



**BlueCross BlueShield
of Texas**



QUICK REFERENCE GUIDE

Group Name	HealthSelect SM of Texas
Group Numbers	038000 and 038001
Customer Service (Providers)	(800) 451-0287
Customer Service (Members)	(800) 252-8039
iEXCHANGE [®] (for referrals and preauthorization)	(800) 413-0869 (www.bcbstx.com/provider)
Behavioral Health (INROADS [®])	(800) 528-7264
Alpha Prefix	HXE
Plan Type	Point of Service (POS) and Traditional
Referral Required	Yes (Network) No (Non-Network and Out-of-Area)
Electronic Claims	Provider Automation Helpline (800) 282-4548
Address to File Claims	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044
Caremark	(888) 886-8490
Caremark FastStart [®] Mail Service Program	(800) 875-0867

Sample ID Cards

In-Area

Out-of-Area

Plan Name (indicated by dashed line)

Group Number (indicated by dashed line)

Copay Information (indicated by dashed line)

Customer Service Phone Numbers

Customer Service Phone Numbers

HealthSelect is administered by Blue Cross and Blue Shield of Texas

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HEALTHSELECT PLAN HIGHLIGHTS — EFFECTIVE SEPTEMBER 1, 2008

Refer to the patient's HealthSelect ID card to determine which benefits apply. A patient will have out-of-area coverage if he or she resides outside of Texas or is retired age 65 or over. Prescription drug benefits are administered by Caremark. For information about the patient's prescription drug program, contact Caremark.

PATIENT PAYS	NETWORK	NON-NETWORK	OUT-OF-AREA
DEDUCTIBLE (per calendar year; individual/family)	\$0	\$500/\$1,500	\$200/\$600
COINSURANCE MAXIMUM (per calendar year; individual)	\$1,000	\$3,000	\$1,000
COINSURANCE	20%	40%, after deductible	30%, after deductible
INPATIENT COPAYMENT MAXIMUM (per calendar year) Does not include office visit, outpatient day-surgery or emergency copayments	\$1,500 per person		
OFFICE VISIT Primary Care Physician (PCP) Specialist Office Visit	\$20 copay \$30 copay	40%, after deductible 40%, after deductible	30%, after deductible 30%, after deductible
PREVENTIVE CARE <ul style="list-style-type: none"> • Routine physical (one per calendar year) • Well-woman exam (one per calendar year) • Routine mammogram (one per calendar year) • Well-baby care • Immunizations • Vision exam (one per calendar year) • Hearing exam • Prostate (PSA) screenings • Colorectal cancer screenings 	\$20 copay with PCP, \$30 copay with Specialist, or 20% surgical	40%, after deductible	30%, after deductible
PHYSICAL, OCCUPATIONAL, SPEECH THERAPY, AND CHIROPRACTIC CARE	20% if no office visit; if office visit, \$30 copayment, plus 20%	40%, after deductible	30%, after deductible
*BEHAVIORAL HEALTH OUTPATIENT VISITS (maximum of 30 visits per calendar year)	20% (even after out-of-pocket coinsurance maximum is met)	40%, after deductible (even after out-of-pocket coinsurance maximum is met); maximum allowable amount of \$60 per visit	30%, after deductible (even after coinsurance maximum is met); maximum allowable amount of \$60 per visit
DIABETIC SUPPLIES (other than insulin and syringes)	20%		30%, after deductible
MATERNITY CARE (GLOBAL FEE) <ul style="list-style-type: none"> • With PCP • With a Specialist 	one-time copay of \$20 one-time copay of \$30	40%, after deductible 40%, after deductible	30%, after deductible 30%, after deductible
OUTPATIENT SURGICAL FACILITY CHARGES	\$100 copay and 20% of remaining charges	\$100 copay and 40%, after deductible	\$100 copay and 30%, after deductible
INPATIENT CARE FACILITY CHARGES	\$100 copay per day (\$500 max) and 20% of remaining charges	\$100 copay per day (\$500 max) and 40%, after deductible	\$100 copay per day (\$500 max) and 30%, after deductible. No deductible for facility charges
EMERGENCY ROOM	\$100 copay and 20% of remaining charges	40%, after deductible	30%, after deductible

*Does not include serious mental illness or chemical dependency, which is covered as any other illness.



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