

## **Making Your Benefits Work For You**

**Employees and Retirees Under Age 65  
Effective May 1, 2003**



**BlueCross BlueShield  
of Texas**

*HealthSelect administered by Blue Cross and Blue Shield of Texas, A Division  
of Health Care Service Corporation, a Mutual Legal Reserve Company\**

*\*Independent Licensee of the Blue Cross and Blue Shield Association*

**The HealthSelect Benefits Book is a summary of the Master Benefit Plan Document, statutes, and administrative rules governing HealthSelect. In case of conflict between the provisions of these books and the plan document, statutes, or administrative rules, the appropriate plan document provision, statute, or administrative rule will control. Although the ERS intends to continue our health care plan into the future, the agency reserves the right, at all times, to change, suspend, or end the plan.**

**NOTICE OF ELECTION OF EXEMPTION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans as follows:

1. Limitations on preexisting conditions exclusions periods;
2. Special enrollment periods for individuals (and dependents) losing other coverage;
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status;
4. Standards relating to benefits for mothers and newborns; and
5. Parity in the application of certain limits to mental health benefits.

However, HIPAA permits certain governmental group health plans the right of exemption from certain provisions of this federal law. For the plan year beginning September 1, 2002 through August 31, 2003, the Employees Retirement System of Texas (ERS) has elected to exempt HealthSelect of Texas (HealthSelect) from HIPAA provisions 2 and 3 above. Therefore, employees and retirees who do not enroll themselves and their dependents in HealthSelect during their initial period of eligibility may be subject to evidence of insurability requirements if they wish to enroll at a later date.

**HealthSelect is a self-funded, managed health care plan with medical benefits administered by Blue Cross and Blue Shield of Texas (BCBSTX).**

**In order for BCBSTX to receive information from or give information to anyone other than the member or covered dependent (including but not limited to PCP selections or changes, claims information, or general membership information regarding a patient covered under HealthSelect), please be prepared to submit an authorization from the member, divorce decree showing custodial responsibility, or a court order. This will ensure confidentiality of all patient information.**

**For further privacy information, please see: <http://www.bcbstx.com/privacy.htm> (BCBXTX) and <http://www.ers.state.tx.us/Privacy/ERSpolicy.htm> (ERS).**

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# Section One

## About This Benefits Book

The purpose of this book is to be a resource guide to your HealthSelect benefits. This book is intended as an information source and not as a contract. It will help provide you with valuable information on such topics as:

- What is covered and not covered;
- Prescription Drug Benefits; and
- How to read your Explanation of Benefits.

**TIP: Throughout this book, you will see “TIPS” for getting the most out of your HealthSelect benefits.**

## Glossary of important terms

Included in this benefits book is a section which defines frequently used terms. You should read the Glossary of Important Terms, Section Eight, beginning on page 91 for definitions of terms such as “Medically Necessary,” “Allowable Amount,” or “Covered Oral Surgery.”

**This book is meant for active employees, retirees under age 65, and their dependents.** The information in this book applies only to active employees, retirees under age 65, and covered dependents. If you are a retiree age 65 or over, download a copy of the HealthSelect benefits book for retired employees age 65 and over from the ERS website at [www.ers.state.tx.us](http://www.ers.state.tx.us) or call BCBSTX Customer Service at (800) 252-8039 for additional information.

## Do you live in-area or out-of-area?

You have in-area coverage if you reside in Texas; otherwise you have out-of-area coverage. If you live out-of-area, but work in-area, you can “opt-in” based on your work county. See your benefits coordinator for details if you are an active employee; if you are a retiree, contact the ERS.

Because there are important differences between in-area and out-of-area coverage, you should find out which applies to you and then go directly to that area in this book.

## Your HealthSelect ID card

Your HealthSelect ID card is very important. Always carry it with you. Do not throw away your current HealthSelect ID card unless you receive a new one. Your HealthSelect ID card does not expire as long as the information printed has not changed. Your ID cards will list important information such as, your subscriber number, PCP and other important telephone numbers.

**TIP: If you would like additional HealthSelect ID cards, contact BCBSTX Customer Service at (800) 252-8039.**


## Easy-to-read Explanation of Benefits (EOB)

Understanding your EOB is essential to understanding your benefits. BCBSTX has an EOB form, which makes it easier to locate the information that is important to you. It also provides definitions of terms like “coinsurance.”

The form clearly displays the amount you are responsible for paying, if any, and the amount BCBSTX paid your provider.

**TIP: Match up your EOB with your provider’s statement, and file together for future reference.**

Below is the new look for your HealthSelect Explanation of Benefits (EOB). Remember to match up your EOB with the provider’s statement, and file them together for future reference.

 <p><b>BlueCross BlueShield of Texas</b> P.O. Box 660044 Dallas, Texas 75266-0044</p>	<p>Explanation of Claims Benefits (EOB). <b>This is not a bill</b> <b>HEALTHSELECT</b> 11-21-01</p>															
<p>Name _____ Address _____</p>	<p>Customer Service: 800-252-8039</p> <p>Customer Service Hours 7:00 A.M. - 7:00 P.M. C.S.T. Sunday - Saturday</p> <p>Member Name: _____ Group/ID Number: _____ Claim Number: _____ Patient Name: _____</p>															
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## List of frequently called phone numbers and addresses

### **BCBSTX Customer Service**

1-800-252-8039  
P.O. Box 833988  
Richardson, TX 75083-3988

### **TDD Phone Line for Hearing Impaired**

1-800-735-2989

### **Coordination of Benefits**

1-800-252-8039  
P.O. Box 833988  
Richardson, TX 75083-3988  
Attention: Coordination of Benefits

### **Inpatient Hospital Admission**

Extended Care Services /  
Home Infusion Therapy  
In Dallas: 1-972-238-7712  
Within Texas: 1-800-344-2354  
Outside Texas: 1-800-343-0125

### **Evidence of Insurability**

Fort Dearborn Life Insurance  
1-800-451-0271 (option #1)  
P.O. Box 655403  
Dallas, TX 75265

### **Employees Retirement System of Texas**

Outside Austin: 1-877-275-4377  
Austin: 1-512-867-7711  
P.O. Box 13207  
Austin, TX 78711-3207

### **Prescription Drug Program**

Medco Health Solutions, Inc.  
1-800-903-8345  
P.O. Box 650322  
Dallas, TX 75265-0322

### **Prescription Drug Reimbursement**

Medco Health Prescription Solutions, LLC  
P.O. Box 2187  
Lee's Summit, MO 64063-2187

### **Claims Filing Address**

Blue Cross Blue Shield of Texas  
P.O. Box 660044  
Dallas, TX 75266-0044  
Attention: Claims

### **UGIP Forms/PCP Changes**

BCBSTX Membership/Group Accounts  
P.O. Box 6109  
Abilene, TX 79608-6109  
OR Call 1-800-252-8039

### **Behavioral Health Services**

INROADS® Behavioral Health Services  
a Magellan Behavioral Health Company  
In Dallas 1-972-766-5201  
Outside Dallas 1-800-528-7264

### **Medicare Part A**

1-800-442-2620

### **Medicare Part B**

1-800-442-2620

### **Mail Order Prescription Drugs**

Medco Health Home Delivery Pharmacy Service  
P.O. Box 650322  
Dallas, TX 75265-0322

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## About the HealthSelect website

The information found in this benefits book and much more is available on the HealthSelect website. You can search for network and ParPlan physicians and providers, review your benefits, email BCBSTX Customer Service, review participant eligibility and claim status, re-print your Explanation of Benefits (EOB), download claim forms and obtain up-to-date information about HealthSelect. You can also link to Medco Health's website and search for contracting pharmacies and download the latest preferred drug list. You can access the HealthSelect website through the "Health and Dental Links" on the ERS website at [www.ers.state.tx.us](http://www.ers.state.tx.us).

## Online provider directory

Regional Provider Directories, located on the HealthSelect website [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002), provide you with the most up-to-date information regarding HealthSelect network and ParPlan physicians and providers. The HealthSelect website is updated every two weeks and is available 24 hours a day.

The Online Provider Directory provides detailed information about the physicians including; if they are accepting new patients, board certification, hospital affiliations, where the physician attended medical school, if the physician has a website and much more. You can conduct customized searches for primary care physicians or specialists or download an entire directory. The Online Provider Directory also allows you to email your search results to a family member, your physician, or anyone with a valid email address.

Although every attempt has been made to ensure that the Online Provider Directory is correct, some additions, deletions and changes may not be reflected. To verify that a physician or provider is still in the HealthSelect network, you can contact BCBSTX Customer Service at (800) 252-8039, or call the provider's office to verify their status.

## Email BCBSTX customer service

Have you ever had any questions for Customer Service and were unable to call during business hours? Now you can email Customer Service your questions and comments 24 hours a day, 7 days a week! Please be sure to provide a daytime phone number in your email so that a Customer Service Representative can contact you about your inquiry.

## BlueAccess

BlueAccess is an exciting feature on the HealthSelect website that allows you to access your claim and participant eligibility information as well as review and print an Explanation of Benefits (EOB). BlueAccess can also alert you via email when a claim has been finalized. When you first logon to BlueAccess, you must request a BlueAccess Password to access your account information. You will receive this password in the mail in about two weeks.

BlueAccess is available from 6 a.m. to 3 a.m. (CT), Monday-Friday, and Saturday from 6 a.m. to 3 p.m. (CT). ***BlueAccess is not available on Sundays and Holidays.***

**TIP: When you request your BlueAccess password it will be mailed to the address BCBTX has on file. It is important to make sure that ERS has your most current address.**

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**Please remember that these topics apply to you only if you have in-area coverage.**

## Section Three

### Guide to In-Area Benefits

This section is your guide to HealthSelect in-area coverage. It explains the difference between network and non-network benefits, what's covered, and the steps to getting medical care.

We have added a subsection in the back of this section titled "Q & A Quick Reference." You may want to review this section that includes questions frequently asked by in-area participants.

#### General information about in-area coverage

If you have in-area coverage, HealthSelect helps you coordinate your overall health care program through a network of doctors, hospitals, and other health care providers and facilities.

You and each covered family member should choose a Primary Care Physician (PCP) from the network. This doctor will provide most of your medical care and coordinate the care of specialists when needed. Your PCP will also help you make important decisions about your complete program of health and wellness.

You can receive care outside the network and still get benefits. You'll pay less, however, when medical services are provided by your PCP or by a specialist to whom you are referred by your PCP.

**TIP: Each family member can have a different PCP, according to individual needs.**

#### If you have covered dependents who do not live in Texas

In most cases, if you have in-area coverage, so do your covered dependents. But there may be exceptions. If you have a covered dependent who:

- Does not live with you; and
- He or she does not live in Texas,

**then...**

You may select either *in-area or out-of-area coverage* for that dependent.

***For your dependent to have out-of-area coverage***, simply complete the name and address section on your UGIP Supplemental Information Form, listing your dependent's name and address outside of Texas; or call BCBSTX Customer Service at (800) 252-8039 to change his or her address. If you do not do this, your dependent will have in-area coverage.

Please note: Section Four describes out-of-area benefits.

## Network and Non-Network Benefits

HealthSelect covers a wide range of medical services and supplies. The amount paid by HealthSelect depends on whether you receive your medical care through the network. In general, you pay less when you use the network.

