HealthSelect of Texas® | CONSUMER DIRECTED HealthSelect™

HEALTH CARE WHEREVER YOU ARE

2023 Summer Enrollment

The 2024 plan year begins Sept. 1, 2023, and runs through Aug. 31, 2024.

www.healthselectoftexas.com

Plan Comparison Chart

PLAN COMPARISON CHARTS

Effective September 1, 2023

Medical Benefits

	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, 2023: $7,050 per person; $14,100 per family Jan. 1 – Dec. 31, 2024: $7,500 per person; $15,000 per family		Jan. 1 – Dec. 31, 2023: $7,050 per person; $14,100 per family Jan. 1 – Dec. 31, 2024: $7,500 per person; $15,000 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 non-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.

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[2]	• 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.
Diagnostic A1c testing (for participants diagnosed with diabetes)	20% coinsurance; see page 6 for details.	40% coinsurance after annual deductible is met; see page 6 for details.	20% coinsurance after annual deductible is met; see page 6 for details.	40% coinsurance after annual deductible is met; see page 6 for details.
Diabetes equipment[2]	20% coinsurance; see page 6 for details.	40% coinsurance after annual deductible is met; see page 6 for details.	20% coinsurance after annual deductible is met; see page 6 for details.	40% coinsurance after annual deductible is met; see page 6 for details.
Diabetes supplies	See page 6 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[2]	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.	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.
Facility emergency care (non-FSER) and hospital-affiliated freestanding emergency departments[2]	$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 facility (FSER)	$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.
Habilitation and rehabilitation services - outpatient therapy (including physical therapy, occupational therapy and speech therapy)[2]	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met

[2]Prior authorization may be required.

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
Hearing aids requiring a prescription (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 requiring a prescription (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)[2]	$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[2]	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Hospice care[2]	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)[2]	• $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 charge for routine postnatal appointments	40% coinsurance after annual deductible is met	No charge for 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[2]	• 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[2]	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[2]	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met

[2]Prior authorization may be required.

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
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
Surgery (outpatient) other than in physician's office[2]	$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 if Doctor On Demand or MDLIVE is used	Not covered

Mental Health/Behavioral Health/Substance Abuse Benefits

Benefits apply to all covered mental health/behavioral health/substance abuse services (including serious mental illness treatment, substance abuse 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[2]	• $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 copay • 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)[2]	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/e-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	Not covered

[2]Prior authorization may be required.

Diabetes Equipment and Supplies

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 Prescription Drug Program (PDP) customer care toll-free at **(855) 828-9834 (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 HealthSelect 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 HealthSelect PDP benefits.
Continuous glucose monitors / insulin pumps	Certain brands of continuous glucose monitors and related supplies will be available starting Jan. 1, 2024.	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 will be available starting Jan. 1, 2024.	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 HealthSelect 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 HealthSelect 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@hscs.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 એવા 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 है, 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, ທ່ານມີສິດຂໍຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. 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.

BlueCross BlueShield of Texas

WE'RE HERE TO HELP YOU

BCBSTX PERSONAL HEALTH ASSISTANTS

They can:

- answer questions about medical and mental health benefits,
- assist with prior authorizations and 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.

24/7 NURSELINE

If you're not sure where to go for care, call the 24/7 Nurseline and speak with a registered nurse toll-free at **(800) 581-0368**. Call any time, any day of the year.

BLUE ACCESS FOR MEMBERS℠

Your online portal where you can:

- view your claims and explanation of benefits (EOB),
- find in-network doctors, hospitals and other providers,
- select and change your PCP,
- compare costs for procedures from different providers,
- download a temporary ID card or order a new one and
- confirm your prior authorizations and referrals on file.

To access Blue Access for Members, visit **www.healthselectoftexas.com** and click on *"Log In"* in the upper-right corner. If you do not have an account yet, click *"Register Now"* and use the information on your medical ID card to create an account.

BCBSTX APP

With the BCBSTX App, your benefits are at your fingertips, wherever you are. Text **BCBSTXAPP** to **33633** to download.

762240.0423