HealthSelect Plan Highlights — Effective September 1, 2011

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)	$2,000	$7,000	$3,000
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	$2,250 per person		
Office Visit Primary Care Physician (PCP) Specialist Office Visit Retail Health Clinic	 $25 copay $40 copay $25 copay	 40%, after deductible 40%, after deductible 40%, after deductible	 30%, after deductible 30%, after deductible 30%, after deductible
Urgent Care Clinic (eff. 6/1/10)	$50 copay and 20%	40%, after deductible	60%, after deductible
Preventive Care *Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e. at no cost to the participant) conditioned upon physician billing and diagnosis. In some cases, you will still be responsible for payment on some services.	100%	40%, after deductible	100%
Physical, Occupational, Speech Therapy, and Chiropractic Care	20% if no office visit; if office visit, $40 copayment, plus 20%	40%, after deductible	30%, after deductible
Chiropractic Care (maximum 30 visits per calendar year, per participant)	$40 office visit copay and/or 20% plus amount over $75 benefit maximum	40% and amount over $75 benefit maximum	30% and amount over $75 benefit maximum
***Behavioral Health Outpatient Visit** (maximum of 30 visits per calender 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) • With PCP • With a Specialist	 one-time copay of $25 one-time copay of $40	40%, after deductible	30%, after deductible
High-tech radiology: • CT scan • MRI • Nuclear medicine	$100 copay and 20% (Copay waived if high-tech radiology performed during ER visit or inpatient admission)	$100 copay and 40% (Copay waived if high-tech radioology performed during ER visit or inpatient admission)	$100 copay and 30% (copay waived if high-tech radiology performed during ER visit or inpatient admission)
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	$150 copay per day ($750 max) and 20% of remaining charges	$150 copay per day ($750 max) and 40%, after deductible	$150 copay per day ($750 max) and 30%, after deductible. No deductible for facility charges
Emergency Room	$150 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.

BlueCross BlueShield of Texas

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