### Emphasis on preventive care

HealthSelect is designed to encourage preventive care and does so by providing benefits for the following preventive care services:

- Participants 18 years of age and older can receive one routine physical exam each calendar year;
- For children under age 18, HealthSelect covers more frequent visits when using the network;
- Women can receive one annual well-woman exam by a gynecologist, if those services are not performed during their routine physical exam;
- Each participant can receive one routine eye exam per calendar year;
- Men age 50 and over are eligible for coverage for an annual diagnostic medical examination for prostate cancer. Men age 40 and over with a family history of prostate cancer are also eligible for this exam.

### Childhood immunizations for dependents

For children newborn through 6 years of age, the following immunizations are covered at 100% except when performed during an office visit (see Section Eight, page 99 for definition of office visit):

- Diphtheria;
- Haemophilus influenzae type B;
- Hepatitis B;
- Measles;
- Mumps;
- Pertussis (whooping cough);
- Polio;
- Rubella;
- Tetanus;
- Varicella (chicken pox); and
- Rotovirus.

**TIP: Every time you need medical care, you have a choice of using a network provider or going outside the network for care.**

## Freedom of choice

Although you can save money by using the network, you are not limited to network providers. If you go outside the network, you may have greater freedom of choice in selecting providers, but you will pay more of the cost. You will find a comparison of network and non-network benefits later in this section.

**TIP: If your HealthSelect ID card says “NO PCP ON FILE” (after your first 60 days of in-area coverage), and you want to obtain network benefits, call BCBSTX Customer Service at (800) 252-8039 to select a PCP.**

## The network saves you money

Network services generally cost you less than non-network services. With network services, your PCP coordinates your medical care, referring you to network specialists when they determine it is appropriate. By working together, network providers eliminate much of the duplication of services that occurs outside the network. Also, network providers have entered into an agreement with BCBSTX to accept a predetermined amount for most covered services or supplies. Of this amount, HealthSelect pays a larger share. That’s how you save money by using the network.

## Your share of the cost

Here is a comparison of how much you pay for network and non-network medical services:

	Network	Non-Network
Office visit with your designated Primary Care Physician (PCP) (routine immunizations, injections, lab work and x-rays, done at the same time in physician’s office are covered under copay)	You pay a \$20 PCP copayment per visit	You pay 40%* after deductible
Specialty Office Visit (visit with a physician other than your designated PCP)	You pay a \$30 specialty copayment per visit	You pay 40% after deductible
Coinsurance for most other services	You pay 20% up to coinsurance maximum	You pay 40%* after deductible
Calendar year coinsurance maximum	\$500 per person per calendar year **	\$1500 per person per calendar year **
Inpatient Medical Care **	You pay a \$100 copayment per day (\$500 max) plus 20%, up to coinsurance maximum	You pay a \$100 copayment per day (\$500 max) plus 40%, up to coinsurance maximum

	<b>Network</b>	<b>Non-Network</b>
Calendar year inpatient copayment maximum (includes inpatient copayments paid for both network and non-network benefits)	\$1,500 per person	\$1,500 per person
Hospital outpatient day-surgery	You pay a \$100 copayment plus 20% , up to coinsurance maximum	You pay a \$100 copayment plus 40% , up to coinsurance maximum
Calendar year deductible	None	\$500 per person \$1,500 per family

\* Benefits are paid on the BCBSTX allowable amount.

\*\* Coinsurance maximum does not include deductibles, copayments, or any other disallowed charges.

**TIP: Using ParPlan providers can limit your liability for amounts over the allowable. See Section Six, page 83 for more details about BCBSTX ParPlan providers.**

## Allowable amounts

**IMPORTANT!** All claim payments are based on allowable amounts. Providers who contract with BCBSTX (HealthSelect network and ParPlan) must accept these allowable amounts as payment in full. If you use a non-network or non-ParPlan provider (physician, hospital, lab, radiology, pathology, anesthesiologist, assistant surgeon, etc.) you will be responsible for charges over the BCBSTX allowable amount.

**Reminder:** In order to receive network benefits when seeing a network specialist, you must have a current referral from your PCP, approved by BCBSTX. It is your responsibility to ensure there is a valid referral on file before services are rendered.

**TIP:** When you are using non-network providers, using ParPlan providers can save you money. You can research individual providers online at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002), or you can call BCBSTX Customer Service at (800) 252-8039.

**TIP:** During the precertification process for inpatient admissions, BCBSTX determines the benefit level based on the status of the attending physician (network or non-network). You must have a valid referral to the admitting physician in order to receive network benefits for your inpatient stay.

# Your Primary Care Physician

## Selecting your PCP

If you choose a PCP when you enroll, the PCP's name will be printed on your HealthSelect ID card. If you do not choose one right away, your card will state "NO PCP ON FILE."

- You will be eligible for network benefits during your first 60 days of in-area coverage if you receive care from any network PCP, **and** have not designated a PCP. During this grace period, if you have an office visit with a network PCP you will be responsible for the \$20 PCP office visit copayment.
- If you have not chosen a PCP after the initial 60-day grace period, only non-network benefits will be available to you until you contact BCBSTX and select a network PCP.
- Once you have selected a PCP, you will receive network benefits when seeing that PCP and will be responsible for a \$20 PCP office visit copayment and any applicable coinsurance.
- If you have completed a UGIP Supplemental Information Form or called in your selection to BCBSTX during the grace period and then decide to change your PCP within the 60-day grace period, you must contact BCBSTX to inform them of your change in order to receive network benefits.

**TIP: For information on PCPs and specialists in your area (or anywhere in Texas), visit the Online Provider Directory found on the HealthSelect website at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002)**

## Changing your PCP

Select your PCP with care. If you or any of your covered dependents want to change PCPs after you enroll, you may do so.

Call BCBSTX Customer Service at (800) 252-8039. A representative can give you the names of several PCPs in your area and take your selection by phone. You can also search for a PCP on the HealthSelect Online Provider Directory, [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002).

## If your PCP leaves the network

PCPs participate in the network because of an agreement they have entered into with BCBSTX. If this agreement is terminated by either your PCP or BCBSTX:

- Your PCP will no longer be considered a network PCP.
- You will receive a postcard indicating your PCP's effective date of termination and requesting that you select a new PCP.
- You will have 60 days from your PCP's effective date of termination to select a new PCP. During this 60-day period you will be eligible for network benefits if you receive care from any network PCP, and have not designated a new PCP. During this grace period, if you have an office visit with any network PCP, you will be responsible for the \$20 PCP office visit copayment.
- If you have not designated a new PCP after the 60-day period, only non-network benefits will be available to you until you designate a new network PCP.

- Once you have selected a PCP, you will receive network benefits when seeing that PCP and will be responsible for a \$20 PCP office visit copayment and any applicable coinsurance.

**TIP: When you call BCBSTX to change or add a PCP, the selection is effective the day you call.**

## **Your PCP manages your health care**

If your PCP decides that he or she cannot treat you for a particular condition, your PCP may refer you to a specialist. The copayment for an office visit with a specialist who has a valid referral is \$30. The specialist must be a HealthSelect network provider. In rare instances, however, your PCP may refer you to a non-network provider. *BCBSTX approves such referrals only when there is no network provider to provide the necessary medical care.*

**TIP: Your PCP may not issue a referral for behavioral health services. See Section Three, page 17 for more information.**

When a referral has been authorized by BCBSTX, a letter of confirmation will be sent to you, the specialist, and/or the hospital or facility to which you are referred. This letter notifies you of the length of time and the number of visits approved by BCBSTX. The time and visits are determined based on the diagnosis and treatment information that your PCP shares with BCBSTX.

**It is your responsibility to ensure there is a valid referral on file before services are received.**

### *Please Note:*

- You do not need to wait for the referral letter to visit the network specialist.
- Simply confirm with your PCP that the referral has been approved, schedule the appointment and go directly to the network specialist.
- **It is your responsibility to inform your PCP or specialist when a referral is about to expire. Your provider may then contact BCBSTX for an extension.**

**TIP: Mark on your calendar when a referral will expire. Call your PCP at least two weeks prior so that an extension can be arranged.**

- **Obtaining a referral does not guarantee payment. All plan limitations and exclusions still apply.**
- Charges for treatment received beyond the length of the referral period will be reimbursed at the non-network level.
- If you see a specialist (even if the specialist is in the network) without your PCP's referral, you will receive **non-network benefits**.
- At the time of the visit, you will pay a \$30 specialist office visit copayment and any applicable coinsurance amount.
- If a referral is approved by BCBSTX to a non-contracting provider (non-network and non-parplan), you will receive network benefits based on the **billed amount**.

**TIP: For network benefits, physician assistants and advanced nurse practitioners must be employed by and supervised by a network PCP or specialist.**

## **IMPORTANT!!!!**

If your PCP or specialist with a valid referral sends you for laboratory and/or radiology work, it is **YOUR** responsibility to ensure that you are receiving treatment through a network laboratory or radiologist. If you use a non-network provider you will receive **non-network** benefits. **Keep in mind that if you use a provider who is non-network you will receive non-network benefits and can be billed for any amounts above the BCBSTX allowable as well as any services determined not medically necessary by BCBSTX.**

## **Direct access to obstetricians and gynecologists**

Women have direct access to OB/GYN specialists without a PCP referral for an annual well-woman exam, maternity care, and any OB/GYN-related illness. For care by a network OB/GYN, female participants will be responsible for the \$30 specialist office visit copayment plus applicable coinsurance, unless the OB/GYN is your designated PCP. If the network OB/GYN is also your designated PCP, you will be responsible for the PCP office visit copayment of \$20 plus applicable coinsurance.

To obtain the **network** level of benefits, schedule an appointment with a network OB/GYN. Should it be necessary, your OB/GYN can contact the BCBSTX Referral Department if you then need to be referred to another specialist for OB/GYN-related care. (To receive **non-network** benefits, simply schedule an appointment with any valid OB/GYN.) You can search for a network OB/GYN on the HealthSelect Online Provider Directory at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002).

## **Maternity and Newborn Care**

Female participants are eligible for coverage for maternity care. The participant will receive network benefits when maternity care is received from a network OB/GYN or the designated PCP. Maternity care includes charges billed by the physician for pre and post natal care. See Section Eight, page 98 for a complete description of maternity care. If maternity care is received from the designated PCP, the participant will be responsible for a one-time copayment of \$20 for physician services only. If the maternity care is with a network OB/GYN specialist, the patient will be responsible for a one-time copayment of \$30 for physician services only. Applicable copayments and coinsurance will apply for hospital charges (i.e., delivery) and other charges. See benefits summary on page 26-29 for coinsurance and copayment information for hospital charges.

**TIP: Maternity care is also available for eligible dependent children. Your child may go directly to a network OB/GYN for her care and receive network benefits.**

Hospital and medical expenses for routine well-baby nursery care of a newborn natural child or an **eligible** \* newborn grandchild incurred during the mother's hospital admission for the delivery are considered eligible expenses, provided the mother, father, or grandparent is covered under HealthSelect on the date the mother delivers the child.

The newborn child's hospitalization is covered under the precertification for the mother's hospital stay and benefits will be at the same level. If the mother is not precertified or is not covered under HealthSelect, the newborn will need his or her own precertification to receive benefits.

If the mother is a covered participant, she will be responsible for inpatient copayments of \$100 per day, not to exceed \$500 per stay, in addition to any applicable coinsurance. A separate inpatient copayment will not be charged for the baby unless the baby's stay exceeds the mother's or unless the mother is not a covered participant on the HealthSelect policy. Applicable coinsurance will be charged for the baby.

Should the newborn remain hospitalized after the mother is released, so that the correct benefit level is paid and a penalty is not applied, the participant should ensure that:

- A separate precertification for the child is obtained; and
- The child is “admitted” to the hospital in its own name for treatment by a physician or other provider for the non-routine services.

