limit of one hearing aid per ear for any consecutive 36-month period and $1 per battery (In-network and out-of-network hearing aids are covered at the same benefit level.)		20% coinsurance after annual in-network deductible is met (In-network and out-of-network hearing aids are covered at the same benefit level.)	
High-tech radiology (CT scan, MRI and nuclear medicine)	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Home health care	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Inpatient and outpatient hospice and rehabilitation	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Inpatient hospital facility (semi-private room and day's board, and intensive care unit)	• $150/day copay plus 20% coinsurance • $750 copay max, up to 5 days per hospital stay • $2,250 copay max per calendar year per person	• $150/day copay plus 40% coinsurance after annual deductible is met. • $750 copay max, up to 5 days per hospital stay • $2,250 copay max per calendar year per person	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Maternity care doctor charges only; inpatient hospital copays will apply	$25 or $40 for first prenatal visit; no copay for subsequent routine prenatal or postnatal appointments	40% coinsurance after annual deductible is met	No cost for subsequent routine prenatal and postnatal appointments after annual deductible is met and 20% coinsurance for initial visit	40% coinsurance after annual deductible is met
Medications and injections administered by a provider	• Physician's office: Covered at 100% after copay (or 100% if no charge is assessed for office visit) • Any other outpatient location: 20% coinsurance. • Preventive vaccines covered at 100%	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met Preventive vaccines covered at 100%	40% coinsurance after annual deductible is met
Office surgery and diagnostic procedures	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
PCP office visit	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Private duty nursing	20% coinsurance	40% coinsurance after annual deductible is met Maximum of 96 hours per calendar year	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met Maximum of 96 hours per calendar year
Retail health/ convenience care clinic	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Routine eye exam, one per year per participant	$40 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Routine preventive care	No cost to participant(s)	40% coinsurance after annual deductible is met	No cost to participant(s)	40% coinsurance after annual deductible is met
Skilled nursing facility/ inpatient rehabilitation facility services	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Specialist physician office visit	$40 copay with valid PCP referral on file	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met

PLAN COMPARISON CHARTS

Service	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Surgery (outpatient) other than in physician's office	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Telemedicine visit	Coverage is based on place of treatment billed. • Provider's office: $25/$40 copay for physician's office visit • Any other outpatient telemedicine: 20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Therapeutic treatments - outpatient	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Urgent care clinic	$50 copay plus 20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Virtual Visits (medical)	$0 copay for Virtual Visits when provided by Doctor On Demand® or MDLIVE®	Not covered	20% coinsurance after annual deductible is met for Virtual Visits when provided by Doctor On Demand or MDLIVE	Not covered

Mental Health/Behavioral Health/Substance Use Benefits

Benefits apply to all covered mental/behavioral/substance use services (including serious mental illness treatment, substance use treatment, autism spectrum disorder services, etc.).

	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Inpatient hospital mental health stay	• $150/day copay plus 20% coinsurance • $750 copay max, up to 5 days per hospital stay • $2,250 copay max per calendar year per person	• $150/day copay plus 40% coinsurance after annual deductible is met • $750 copay max, up to 5 days per hospital stay • $2,250 copay max per calendar year per person	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Mental health telemedicine	Coverage is based on place of treatment billed. • Provider's office: $25 • Any other outpatient telemedicine: 20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Outpatient facility care (partial hospitalization/ day treatment and extensive outpatient treatment)	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Outpatient physician or mental health provider office visit	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Applied Behavioral Analysis (ABA) treatment	Coverage is based on place of treatment. • $25 copay if administered in a mental health provider's office • 20% coinsurance for any other outpatient location, including the home	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Virtual Visits (mental health)	$0 copay for virtual visits when provided by Doctor On Demand or MDLIVE	Not covered	20% coinsurance after annual deductible is met for Virtual Visits when provided by Doctor On Demand or MDLIVE	Not covered

DIABETES EQUIPMENT AND SUPPLIES BY PLAN

Other diabetes equipment, supplies, and prescription drugs not listed below may be covered under these plans. For more information about your prescription drug benefits or for help finding an in-network pharmacy, contact HealthSelect PDP customer care toll-free at **(800) 935-7189 (TTY: 711)**. For more information on your medical plan benefits, contact a BCBSTX Personal Health Assistant toll-free at **(800) 252-8039 (TTY: 711)**.