**\* TIP: HealthSelect allows benefits automatically for the first 31 days for a newborn natural child if the mother or the father is a covered participant. After 31 days, the baby must have been added to your coverage to continue to receive benefits. Newborn grandchildren are not covered automatically – if eligible, they must be added to your coverage for benefits. Active employees should contact their benefits coordinator for more information. Retirees should contact the ERS.**

**TIP: For in-area participants, should your OB/GYN cancel his or her contract with BCBSTX during your pregnancy, you will need to seek services from another network OB/GYN to receive network benefits.**

## Referrals for routine eye exams

One routine eye exam **per calendar year**, per participant, is covered (non-network, subject to calendar year deductible) without a referral from your PCP. To receive these services at the network level of coverage, simply schedule an appointment with a **network** optometrist or ophthalmologist and obtain care. You will be responsible for the \$30 specialty office visit copayment for your routine eye exam.

If your network provider discovers a condition requiring additional treatment, **you must have a referral from your PCP in order to receive network benefits.**

To receive **non-network benefits**, schedule an appointment with any appropriate valid provider and receive care. You will be responsible for 40% of the allowable amount plus the difference between billed charges and the allowed amount after you have satisfied your calendar year deductible.

**TIP: You can search for network providers through the HealthSelect Online Provider Directory at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002).**

## Referrals for behavioral health services

There are separate guidelines for network treatment of behavioral health (which includes mental health, serious mental illness, substance abuse, and speech disorders). INROADS® Behavioral Health Services can work with you directly to obtain a referral. **Your PCP is not utilized in this process.** INROADS® Behavioral Health Services will refer you to a network counselor, psychologist, psychiatrist, or treatment center, and will send you a referral stating the approved time span and approved number of visits. (Please refer to definition of “Network Behavioral Health Services Provider” in Section Eight, page 98.

Your out-of-pocket cost may vary, depending on your choice of providers, your diagnosis, and the type of treatment. If you have a referral to a **network** provider for outpatient treatment and your diagnosis is not a serious mental illness (as defined by Texas law and found in Section Eight, page 102 of this benefits book), you will be responsible for a per-visit coinsurance, subject to the outpatient visit limit.

If you have a referral to a **network** provider for outpatient treatment and your diagnosis is a serious mental illness (as defined by Texas law), you will pay your \$30 specialty office visit copayment for each visit. Treatment for a serious mental illness will **not** be subject to the 30-outpatient visit calendar year maximum. Treatment for a serious mental illness is covered like any other injury or illness.

As with other covered services, you may receive care from a **non-network** provider; but benefits will be paid at **non-network** levels, with a benefit maximum dollar amount allowed per outpatient visit. You can be responsible for the difference between the benefit maximum dollar amount of \$60 allowed under HealthSelect and the amount billed by the provider, in addition to any applicable coinsurance and deductible. If you seek care from a ParPlan provider, you may also be responsible for the difference between that ParPlan provider's allowable amount and the benefit maximum of \$60. (The benefit maximum dollar amount does not apply to services for treatment of serious mental illness.)

For inpatient and intermediate care you will be responsible for copayments plus applicable coinsurance. For inpatient treatment, you will be responsible for a \$100 copayment per day, not to exceed \$500 per stay. Your copayment for intermediate care is less, at \$50 per day, not to exceed \$500 per stay. These copayments also apply to the calendar year inpatient copayment maximum of \$1,500 per person.

**TIP: Services for speech therapy may be considered behavioral health charges (and apply toward the 30-visit maximum per calendar year), depending upon the diagnosis submitted on the claim.**

**Network** benefits for behavioral health care are available by calling INROADS Behavioral Health Services. Either you or a family member may call.

**INROADS® Behavioral Health Services telephone numbers:**

In Dallas (972) 766-5201  
Outside Dallas (800) 528-7264

**If you do not obtain referrals for behavioral health treatment through INROADS Behavioral Health Services, benefits will be paid at *non-network* levels.**

**If you are using a network provider for behavioral health care, the provider is responsible for obtaining the referral. If the referral is not obtained, the provider may not be eligible for reimbursement for the services rendered. Please ensure that your network provider has obtained a referral.**

## **Residential Treatment Centers and Substance Abuse Facilities**

A **Residential Treatment Center (RTC)** provides treatment to children and adolescents for behavioral health problems. In order for benefits to be available, the facility must be licensed by the appropriate licensing body (see definition in Section Eight, page 101). Care received at RTCs must be precertified through INROADS® Behavioral Health Services.

Inpatient treatment of substance abuse (chemical dependency) must be provided in a **Substance Abuse Facility** (see definition in Section Eight, page 102). All inpatient treatment of substance abuse (chemical dependency) must be precertified through INROADS® Behavioral Health Services.

**Please note:** BCBSTX has no contracts with **RTCs** to provide care for substance abuse (chemical dependency), even though the facilities may be licensed to provide certain levels of care. Consequently, **if service in the RTC is approved**, you will be responsible for charges over the BCBSTX allowable amount, and in-area participants will be eligible for **non-network benefits only**.

*If you do not obtain precertification for these services, you may be responsible for the full cost of the services, until the medical necessity of your treatment can be determined. Benefits may be reduced or denied if the treatment is not medically necessary.*

**INROADS® Behavioral Health Services telephone numbers:**

In Dallas (972) 766-5201  
Outside Dallas (800) 528-7264

## **Precertification of certain services**

HealthSelect requires precertification of certain medical services. Precertification determines, in advance, the medical necessity of the care you are to receive. Precertification is **not required for outpatient medical services**; however, it is required for:

- Inpatient hospital admissions;
- Skilled nursing care in a skilled nursing facility;
- Private-duty nursing;
- Home health care;
- Hospice care; and
- Home infusion therapy (use of a BCBS contracting provider is required to receive *any* benefits).

**Care for behavioral health must be precertified through a separate process, described in Section Three, page 20.**

Precertification merely determines the medical necessity of the admission. **It does not guarantee payment.** Payment will be determined after the claim is filed and is subject to eligibility requirements and other HealthSelect provisions, exclusions and limitations, including, **but not limited to:**

- Cosmetic procedure limitation;
- Requirement to call for precertification as explained below on a timely basis - (prior to an elective admission and within 48 hours of an emergency admission); and
- Payment of premium for the date on which services are rendered.

## **How to precertify**

When you use the network, either your PCP or the specialist for whom you have a valid referral will be responsible for precertification.

If you **do not** use the network, **you** are responsible for precertification. Either you, your provider, or a family member must ensure that your treatment has been precertified by BCBSTX.

If precertification is not obtained when using non-network benefits, a penalty deductible will be applied to hospital admissions, in addition to your calendar year deductible and coinsurance. Also, benefits will not be paid for services which are not medically necessary, including room and board charges for unapproved inpatient hospital days.

**TIP: A hospital stay is considered to be in-patient if it is at least 24 hours in duration.**

## Recertification numbers to call:

In Dallas	(972) 238-7712
Within Texas	(800) 344-2354
Outside Texas	(800) 343-0125

## Recertification of behavioral health services

When using the network, your network provider is responsible for recertification of behavioral health services. If your network provider does not obtain the recertification, however, the provider may not be eligible for reimbursement for the services rendered. ***Please ensure that recertification for behavioral health services has been obtained through INROADS® Behavioral Health Services.***

If you **do not** use the network, **you** are responsible for recertification of the following:

- Hospital admissions;
- Intermediate care facilities;
- Residential treatment centers;
- Crisis stabilization units;
- Psychiatric day treatment facilities;
- Inpatient treatment of substance abuse; and
- Inpatient treatment of serious mental illness.

## Predetermination of benefits

As participants in HealthSelect, you and your covered dependents are entitled to a review by the BCBSTX Medical Division to determine the medical necessity of any proposed medical procedure. This process is called a **predetermination of benefits**. It will inform you in advance if BCBSTX considers the service to be medically necessary, and therefore eligible for benefits. See Section Eight, page 98 for definition of medical necessary.

To have a predetermination conducted, have your physician provide BCBSTX a letter of medical necessity and any pertinent medical records supporting this position. After a decision is reached, you and your physician will be notified in writing.

**TIP: It is best to start the predetermination process several weeks prior to the scheduled procedure.**

## Reviews by an independent review organization (IRO)

Even if a life-threatening condition is **not** involved, if BCBSTX initially determines that the health care services proposed are not medically necessary, and this adverse determination is upheld at the highest level of review at BCBSTX, you may seek review of the decision by an independent review organization (IRO).

If you have a life-threatening condition, you are entitled to an immediate review by an IRO rather than having to follow the normal appeal procedures under HealthSelect.

## Steps for seeking a review by an IRO

- Step 1:** BCBSTX will provide information to you, your designated representative, or your provider of record on how to obtain review of the denial by an IRO.
- Step 2:** This information will be provided at the time of determination following the denial, or in case of a life-threatening condition, upon the initial denial.
- Step 3:** You, your designated representative, or your provider of record will be given an appropriate form for requesting the IRO review.
- Step 4:** You, your designated representative, or your provider of record must complete the form and return it to BCBSTX.
- Step 5:** In life-threatening situations, you, your designated representative, or your provider of record may contact BCBSTX by phone at (800) 252-8039 to request the IRO review and provide the needed information.

You may still appeal a denied claim after charges have been incurred by following the normal appeal procedures under HealthSelect.

**Reminder:** The Independent Review Organization (IRO) process, is **NOT available for contract exclusions** (for example, experimental/investigational procedures.)

## In Case of Emergency

### Definition of emergency

**Emergency** - The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his condition, sickness or injury is of such a nature that failure to get immediate medical care could reasonably result in:

1. Placing the participant's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

### Getting emergency care

When you or a covered dependent has an emergency, appropriate medical treatment should be obtained immediately. The chart in Section Three, page 42, provides the steps you should follow in receiving emergency care.

For medically necessary emergency care during the first 48 hours, services will be paid at the network level based on the BCBSTX allowable amount. You will pay a \$100 emergency room copayment plus 20% of the allowable amount after the copayment. If your annual out-of-pocket coinsurance maximum has been reached, you will not have to pay 20%, but will still be responsible for your emergency room copayment of \$100. Should you be admitted to the hospital as an inpatient, the \$100 emergency room copayment will be waived; however, you will be responsible for the inpatient hospital copayment.

**If you are treated by a non-contracting provider during the first 48 hours of your emergency, benefits will be paid at the network level based on the BILLED amount, holding you harmless (you will not be financially responsible for any charges that have been disallowed). If treatment is received after the first 48 hour of an emergency without a referral from your PCP, you will receive non-network benefits based on the ALLOWABLE amount.. *This means you will pay 40% of the allowed amount plus the calendar year deductible if not already satisfied, and the difference between the provider's billed charges and the BCBSTX allowed amount.***

**If your PCP issues you a referral for treatment received after the first 48 hours of an emergency, you will receive network benefits based on the allowable amount. If you receive care from a non-ParPlan provider, you will be responsible for any charges above the allowable amount.**

**If you receive treatment in an emergency room for a situation that is not an emergency, you will receive non-network benefits (unless referred by your PCP, or by a valid network specialist with a current referral).**

**TIP: When you are using non-network benefits, ParPlan providers can save you money. You can research individual providers online at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002), or you can call BCBSTX Customer Service at (800) 252-8039.**

## **Ambulance services**

HealthSelect pays benefits for Ambulance Services received at the time of an emergency and when determined to be medically necessary by BCBSTX. Benefits are paid based on the *allowable amount*, and **you** are responsible for any balance billed by the provider. There are no benefits available for Ambulance Services, unless a patient is transported to the nearest hospital equipped and staffed to treat the condition. (See definition of “Ambulance Services” in Section Eight, page 92).

**TIP: When possible, contact your PCP prior to going to the emergency room. When not possible, have a family member call within 48 hours.**

## **If you have been admitted to the hospital**

If you have been admitted as an inpatient to the hospital from the emergency room, your emergency room copayment of \$100 is waived but the inpatient hospital copayment will apply. Benefits will be paid at network levels for the first 48 hours. **You must call your PCP within 48 hours of your admission** to obtain proper referrals to receive network benefits. Your PCP is responsible for precertifying your hospitalization and setting up referrals to specialists.

If your PCP is not managing your care, you will be responsible for contacting the BCBSTX Precertification Department within 48 hours of your admission to get your hospital stay precertified. If you cannot make the call yourself, have a family member call for you. **If you do not precertify your stay, you will have to pay an additional penalty deductible**. Precertification is described in Section Three, page 19 of this book.

Remember, if your PCP is not managing your care, you are probably going to receive non-network benefits on covered services **even if you are receiving treatment at a network facility**. This means you will be responsible for:

- Calendar year deductible, if not previously satisfied;
- Precertification penalty deductible, if you did not precertify;
- Services and supplies that are not medically necessary;
- Your coinsurance and inpatient copayments as shown on the in-area benefits summary (Section Three, pages 26-29); and

- Any difference between the provider's billed amount and the BCBSTX allowable amount, if you do not use a network or parplan provider.

**TIP: Contacting your PCP within 48 hours of emergency admission will reduce your out-of-pocket expense.**

## Telemedicine

HealthSelect covers medically necessary services provided through telemedicine. Telemedicine includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education. Refer to Section Eight, page 103 for the complete definition of telemedicine.

## Durable medical equipment

Durable Medical Equipment (DME), which consists of therapeutic supplies and rehabilitative equipment required for therapeutic use, is covered under HealthSelect when medically necessary. Whether you receive network or non-network benefits is determined by your choice of physician directing your care **and** your choice of DME supplier.

If your PCP or specialist with a valid referral prescribes DME, simply take the prescription to a **network** DME supplier to receive **network** benefits. A separate referral to the DME supplier is not required. Visit [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002) or call BCBSTX Customer Service for a list of network DME providers.

If you visit a **non-network DME supplier** you will receive **non-network benefits** for covered medically necessary services or supplies, even if your PCP or a specialist with a valid referral refers you. **If you use a non-contracting (non-network or non-ParPlan) DME supplier and the charge is greater than the BCBSTX allowable amount, you will be responsible for the difference.**

*Please note: Equipment designed for alleviation of pain or provision of patient comfort (i.e., motorized lift, air fluidized mattress, blood pressure cuff), is **NOT covered, even if prescribed by a physician.** DME must be medically necessary and required for therapeutic use.*

## Diabetic management

Diabetic management services include **Diabetes Equipment, Diabetes Supplies, and Diabetes Self-Management Training Programs**, which are rendered by or at the direction of a physician. See Section Eight, pages 94-95, for specific definitions of these services. Diabetes Supplies are covered in the following manner:

**Insulin and syringes** are covered under your prescription drug benefits (see Section Five, page 66, for information on your prescription drug benefits).

**Other diabetes supplies** (see Section Eight, pages 94-95, for a complete definition) are covered under your medical benefits as Durable Medical Equipment (DME), at 80% of the BCBSTX allowable amount. However, if you use a non-contracting supplier and the charge is greater than the allowable amount, **you will be responsible for the difference.**

If you use a DME provider who does not contract with BCBSTX, you will be required to file your claim and can be billed for amounts above the allowable. To file a claim for diabetes supplies, attach your cash register receipt, showing quantity

of each item purchased, to a completed medical claim form (keeping copies for your records). Mail to BCBSTX at P.O. Box 660044, Dallas, TX 75266-0044.

If you use a DME provider who contracts with BCBSTX, you will not be required to file your claim and will not be responsible for any charges above the allowable amount. You can search for contracting DME providers through the HealthSelect Online Provider Directory. When conducting a customize search, DME providers are found under “Ancillary Providers.” You can also use ParPlan (see Section Eight, page 100, for a complete definition) DME providers for your diabetic supplies. To obtain names of ParPlan Providers in your area, contact Customer Service at (800) 252-8039. Once locating a DME provider, you will need to contact that provider to determine if they carry your supplies.

## Hearing aids

HealthSelect allows a \$500 maximum benefit per hearing loss (per ear) every 36 months for hearing aids, fittings, and molds – but not repairs. If you use a network provider, the provider’s total payment is based on the BCBSTX allowable amount. BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between that benefit and the contracted BCBSTX allowable amount. If you use a non-network provider, BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between the benefit and the provider’s billed charges. In addition, hearing aid batteries are covered and are not subject to the \$500/three year limitation. Please refer to the Benefits Summary in Section Three, pages 26-29, for more information.

**TIP: When filing a claim for a hearing aid, be sure to indicate right or left ear on your receipt.**

## BlueCard Worldwide®

This benefit is available to you when you travel or live outside the United States.

### How BlueCard Worldwide® works

When you’re traveling or living outside the U.S. and require inpatient hospital care, all you need to do is follow these easy steps:

- Step 1:** Remember to carry your most current HealthSelect ID Card.
- Step 2:** Call BlueCard Access at 1-800-810-BLUE (2583) to identify BlueCard Worldwide participating hospitals. (You can use the toll-free number outside of the U.S. by using an AT&T Direct® Access Number.)
- Step 3:** Go to the nearest participating hospital in your international location and present your ID card.
- Step 4:** Call Blue Cross and/or Blue Shield for pre-certification/prior authorization, where necessary. Refer to the phone number on your ID card. It differs from the BlueCard Access number.

## Carry your ID card abroad, and we’ll take care of the rest

By using a participating hospital, you will only need to pay for out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance). BCBSTX will take care of the rest, and will send an Explanation of Benefits to your home.

## Making the Most of your Benefits

### Steps to *network* benefits

- Step 1:** Call your PCP for an appointment (unless you need care for behavioral health, as described in Section Three, pages 17-18).  
Tell your PCP that you have HealthSelect coverage.
- Step 2:** See your PCP. You will be responsible for the \$20 PCP office visit copayment and any applicable coinsurance.  
Show your HealthSelect ID card.  
Your PCP will treat you, or will obtain approval from BCBSTX if a referral to a network specialist is appropriate. If you see a network specialist, you will be responsible for the \$30 specialty office visit copayment and any applicable coinsurance.  
If your PCP refers you to a non-network provider, and it is approved by BCBSTX, you will still receive network benefits. **You will be referred to a non-network provider only if there are no network providers who can treat you.**  
If you need to be admitted to a hospital, your PCP will arrange your admission to a network facility.
- Step 3:** You will receive an EOB from BCBSTX. (See Section One, page 5 for a description of the EOB.)

**TIP: File your BCBSTX EOB and provider's statement together for future reference.**

### Steps to *non-network* benefits

- Step 1:** Call any provider (see definition of provider in Section Eight, pages 101), preferably a BCBSTX ParPlan provider. (See explanation of ParPlan Provider in Section Six, page 83).  
Tell the provider you have HealthSelect coverage.
- Step 2:** See the provider. You will be responsible for 40% of the allowed amount, etc.  
Show your HealthSelect ID card.  
The provider will treat you and may recommend further treatment, hospitalization, and/or surgery.
- Step 3:** Precertify the treatment, if necessary. (See Section Three, pages 19 for a list of services and procedures requiring precertification.)
- Step 4:** If you use a non-ParPlan provider, you may have to file a claim form. (See Section Six, page 84 for instructions.)
- Step 5:** You will receive an EOB from BCBSTX.

**TIP: With non-network benefits, all preventive services are subject to the calendar year deductible.**

## In-Area Benefits Summary

The benefits summary that follows shows covered services and supplies, with a comparison of network and non-network benefits. Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers for non-network benefits will protect you from liability for amounts over the allowable.

General Provisions	Network	Non-Network
		<i>Calendar year deductible applies to charges except as noted.</i>
Calendar year deductible	None	\$500 individual
Calendar year out-of-pocket coinsurance maximum (does not include copayments)	\$500 per person (includes network and non-network coinsurance)	\$1,500 per person (does not include network coinsurance)
Calendar year inpatient copayment maximum (does not include office visit or outpatient day-surgery copayments)	\$1,500 per person (includes both network and non-network inpatient copayments)	\$1,500 per person (includes both network and non-network inpatient copayments)
Precertification penalty deductible	None	\$200 per hospital admission (if not precertified)
Responsibility for precertification	Provider	Participant
Lifetime maximum benefit	None	\$1,000,000
Doctors' and Lab Services		
PCP office visits (includes immunizations, injections, diagnostic x-rays and lab tests)	\$20 copayment per visit	Plan pays 60%, you pay 40%
Specialist office visits (includes immunizations, injections, diagnostic x-rays and lab tests)	\$30 copayment per visit	Plan pays 60%, you pay 40%
Physicals	\$20 copayment with designated PCP or \$30 copayment with a Specialists (one per calendar year for adults, periodic for children- women are allowed one routine well-woman office visit to an OB/GYN each calendar year)	Plan pays 60%, you pay 40% (one per calendar year for adults and children – women are also allowed one well-woman office visit to an OB/GYN each calendar year)
Diagnostic x-rays, mammography, routine immunizations and lab tests (except when performed during an office visit)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%

## In-Area Benefits Summary

The benefits summary that follows shows covered services and supplies, with a comparison of network and non-network benefits. Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers for non-network benefits will protect you from liability for amounts over the allowable.

Doctors' and Lab Services	Network	Non-Network
Immunizations for children 06 years old (except when performed during an office visit)	Plan pays 100%	Plan pays 100%
Allergy injections and antigens (when no office visit is billed)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Office surgery and diagnostic procedures	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Inpatient doctor visits	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Outpatient surgery and anesthesia (physician charges)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Routine eye exam (1 per calendar year per participant)	\$30 Specialist copayment	Plan pays 60%, you pay 40%
Maternity care (doctor charges only; see Hospital Services for inpatient charges)	If care is with designated PCP; \$20 for the first office visit, then Plan pays 100% for maternity care If care is with Specialist; \$30 for the first office visit, then Plan pays 100% for maternity care	Plan pays 60%, you pay 40%
<b>Hospital Services</b>		
Inpatient hospital (semi-private room and board or intensive care unit)	After a \$100 copayment per day (\$500 max per stay), Plan pays 80%, you pay 20%	After a \$100 copayment per day (\$500 max per stay), Plan pays 60%, you pay 40%
Other inpatient charges, including surgery and anesthesia	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Outpatient facilities, including treatment room and/or pre-admission testing	After a \$100 copayment, Plan pays 80% ,you pay 20%	After a \$100 copayment, Plan pays 60%, you pay 40%
Emergency care	After a \$100 copayment (waived if you are admitted - hospital stay of at least 24 hours; however inpatient hospital copayment will apply), Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%

## In-Area Benefits Summary

The benefits summary that follows shows covered services and supplies, with a comparison of network and non-network benefits. Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers for non-network benefits will protect you from liability for amounts over the allowable.