	HealthSelect of Texas® and HealthSelect℠ Out-of-State		Consumer Directed HealthSelect℠	
	Prescription Drug Program (PDP) benefits	**Medical plan benefits**	**Prescription Drug Program (PDP) benefits**	**Medical plan benefits**
Diabetes glucometers	Certain brands of preferred glucometers are covered at no cost to participants when received through the free glucometer program*. For more information on the free glucometer program, call HealthSelect PDP customer care.	Refer to Prescription Drug Program (PDP) benefits	Certain brands of preferred glucometers are covered at no cost to participants when received through the free glucometer program*. For more information on the free glucometer program, call HealthSelect PDP customer care.	Refer to Prescription Drug Program (PDP) benefits
Continuous glucose monitors / insulin pumps	Certain brands of continuous glucose monitors and related supplies	20% coinsurance for in-network and out-of-network covered continuous glucose monitors, insulin pumps, and related supplies through durable medical equipment benefits	Certain brands of continuous glucose monitors and related supplies	20% coinsurance for in-network and out-of-network covered continuous glucose monitors and insulin pumps, and related supplies after annual deductible is met; through durable medical equipment benefits
Diabetic supplies	Certain brands of preferred diabetic test strips* are covered at no cost to participants when purchased from a PDP in-network pharmacy. Lancets and lancing devices, and syringes are covered at no cost to participants when purchased from a PDP in-network pharmacy.	Refer to Prescription Drug Program (PDP) benefits	20% coinsurance for covered diabetic supplies after annual in-network deductible is met when purchased from a PDP in-network pharmacy 40% coinsurance after annual out-of-network deductible is met when purchased from a PDP out-of-network pharmacy	Refer to Prescription Drug Program (PDP) benefits
Prescription insulin	In-network pharmacy: Insulin products on the PDP drug list (formulary) are covered with a maximum $25 copay per 30-day supply, regardless of tier. Out-of-network pharmacy: Insulin products are covered at a Tier 1, Tier 2 or Tier 3 copay and 40% coinsurance.	Not covered under medical plan benefits	In-network pharmacy: 20% coinsurance (up to $25 maximum per 30-day supply) for insulin products on the PDP drug list (formulary) Out-of-network pharmacy: 40% coinsurance for insulin products after annual out-of-network deductible is met	Not covered under medical plan benefits

*Benefits and covered brands of glucometers and test strips are subject to change.

NON-DISCRIMINATION POLICY

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, age or disability.

To receive language or communication 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, contact us to file a grievance.

Office of Civil Rights Coordinator 300 E. Randolph St. 35th Floor Chicago, Illinois 60601	Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960 Email: CivilRightsCoordinator@hcsc.net

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

U.S. Dept. of Health & Human Services 200 Independence Avenue SW Room 509F, HHH Building 1019 Washington, DC 20201	Phone: 800-368-1019 TTY/TDD: 800-537-7697 Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ASSISTANCE

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 855-710-6984.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したり することができます。料金はかかりません。通訳とお話される場合、855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی،با شمار 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-710-6984.

WE'RE HERE TO HELP YOU

BCBSTX PERSONAL HEALTH ASSISTANTS CAN:

- answer questions about medical and mental health benefits,
- assist with referrals,
- help you locate in-network providers and schedule or cancel doctor's appointments,
- provide you with cost estimates for services and
- help you shop for cost-effective providers and earn HealthSelectShoppERS℠ rewards.

Call HealthSelect customer service at BCBSTX toll-free at **(800) 252-8039 (TTY: 711)**. BCBSTX Personal Health Assistants are available Monday- Friday, 7 a.m.-7 p.m. and Saturday, 7 a.m.-3 p.m. CT.

Chat with a BCBSTX Personal Health Assistant via Blue Access for Members or the BCBSTX App, Monday–Friday, 8 a.m.-5 p.m. CT.

BlueCross BlueShield of Texas

Learn to Live provides educational behavioral health programs. Members considering further medical treatment should consult with a physician. 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.

Hinge Health is an independent company that has contracted with BCBSTX to provide an online musculoskeletal program for members with coverage through BCBSTX.

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