Extended Care Services	Network	Non-Network
*Skilled nursing care in a skilled nursing facility (does not include custodial care)	Plan pays 80%, you pay 20% (60 day maximum per calendar year)	Plan pays 60%, you pay 40% (60 days/ \$4,200 maximum per calendar year)
*Hospice care (\$18,000 lifetime maximum)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
*Home health care	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% (100 visits up to \$3,500 calendar year maximum)
*Private duty nursing	Plan pays 80%, you pay 20% (even after out-of-pocket coinsurance is met)	Plan pays 60%, you pay 40% (even after out-of-pocket coinsurance maximum is met); \$7,000 calendar year maximum, \$35,000 lifetime maximum
Other Medical Services		
Hearing aids (repairs not covered)	Plan pays 100% (up to \$500 per ear every three years)	Plan pays 100% (no deductible – up to \$500 per ear every three years)
Hearing aid batteries	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for the use in your hearing aid (not subject to the \$500/three year limitation)	
Diabetes supplies, other than insulin and syringes	Plan pays 80%, you pay 20%	Plan pays 80%, you pay 20%
Durable medical equipment (includes medically necessary purchase and/or rental)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Prosthetic appliances (\$10,000 maximum per occurrence)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Physical, occupational, speech therapy, and chiropractic care	Plan pays 80%, you pay 20% if no office visit, with office visit \$30 copayment plus 20%	Plan pays 60%, you pay 40%
Ambulance services	Plan pays 80%, you pay 20% plus charges above the allowable amount	Plan pays 60%, you pay 40% plus charges above the allowable amount

## In-Area Benefits Summary

The benefits summary that follows shows covered services and supplies, with a comparison of network and non-network benefits. Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers for non-network benefits will protect you from liability for amounts over the allowable.

Other Medical Services	Network	Non-Network
*Home infusion therapy (HIT)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% if you use a BCBSTX contracting provider; Plan pays 0% and you pay 100% if you use a non-contracting provider
<b>Behavioral Health</b> (Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)		
Outpatient visits (maximum 30 visits per calendar year), including speech therapy for certain speech disorders	Plan pays 80%, you pay 20% (even after out-of-pocket coinsurance is met)	Plan pays 60%, you pay 40% (even after out-of-pocket coinsurance maximum is met); maximum allowable amount \$60 per visit
*Inpatient visits (maximum 30 days per calendar year)  Inpatient copayments apply toward calendar year inpatient copayment maximum of \$1,500 per person.	After \$100 copayment per day (\$500 max per stay), Plan pays 80% for the first 15 days, you pay 20%. The next 15 days, Plan pays 60%, you pay 40%	After \$100 copayment per day (\$500 max per stay), Plan pays 60% for the first 15 days, you pay 40%. The next 15 days, Plan pays 50%, you pay 50%
**Intermediate care facility (maximum 60 days per calendar year)  Intermediate copayments apply toward the calendar year inpatient copayment maximum of \$1,500 per person.	After \$50 copayment per day (\$500 max per stay), Plan pays 80% for the first 30 days, you pay 20%. The next 30 days, Plan pays 60%, you pay 40%	After \$50 copayment per day (\$500 max per stay), Plan pays 60%, for the first 30 days, you pay 40%. The next 30 days, Plan pays 50%, you pay 50%
<b>Prescription Drugs</b>		
At participating pharmacies	<b>Up to a 30-day supply</b> for non-maintenance drugs Copayments: \$10 for generic drugs, \$25 for preferred brand name drugs, \$40 for non-preferred brand name drugs *** <b>Effective July 1, 2003, Up to a 30-day supply for maintenance drugs</b> Copayments: \$15 for generic drugs, \$35 for preferred brand name drugs, \$55 for non-preferred brand name drugs***	
At non-participating pharmacies	<b>Up to a 30-day supply</b> 60% of the lesser of: the amount you pay for the prescription, minus your copayment OR the average wholesale price of the drug, plus the dispensing fee, minus your copayment ***	
Mail order pharmacy	<b>90-day supply</b> Copayments: \$30 for generic drugs, \$75 for preferred brand name drugs, \$120 for non-preferred brand name drugs ***	

\*Precertification required

\*\*Precertification required. This includes residential treatment centers for children and adolescents, crisis stabilization units, and psychiatric day treatment facilities. Each day of a hospital inpatient stay reduces by two the number of days available for psychiatric intermediate care facilities services. Each two days of intermediate care facilities services reduces by one the number of days available for hospital inpatient stays.

\*\*\*If a brand-name drug is dispensed that has a generic available, in addition to paying the generic copayment, you are also responsible for the difference between the generic and the preferred or non-preferred brand-name drug.

## What's not covered

HealthSelect covers a wide range of medical services and supplies. However, HealthSelect specifically excludes payment in certain instances. You should read the Glossary of Important Terms, Section Eight, beginning on page 92 for definitions of terms such as "Medically Necessary," "Allowable Amount," or "Covered Oral Surgery."

**TIP: If you are unsure if a specific medical service or supply is covered, call BCBSTX Customer Service at (800) 252-8039.**

## Exclusions

### HealthSelect does not cover expenses for:

- A. Services or supplies that BCBSTX determines are not medically necessary.
- B. Occupational illness or injuries sustained at work, regardless of whether they are covered by Workers' Compensation or similar state or federal programs.
- C. Charges that would not be made if you did not have health insurance, or charges that you are not legally required to pay.
- D. Services or supplies provided by a facility or hospital that has not been approved as a facility or hospital by BCBSTX, as defined by HealthSelect.
- E. Injuries sustained as a result of war or an act of war, or while on active or reserve duty in the armed forces.
- F. Charges for appointments not kept, completion of forms, or obtaining medical records.
- G. Room and board charges during a hospital admission for diagnostic or evaluative procedures, unless BCBSTX determines that inpatient status is medically necessary.
- H. Any expenses incurred for Dental Care Services, except for Covered Oral Surgery, services and supplies provided to a newborn natural child or eligible newborn grandchild which are necessary for the treatment or correction of a congenital defect, and Inpatient Hospital Expenses and Other Medical Expenses incurred for a medically necessary hospital or ambulatory (day) surgery facility admission for Dental Care Services or Covered Oral Surgery.
- I. Any services or supplies provided for the non-surgical and/or non-diagnostic treatment of or related services to the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions with oral appliances, oral

splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaw to eliminate pain or dysfunction of the TMJ and all adjacent or related muscles and nerves. This exclusion shall not apply to any physical therapy which is necessary as a result of TMJ surgery, as described in the fourth bullet of the definition of Covered Oral Surgery.

- J. Contact lens exams, prescriptions or fittings of contact lenses or eyeglasses, and the cost of the contact lenses or eyeglasses.
- K. Treatment of myopia and other errors of refraction, orthoptics, visual training, or radial keratotomy, including related corrective vision procedures.
- L. Services or supplies for routine foot care, shoe orthotics, insoles, or shoe inserts of any type, except when prescribed for a diagnosis of or related to diabetes.
- M. Cosmetic, reconstructive, or plastic surgery, unless medically necessary due to accidental injury while covered under the Texas Employees Uniform Group Insurance Program, congenital defect (up to age 19), neoplastic (cancer) surgery, or following a mastectomy. Coverage is provided for surgical breast reconstruction following a mastectomy to restore or achieve breast symmetry. Surgical reconstruction of the breast on which mastectomy surgery was performed and surgical reconstruction of the breast on which mastectomy surgery has not been performed are both covered.
- N. Marriage and family therapy/counseling; self-therapy; or therapy as a part of training.
- O. Travel services and accommodations, whether or not recommended or prescribed, except ambulance services.
- P. Weight reduction programs, services, supplies, surgeries including but not limited to Gastric Bypass or Vertical Banding, or gym memberships, even if the participant has medical conditions that might be helped by weight loss; or even if prescribed by a physician.
- Q. Sterilization reversal, transsexual surgery, gender reassignment, artificial insemination and related services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures.
- R. Abortion, unless the participant's life would be endangered by continuing the pregnancy, or there is a diagnosed fetal anomaly, or unless the pregnancy is caused by a criminal act such as rape or incest.
- S. Home infusion therapy treatment provided by an entity that does not contract with BCBS as a provider of home infusion therapy.
- T. Transplant procedures (including transplantation of non-human organs) or the services performed in preparation for, or in conjunction with such procedure, which BCBSTX considers to be Experimental and/or Investigational in nature; living and travel expenses of the live donor or recipient; organ donor search and acceptability testing of potential living donors; expenses related to maintenance of life for purpose of organ donation; purchase of organ or tissue; and donor expenses where donor is not a participant under the Texas Employees Uniform Group Insurance Program.
- U. Medical social services, bereavement counseling (except as part of a precertified hospice treatment plan), or vocational counseling.

- V. Items for patient convenience or comfort as determined by BCBSTX such as, but not limited to, motorized lifts, over-the-counter splints or braces, air conditioners or purifiers, humidifiers, dehumidifiers, physical fitness and/or whirlpool bath equipment, personal hygiene protection, allergen-free pillows, home air fluidized beds, mattresses, blood pressure cuffs, etc., even if recommended or prescribed by a physician or other provider.
- W. Environmental sensitivity, clinical ecology, or inpatient allergy testing or treatment. Chelation therapy except for treatment of acute metal poisoning.
- X. Services or supplies that require precertification under HealthSelect, but were not precertified.
- Y. Dietary and nutritional services, except for an inpatient nutritional assessment program provided in and by a hospital and approved by BCBSTX, or diabetic management services that are provided by or directed by a physician approved by BCBSTX.
- Z. Prescription drugs or medicines which are covered under a separate prescription drug program with its own limitations and exclusions, described in this book.
- AA. Any services or supplies for acupuncture.
- BB. Any services or supplies provided before the participant's effective date or after the expiration date of coverage except as provided through extension of benefits as described in Section Six, page 77.
- CC. Any occupational therapy services which do not consist of traditional physical therapy modalities.
- DD. The excess of any charge greater than the allowable amount as determined by BCBSTX.
- EE. Any services or supplies provided for, in preparation for, or in conjunction with autologous or allogenic bone marrow transplant with or without high dose chemotherapy, except for those nonexperimental transplants (as determined and precertified by BCBSTX) or as may be provided by BCBSTX through case management as described in Section Six, page 82.
- FF. Difference between the charge for a hospital private room and semiprivate room, except when coordinating secondary benefits with Medicare Part A.
- GG. Any services or supplies for which benefits are not provided under HealthSelect, unless through Case Management or ERS-approved pilot projects.
- HH. Services or supplies provided by a person or entity who is not a provider, as defined by HealthSelect.
- II. Physical examinations conducted solely for school admission, insurance, employment, or licensure examination purposes.
- JJ. Telemedicine services provided by telephone or fax machine.
- KK. Services, supplies and related expenses that the BCBSTX Claims Administrator determines to be experimental and/or investigational.

LL. Services and supplies provided by an immediate family member.

### **About the out-of-pocket coinsurance maximum (network)**

The out-of-pocket coinsurance maximum for network benefits per person, per calendar year, includes network and non-network coinsurance. The out-of-pocket coinsurance maximum does **not** include any copayments (such as for network office visits, outpatient day-surgery, inpatient stays, and for prescription drugs).

### **About the inpatient copayment maximum (network and non-network)**

The calendar year inpatient copayment maximum is \$1,500 per person and includes inpatient copayments paid for both network and non-network inpatient stays. Inpatient behavioral health and intermediate behavioral health care copayments also apply toward the \$1,500 calendar year inpatient copayment maximum. This means that after your copayments have reached the copayment maximum of \$1,500, you will no longer be responsible for inpatient copayments for the remainder of that calendar year. The calendar year inpatient copayment maximum does **not** include any copayments paid for office visits, emergency room treatment, outpatient day-surgery or prescription drugs.

### **About the deductible (non-network)**

The deductible for non-network benefits is \$500 per person or \$1,500 per family, per calendar year. The family deductible is met when three family members have each met their individual deductible, under one subscriber ID number. If more than the family deductible maximum has been taken in a calendar year, call BCBSTX Customer Service because you may be eligible for a refund.

**TIP: The calendar year is January 1 through December 31.**

If two or more family members are injured in the same accident, only one deductible will be applied to all eligible services resulting from the accident, for the calendar year in which the accident occurred.

### **About the out-of-pocket coinsurance maximum (non-network)**

There is an out-of-pocket coinsurance maximum for non-network benefits per person, **per calendar year**. This means that after your coinsurance share of covered services and supplies reaches the out-of-pocket maximum in a calendar year, HealthSelect will generally pay 100% of covered services and supplies for the rest of that calendar year. The following expenses do not count toward the out-of-pocket coinsurance maximum:

- Your deductible
- Any amount over the allowable amount
- Charges for services and supplies that are not covered or that are limited under HealthSelect

- Room charges for a hospital stay that was not precertified
- Any network coinsurance or copayment amounts
- Any outpatient day-surgery or inpatient copayment amounts
- Any prescription drug copayments

## **Services that are never covered at 100%**

After you meet your out-of-pocket coinsurance maximum as described above, HealthSelect pays 100% for most covered services and supplies. However, there are two exceptions:

- Charges for private-duty nursing; and
- Charges for outpatient behavioral health visits

Your share of the cost of these services **does** count toward the out-of-pocket coinsurance maximum (for network or for non-network benefits). But once you reach that coinsurance maximum, you must continue to pay a portion of the cost of these two services, as shown in the benefits summary.

**TIP: Office visit copayments continue even after your network coinsurance maximum is met.**

## How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 13). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. **If you use a non-contracting provider, you can also be billed for services determined not medically necessary by BCBSTX.**

When you need:	Network benefits	Non-network benefits, when using a <u>non-contracting provider</u> :	Non-network benefits, when using a ParPlan Provider.
Office visit to your Primary Care Physician (PCP)	<ul style="list-style-type: none"> <li>• Select a HealthSelect network PCP</li> <li>• Make an appointment with your PCP</li> <li>• You will pay a \$20 copayment for the office visit and other routine services provided during the visit (excluding surgery)</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any valid provider, (see Section Eight, page 101, for definition)</li> <li>• You will pay 40% of allowable charges, after you meet your annual deductible and be responsible for any amounts above the allowable amount.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any ParPlan provider</li> <li>• You will pay 40% of allowable charges, after you meet your annual deductible</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>
Office visit to a Specialist (other than a behavioral health provider)	<ul style="list-style-type: none"> <li>• Obtain a referral from your PCP</li> <li>• Confirm a referral has been approved by BCBSTX</li> <li>• Make an appointment with your specialist</li> <li>• You will pay a \$30 copayment for the office visit and other routine services provided during the visit (excluding surgery)</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any valid provider, (see Section Eight, page 101, for definition)</li> <li>• You will pay 40% of the allowable amount, after you meet your deductible and be responsible for any amounts above the allowable amount.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any ParPlan provider</li> <li>• You will pay 40% of allowable charges, after you meet your annual deductible</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>

## How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 13). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. **If you use a non-contracting provider, you can also be billed for services determined not medically necessary by BCBSTX.**

When you need:	Network benefits	Non-network benefits, when using a <u>non-contracting provider</u> :	Non-network benefits, when using a ParPlan Provider.
<p>Outpatient medical care by PCP</p> <p>For example: office or any other outpatient surgeries</p>	<ul style="list-style-type: none"> <li>• Make an appointment with your PCP</li> <li>• If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 20% up to the coinsurance maximum.</li> <li>• If services are performed in provider’s office, you will pay 20% of eligible expenses up to the coinsurance maximum</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any valid provider, (see Section Eight, page 101, for definition)</li> <li>• If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 40%, after you meet your annual deductible.</li> <li>• If services are performed in the provider’s office, you will pay 40% after you meet your annual deductible. You will also be responsible for any amounts above the allowable amount.</li> <li>• File your claim</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any ParPlan provider</li> <li>• If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 40%, after you have met your deductible.</li> <li>• If services are performed in the provider’s office, you will pay 40%, after you meet your annual deductible.</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>
<p>Outpatient medical care by specialist</p> <p>For example: office or any other outpatient surgeries</p>	<ul style="list-style-type: none"> <li>• Obtain a referral from your PCP</li> <li>• Confirm a referral has been approved by BCBSTX</li> <li>• Make an appointment with your specialist</li> <li>• If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 20% up to coinsurance maximum.</li> <li>• If services are performed in the provider’s office, you will pay 20% of eligible expenses up to the coinsurance maximum</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any valid provider, (see Section Eight, page 101, for definition)</li> <li>• If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 40%, after you meet your annual deductible.</li> <li>• If services are performed in the provider’s office, you will pay 40% after you meet your annual deductible. You will also be responsible for any amounts above the allowable amount.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any ParPlan provider</li> <li>• If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 40%, after you have met your deductible.</li> <li>• If services are performed in the provider’s office, you will pay 40%, after you meet your annual deductible.</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>

## How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 13). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. **If you use a non-contracting provider, you can also be billed for services determined not medically necessary by BCBSTX.**

When you need:	Network benefits	Non-network benefits, when using a <u>non-contracting provider</u> :	Non-network benefits, when using a ParPlan Provider.
Laboratory/ Radiology testing	<ul style="list-style-type: none"> <li>• Your PCP or specialist with a valid referral will send you to a HealthSelect network laboratory</li> <li>• You will pay 20% of eligible expenses up to the coinsurance maximum</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a valid provider, (see Section Eight, page 101, for definition)</li> <li>• You will pay 40% of allowable charges, after you meet your deductible and be responsible for any amounts above the allowable amount.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a ParPlan provider</li> <li>• You will pay 40% of allowable charges, after you meet your annual deductible</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>
Routine Eye exam (one per calendar year)  <b>Does not include contact lens exam which is non-covered</b>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a HealthSelect network optometrist or ophthalmologist</li> <li>• You will pay \$30 copayment for the office visit</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a valid provider, (see Section Eight, page 101, for definition)</li> <li>• You will pay 40% of allowable charges, after you meet your annual deductible and be responsible for any amounts above the allowable amount.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a ParPlan provider</li> <li>• You will pay 40% of the allowable amount, after you meet your annual deductible</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>

## How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 13). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. **If you use a non-contracting provider, you can also be billed for services determined not medically necessary by BCBSTX.**

When you need:	Network benefits	Non-network benefits, when using a <u>non-contracting provider</u> :	Non-network benefits, when using a ParPlan Provider.
Well-Woman exam (one per calendar year)	<ul style="list-style-type: none"> <li>• Schedule an appointment with a HealthSelect network OB/GYN or your designated PCP</li> <li>• You will pay \$20 copayment for the office visit with your designated PCP or a \$30 specialty office visit copayment with a visit to a network OB/GYN specialist</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a valid provider, (see Section Eight, page 101, for definition)</li> <li>• You will pay 40% of the allowable amount, after you meet your deductible and be responsible for any amounts above the allowable amount.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a ParPlan provider</li> <li>• You will pay 40% of the allowable amount, after you meet your annual deductible</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>
Durable Medical Equipment (DME)	<ul style="list-style-type: none"> <li>• Your PCP or specialist with a valid referral will give you a prescription</li> <li>• Take the prescription to a network DME facility</li> <li>• You will pay 20% of eligible expenses up to the coinsurance maximum</li> </ul>	<ul style="list-style-type: none"> <li>• Take your prescription to a DME provider, (see Section Eight, page 101, for description)</li> <li>• You will pay 40% of allowable charges, after you meet your annual deductible and be responsible for any amounts above the allowable amount.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a ParPlan provider</li> <li>• You will pay 40% of allowable charges, after you meet your annual deductible</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>

## How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 13). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. **If you use a non-contracting provider, you can also be billed for services determined not medically necessary by BCBSTX.**

When you need:	Network benefits	Non-network benefits, when using a <u>non-contracting provider</u> :	Non-network benefits, when using a ParPlan Provider.
<p>Inpatient Medical</p> <p><b>Only covers semi-private room</b></p> <p><b>Both network and non-network inpatient copayments apply toward your calendar year inpatient copayment maximum of \$1,500 per person</b></p>	<ul style="list-style-type: none"> <li>• Your PCP will obtain precertification</li> <li>• Schedule your inpatient surgery in a network HealthSelect hospital</li> <li>• After a \$100 copayment per day (\$500 max per stay), you will pay 20% of eligible expenses up to the coinsurance maximum</li> </ul>	<ul style="list-style-type: none"> <li>• You are responsible for obtaining precertification</li> <li>• After a \$100 copayment per day (\$500 max per stay), you will pay at least 40% after you meet your annual deductible.</li> <li>• You will be responsible for amounts above the allowable amount.</li> <li>• If you do not obtain precertification, you will pay an additional precertification penalty as well as any ineligible services</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• You are responsible for obtaining precertification</li> <li>• After a \$100 copayment per day (\$500 max per stay), you will pay 40%, after you have met your annual deductible.</li> <li>• If you do not obtain precertification, you will pay an additional precertification penalty as well as any ineligible services</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>
<p>Outpatient Behavioral health care (excludes serious mental illness and substance abuse which is treated as any other illness)</p> <p><b>There is a 30-outpatient visit maximum per calendar year (network and non-network combined)</b></p>	<ul style="list-style-type: none"> <li>• Contact INROADS® Behavioral Health Services for a referral</li> <li>• Make an appointment with your specialist</li> <li>• You will pay 20% of eligible expenses (even after the coinsurance maximum has been met)</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a valid provider, (see Section Eight, page 101, for definition)</li> <li>• You will pay 40% of the maximum allowable (\$60), once the annual deductible has been met and be responsible for any amounts above the allowable amount.</li> <li>• You will pay coinsurance (40%) even after your coinsurance maximum has been satisfied</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Make an appointment with any ParPlan provider</li> <li>• You will pay 40% of the maximum allowable (\$60), once the annual deductible has been met</li> <li>• You will pay coinsurance (40%) even after your coinsurance maximum has been satisfied.</li> <li>• You are not responsible for amounts above the allowable</li> </ul>

## How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 13). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. **If you use a non-contracting provider, you can also be billed for services determined not medically necessary by BCBSTX.**

When you need:	Network benefits	Non-network benefits, when using a <u>non-contracting provider</u> :	Non-network benefits, when using a ParPlan Provider.
<p>Inpatient Behavioral Health Care</p> <p>(excludes serious mental illness or substance abuse which is treated as any other illness)</p> <p><b>There is a 30-day inpatient maximum per calendar year (network and non-network combined)</b></p> <p><b>Inpatient copayments apply toward your calendar year inpatient copayment maximum of \$1,500 per person.</b></p>	<ul style="list-style-type: none"> <li>• Contact INROADS® Behavioral Health Services to verify precertification has been obtained</li> <li>• After you pay a \$100 copayment per day (\$500 max per stay), you will pay 20% for the first 15 days. The next 15 days, you will pay 40%</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a valid provider, (see Section Eight, page 101, for definition)</li> <li>• You are responsible for precertification- contact INROADS® Behavioral Health Services</li> <li>• After you pay a \$100 copayment per day (\$500 max per stay), you will pay at least 40% for the first 15 days, after you meet your annual deductible. The next 15 days, you will pay at least 50%., after you meet your annual deductible.</li> <li>• You will be responsible for any amounts above the allowable.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a ParPlan provider</li> <li>• You are responsible for precertification- contact INROADS® Behavioral Health Services</li> <li>• After you pay a \$100 copayment per day (\$500 max per stay), you will pay 40% for the first 15 days, after you meet your annual deductible. The next 15 days, you will pay 50%., after you meet your annual deductible.</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>

## How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 13). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. **If you use a non-contracting provider, you can also be billed for services determined not medically necessary by BCBSTX.**

When you need:	Network benefits	Non-network benefits, when using a <u>non-contracting provider</u> :	Non-network benefits, when using a ParPlan Provider.
<p>Intermediate Behavioral Health Care</p> <p>(excludes serious mental illness or substance abuse which is treated as any other illness)</p> <p><b>There is a 60-day intermediate care maximum per calendar year (network and non-network combined)</b></p> <p><b>Intermediate care copayments apply toward your calendar year inpatient copayment maximum of \$1,500 per person.</b></p>	<ul style="list-style-type: none"> <li>• Contact INROADS® Behavioral Health Services to verify precertification has been obtained</li> <li>• After you pay a \$50 copayment per day (\$500 max per stay), you will pay 20% for the first 30 days. The next 30 days, you will pay 40%</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a valid provider, (see Section Eight, page 101, for definition)</li> <li>• You are responsible for precertification- contact INROADS® Behavioral Health Services</li> <li>• After you pay a \$50 copayment per day (\$500 max per stay), you will pay at least 40% for the first 30 days, after you meet your annual deductible. The next 30 days, you will pay at least 50%., after you meet your annual deductible.</li> <li>• You will be responsible for any amounts above the allowable.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule an appointment with a ParPlan provider</li> <li>• You are responsible for precertification- contact INROADS® Behavioral Health Services</li> <li>• After you pay a \$50 copayment per day (\$500 max per stay), you will pay 40% for the first 30 days, after you meet your annual deductible. The next 30 days, you will pay 50%., after you meet your annual deductible.</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>

## How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 13). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. **If you use a non-contracting provider, you can also be billed for services determined not medically necessary by BCBSTX.**

When you need:	Network benefits	Non-network benefits, when using a <u>non-contracting provider</u> :	Non-network benefits, when using a ParPlan Provider.
Emergency Care	<ul style="list-style-type: none"> <li>• If possible contact your PCP first</li> <li>• You may use any doctor or hospital, but you must notify your PCP within 48 hours for follow up care and any referrals</li> <li>• You will pay \$100 copayment, which is waived if you are admitted (hospital stay of 24 hours or more; however, the inpatient hospital copayment will apply)</li> <li>• You will pay 20% of eligible expenses after the \$100 copayment</li> </ul>	<ul style="list-style-type: none"> <li>• You may use any valid provider or hospital</li> <li>• Benefits will be paid at the network level for the first 48 hours of a true medical emergency</li> <li>• When using a non-contracting provider, benefits will be paid at the <i>billed amount</i> for the first 48 hours for treatment of a <i>true medical emergency</i></li> <li>• After the first 48 hours, you will pay 40% of allowable charges, after you meet your annual deductible. You can be responsible for charges over allowable amounts.</li> <li>• File your claim to BCBSTX</li> </ul>	<ul style="list-style-type: none"> <li>• You may use any ParPlan provider or hospital</li> <li>• Benefits will be paid at the network level for the first 48 hour of a true medical emergency</li> <li>• After the first 48 hours, you will pay 40% of the allowable amount, after you meet your annual deductible</li> <li>• You are not responsible for amounts above the allowable.</li> </ul>

## Q & A Quick Reference

Questions commonly asked by in-area participants:

**Q. I’m sick and I call my PCP. The nurse says the doctor can’t see me for two weeks. What do I do?**

**A.** Request an appointment with your PCP’s backup. Every PCP is required to have one or more backup PCPs. If you are not able to obtain the names and telephone numbers of the backup PCPs, call BCBSTX Customer Service at (800) 252-8039. You will be responsible for a \$20 PCP office visit copayment if seeing your PCP backup.

- Q. My PCP sent me to another network physician for care, but when I received an EOB from BCBSTX, it stated that I had received non-network benefits. Why?**
- A. Your PCP may have forgotten to contact BCBSTX to set up the referral. If you ever receive a confusing EOB from BCBSTX, call BCBSTX Customer Service (800) 252-8039 to investigate and correct any problems with your claims.
- Q. Can I choose whether I'm in-area or out-of-area?**
- A. No. As a HealthSelect participant, you have in-area coverage if you reside in Texas; otherwise you have out-of-area coverage. If you live in-area, you are designated in-area for purposes of determining benefit levels. One exception is during summer enrollment: If you live out-of-area, but work in-area, you may choose in-area coverage. You will have in-area coverage for the entire plan year, as long as your place of employment remains in-area. See Section Three, page 10 for information on changing a dependent's address with BCBSTX, to change their coverage.
- Q. Are all in-area network services available for a copayment?**
- A. No. While you pay a copayment for office visits to a network provider, other services are paid differently. For example, you are responsible for coinsurance for expenses for routine x-rays, immunizations, and lab tests, "except when performed and billed by the same provider during the office visit." When these services are performed and billed by your physician during an office visit, you pay only a copayment for the service and the visit. Refer to Section Three, pages 26-29 of this benefits book for more information.
- Q. Can network copayments be used to satisfy the out-of-pocket coinsurance maximum?**
- A. No, copayments do not apply to your coinsurance maximum.
- Q. What is coinsurance? Once I satisfy my network out-of-pocket coinsurance maximum, do I still have to make copayments?**
- A. Coinsurance means the percentage you pay for services such as allergy injections, hospital care, etc. detailed in Section Three, pages 26-29 of this benefits book. Even after the coinsurance maximum is met, you must pay copayments.
- Q. Can I choose a PCP from another network area, or another network city?**
- A. Yes. You may select any network PCP. Be sure you notify BCBSTX of your selection by calling BCBSTX Customer Service, or by completing the UGIP Supplemental Information form and mailing it to BCBSTX.
- Q. Am I covered when traveling out of the network areas, particularly out of state and out of the country?**
- A. Yes, however, in most cases you will receive non-network benefits, unless you have an emergency. If you obtain emergency medical care, please refer to Section Three, pages 21-22 of this benefits book. For non-emergency medical care, contact your PCP before receiving medical care. See Section Three, page 24 for information on BlueCard® Worldwide.
- Q. As an in-area participant, is there a deductible to satisfy when I use network providers?**
- A. No, deductibles apply only when you receive non-network benefits.

**Q. Once I designate my PCP, can I select another?**

A. Yes, you may change your PCP by calling BCBSTX Customer Service at (800) 252-8039.

**TIP: When you call BCBSTX to select or change a PCP, it is effective the day you call.**

**Q. My EOB was sent to the wrong address. Why? And how can I prevent this?**

A. BCBSTX mails EOBs and subscriber reimbursement checks to the address shown on the claim that was filed. If your provider filed your claim, you should verify they have your correct address.

**Q. How many ID cards are issued to HealthSelect participants?**

A. One card is issued for individual coverage and if you cover any dependents, a separate card is issued for each covered dependent. To receive additional cards, call BCBSTX Customer Service. Your ID card will list your name and PCP, as well as your covered dependents' names and PCP selections.

**Q. Whom should I contact when my address changes?**

A. Contact your benefits coordinator if you are an active employee, or contact the ERS if you are a retiree.

**Q. I live in-area, but my covered dependent does not live with me and is at school outside of Texas. However, my dependent comes home for the summer. Whom do I contact with my dependent's address changes?**

A. Contact BCBSTX Customer Service at (800) 252-8039 with any dependent address changes. See Section Three, page 10 for more information.

**Q. I am a retiree under age 65, and my dependent spouse will turn age 65 before I do. Will my dependent spouse be required to purchase Medicare Part B?**

A. It is recommended that your dependent spouse purchase Medicare Part B; otherwise you will be considered the primary payor and HealthSelect will be secondary.

**Q. Will my office visit copayments and outpatient day-surgery copayments apply toward my calendar year inpatient copayment maximum?**

A. No, only inpatient copayments apply toward the \$1,500 inpatient calendar year copayment maximum. This copayment maximum includes inpatient copayments paid when using both network and non-network benefits.

**Q. If I use my PCP for my maternity care what copayment will I pay?**

A. You will pay the \$20 PCP office visit copayment for any care provided by your designated PCP. For maternity care received from your PCP, you will pay a one time copayment of \$20 for the physician charges only. However, you will also be responsible for coinsurance and copayments for hospital and other services.

**Q. If I am discharged from an inpatient hospital stay and readmitted will have I have to start over on my inpatient copayments?**

A. If you are discharged from an inpatient hospital stay and readmitted within 24 hours of that discharge date, your inpatient copayments will not start over if your original stay was five days or more. However, if your original stay was less than five days, when you are readmitted you will be required to pay copayments up to the \$500 maximum for the two admissions.

**Q. What is my copayment if my PCP refers me to a specialist?**

A. Your copayment to a specialist with a valid referral is \$30. This copayment would cover any laboratory, x-rays or immunizations that are performed and billed by that specialist's office. If you are sent to, or the services are billed by another facility for laboratory or x-rays, you will be responsible for coinsurance.

**Section Four**  
**Out-of-Area Benefits**  
**At-A-Glance**

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**Please remember that these topics apply to you only if you have out-of-area coverage.**

## Section Four

### Guide To Out-of-Area Benefits

#### About out-of-area benefits

You and your covered dependents have out of area coverage if you reside out of the state of Texas, or if a covered dependent is under 65 and the policy holder is over 65 with Medicare primary. If you have out-of-area coverage, HealthSelect offers you traditional medical benefits. You can choose any valid provider (see definition of provider in Section Eight, page 101) if you use BCBSTX ParPlan providers, you will not have to file claims and you cannot be billed for amounts which exceed the allowable amount, because ParPlan providers have agreed to accept the BCBSTX allowable amount as payment in full.

**TIP: Call (800) 942-5270 for a ParPlan Provider Directory or visit the HealthSelect website Online Provider Directory at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002).**

We have added a subsection at the end of this section titled “Q & A Quick Reference.” You may want to review this section, which includes questions frequently asked by out-of-area participants.

#### Allowable amounts

All claim payments are based on the BCBSTX **allowable amounts**. If you use a ParPlan provider (a provider who contracts with BCBS) you will not be responsible for the difference between the provider’s billed charge and the BCBS allowable amount. See Section Eight, page 100, for definition of ParPlan Provider. If you use a non-ParPlan provider, *you* will be responsible for charges over the BCBSTX allowable amount.

#### ParPlan Providers

If you see a ParPlan provider, you pay your coinsurance percentage of the allowable amount after meeting your deductible; HealthSelect pays the remaining percentage, and the provider accepts the two amounts as payment in full. You will not be billed any additional amounts unless the services are not covered, which you will be responsible. See Section Six, pages 83-84, for additional information about ParPlan providers. ParPlan providers have also agreed to:

- File your claims;
- Not bill you for services that are not medically necessary as determined by BCBSTX; and
- Not bill you for services that are experimental and/or investigational based upon unproven treatment methodologies.

#### Emphasis on preventive care

HealthSelect is designed to encourage preventive care:

- Participants can receive one routine physical exam each calendar year;
- Women can receive one annual well-woman exam by an OB/GYN, if those services are not performed during their

routine physical exam; and

- Men age 50 and over are eligible for coverage for an annual diagnostic medical examination for prostate cancer. Men age 40 and over with a family history of prostate cancer are also eligible for this exam.

## **Routine eye exam**

- One routine eye exam **per calendar year**, per participant, is covered (subject, as are other preventive care services, to calendar year deductible);
- Services may be provided by either an optometrist or ophthalmologist; and
- Contact lens exam is not covered.

## **Childhood immunizations for dependents**

For childhood newborn through 6 years of age, the following ten immunizations are covered at 100%:

- Diphtheria;
- Haemophilus influenzae type B;
- Hepatitis B;
- Measles;
- Mumps;
- Pertussis (whooping cough);
- Polio;
- Rubella;
- Tetanus; and
- Varicella (chicken pox).

**All preventive care services are subject to the calendar year deductible.**

## **Maternity and newborn care**

Hospital and medical expenses for routine well-baby nursery care of a newborn natural child or an **eligible** \* newborn grandchild incurred during the mother's hospital admission for the delivery are considered eligible expenses, provided the mother, father, or grandparent is covered under HealthSelect on the date the mother delivers the child.

The newborn child's hospitalization is covered under the precertification for the mother's hospital stay. If the mother is not precertified or is not covered under HealthSelect, the newborn will need his or her own precertification to receive benefits.

If the mother is a covered participant, she will be responsible for inpatient copayments of \$100 per day, not to exceed \$500 per stay, in addition to any applicable coinsurance. A separate inpatient copayment will not be charged for the baby unless the baby's stay exceeds the mother's or unless the mother is not a covered participant on the HealthSelect policy. Applicable coinsurance will be charged for the baby.

Should the newborn remain hospitalized after the mother is released, so that a penalty is not applied, the participant should ensure that:

- A separate precertification for the child is obtained; and
- The child is “admitted” to the hospital in its own name for treatment by a physician or other provider for the non-routine services.

**\* TIP: HealthSelect allows benefits automatically for the first 31 days for a newborn natural child if the mother or the father is a covered participant. After 31 days, the baby must have been added to your coverage to continue to receive benefits. Newborn grandchildren are not covered automatically – if eligible, they must be added to your coverage for benefits. Active employees should contact their benefits coordinator for more information. Retirees should contact the ERS.**

## Telemedicine

HealthSelect covers medically necessary services provided through telemedicine. Telemedicine includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical date, and medical education. Refer to Section Eight, page 103, for the complete definition of telemedicine.

## Hearing aids

HealthSelect allows a \$500 maximum benefit per hearing loss (per ear) every 36 months for hearing aids, fittings, and molds – but not repairs. If you use a ParPlan provider, the provider’s total payment is based on the BCBSTX allowable amount. BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between that benefit and the contracted BCBSTX allowable amount. If you use a **non-ParPlan provider**, BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between the benefit and the provider’s billed charges. In addition, hearing aid batteries are covered and are not subject to the \$500/three year limitation. Please refer to the Benefits Summary on Section Four, pages 56-59, for more information.

**TIP: When filing a claim for a hearing aid, be sure to indicate right or left ear on your receipt.**

## Diabetic management services

Diabetic management services include **Diabetes Equipment, Diabetes Supplies, and Diabetes Self-Management Training Programs**, which are rendered by or at the direction of a physician. See Section Eight, pages 94-95 this book for specific definitions of these services. Diabetes Supplies are covered in the following manner:

**Insulin and syringes** are covered under your prescription drug benefits (see Section Five, page 66, for information about your prescription drug program).

**Other diabetes supplies** (see Section Eight, page 94-95 for a complete definition) are covered under your medical benefits as Durable Medical Equipment (DME), at 70% of the allowable amount. If you use a non-contracting supplier and the charge is greater than the allowable amount, you will be responsible for the difference.

If you use a DME provider who does not contract with BCBSTX, you will be required to file your claim and can be billed for amounts above the allowable. To file a claim for diabetes supplies, attach your cash register receipt, showing quantity

of each item purchased, to a completed medical claim form (keeping copies for your records). Mail to BCBSTX at P.O. Box 660044, Dallas, TX 75266-0044. See Section Six, page 84, of your benefits book for more information.

If you use a DME provider who contracts with BCBSTX, you will not be required to file your claim and will not be responsible for any charges above the allowable amount. You can search for contracting DME providers through the HealthSelect Online Provider Directory, “Out-of-State Providers.” When conducting a search in another state, you must select the “Traditional/Indemnity Network.” Once locating a DME provider, you will need to contact that provider to determine if they carry your supplies.

## Precertification of certain services

HealthSelect requires precertification for certain medical services. Precertification determines, in advance, the medical necessity of the care you receive. It is required for:

- Hospital admissions;
- Skilled nursing care in a skilled nursing facility;
- Private-duty nursing;
- Home health care;
- Intermediate care facilities;
- Hospice care; and
- Home infusion therapy (Use of a BCBS contracting provider is required to receive benefits.)

**TIP: Call (800) 344-2354 for precertification**

Precertification merely determines the medical necessity of the admission. **It does not guarantee payment.** Payment will be determined after the claim is filed and is subject to eligibility requirements and other HealthSelect provisions, limitations and exclusions, including, **but not limited to:**

- Cosmetic procedure limitation;
- Requirement to call on a timely basis - prior to an elective admission or within 48 hours of an emergency admission;
- Payment of premium for the date on which services are rendered.

## How to precertify

You are responsible for ensuring that your treatment has been precertified by BCBSTX. If you cannot make the call yourself, have your doctor or family member call for you. If precertification is not obtained, a penalty deductible will be applied in addition to your calendar year deductible and coinsurance. Also, benefits will not be paid for services which are not medically necessary, including room and board charges for unapproved inpatient hospital days. The telephone numbers to call are:

### **Precertification numbers to call:**

In Dallas (972) 238-7712  
Within Texas (800) 344-2354  
Outside Texas (800) 343-0125

## Behavioral health services

HealthSelect covers services for the treatment of behavioral health (which includes mental health, serious mental illness, substance abuse, and speech disorders). You are eligible for 30-outpatient visits per calendar year. There is a \$60 maximum benefit allowable for each outpatient visit and you can be responsible for any amounts over this maximum in addition to any applicable coinsurance or deductible. To limit your out of pocket expenses, it is recommended that you use ParPlan providers (see Section Six, pages 83-84, for complete definition of ParPlan). ParPlan providers can only bill you the difference between the benefit maximum (\$60) and the BCBSTX allowable amount.

If your diagnosis is a serious mental illness as defined by Texas State Law (definition found on Section Eight, page 102), you will not be subject to the 30-outpatient visit maximum or the \$60 benefit maximum per visit. Your coverage will be treated as any other illness or injury.

**TIP: Services for speech therapy may be considered behavioral health charges (and apply toward the 30-visit maximum per calendar year), depending upon the diagnosis submitted on the claim.**

For inpatient and intermediate behavioral health care you will be responsible for copayments plus applicable coinsurance. For inpatient treatment, you will be responsible for a \$100 copayment per day, not to exceed \$500 per stay. Your copayment for intermediate care is less, at \$50 per day, not to exceed \$500 per stay. These copayments also apply to the calendar year inpatient copayment maximum of \$1,500 per person.

## Precertification of behavioral health services

You are responsible for obtaining precertification for certain behavioral health services. If the precertification is not obtained, you may be responsible for the full cost of the services, until the medical necessity of your treatment can be determined. Benefits may be reduced or denied if the treatment is not medically necessary.

The following behavioral health services require precertification:

- Hospital admissions;
- Intermediate care facilities;
- Residential treatment centers;
- Crisis stabilization units;
- Psychiatric day treatment facilities;
- Inpatient treatment of substance abuse; and
- Inpatient treatment of serious mental illness.

## Residential treatment center and substance abuse facility

A Residential Treatment Center (**RTC**) provides treatment to children and adolescents for behavioral health problems. In order for benefits to be available, the facility must be licensed by the appropriate licensing body (see Section Eight, page 101, for a complete definition of RTC). Care received at RTCs must be precertified through INROADS® Behavioral Health Services.

Inpatient treatment of substance abuse (chemical dependency) must be provided in a **Substance Abuse Facility** (see Section Eight, page 102, for a complete definition of a substance abuse facility). All inpatient treatment of substance abuse (chemical dependency) must be precertified through INROADS® Behavioral Health Services. For inpatient or

intermediate care, you will be responsible for a copayment per day in addition to applicable coinsurance. Please see the benefits summary on page 56-59, for more details regarding copayments and coinsurance.

**Please note:** BCBSTX has no contracts with RTCs to provide care for substance abuse (chemical dependency), even though the facilities may be licensed to provide certain levels of care. Consequently, if service in the RTC is approved, you will be responsible for charges over the BCBSTX allowable amount.

### **Call INROADS® Behavioral Health Services for precertification:**

In Dallas (972) 766-5201  
Outside Dallas (800) 528-7264

## **Predetermination**

As participants in HealthSelect, you and your covered dependents are entitled to a review by the BCBSTX Medical Department to determine the medical necessity of any proposed medical procedure. This process is called a **predetermination of benefits**. It will inform you in advance if BCBSTX considers the services to be medically necessary and therefore eligible for benefits. To have a predetermination of benefits conducted, ask your physician to provide BCBSTX a letter of medical necessity and any pertinent medical records. After a decision is made, you and your physician will be notified in writing.

## **Reviews by an independent review organization (IRO)**

Even if a life-threatening condition is **not** involved, if BCBSTX initially determines that the health care services proposed are not medically necessary, and this adverse determination is upheld at the highest level of review at BCBSTX, you may seek review by an independent review organization (IRO). If you have a **life-threatening** condition, you are entitled to an immediate review by an IRO rather than having to follow the normal appeal procedures under HealthSelect.

### **Steps for seeking a review by an IRO**

- Step 1** BCBSTX will provide information to you, your designated representative, or your provider of record on how to obtain review of the denial by an IRO.
- Step 2** This information will be provided at the time of determination following the denial, or in case of a life-threatening condition, upon the initial denial.
- Step 3** You, your designated representative, or your provider of record will be given an appropriate form for requesting the IRO review.
- Step 4** You, your designated representative, or your provider of record must complete the form and return it to BCBSTX.
- Step 5** In life-threatening situations, you, your designated representative, or your provider of record may contact BCBSTX by phone at (800) 252-8039 to request the IRO review and provide the needed information.

You may still appeal a denied claim after charges have been incurred, by following the normal appeal procedures under HealthSelect.

**Reminder:** The Independent Review Organization (IRO) process *is NOT available for contract exclusions* (for example, experimental/investigational procedures.)

## In Case of Emergency

### Definition of emergency

**Emergency** - The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his condition, sickness or injury is of such a nature that failure to get immediate medical care could reasonably result in:

1. Placing the participant's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

### Getting emergency care

If an emergency situation is not life or limb threatening, you should call your doctor before you visit an emergency room to see if he or she can see you in the office. If it is not possible to call your doctor first, go to the nearest hospital or emergency facility.

### If you have been admitted to a hospital

If you have been admitted to the hospital from the emergency room, you must call the BCBSTX Precertification Department within 48 hours of your admission to get your hospital stay precertified. If you cannot make the call yourself, have your doctor or a family member call for you. **If you do not get your stay precertified, you will have to pay an additional penalty deductible.** Precertification is described in Section Four, pages 50-51, of this book.

For inpatient stays, you are responsible for a \$100 copayment per day, not to exceed \$500 per stay, plus applicable coinsurance. See the benefits summary on page 56-59, for more details regarding copayments and coinsurance.

**TIP: For Precertification call (800) 344-2345.**

### Ambulance services

HealthSelect pays benefits for Ambulance Services received at the time of an emergency and when determined to be medically necessary by BCBSTX. Benefits are paid based on the allowable amount, and **you are responsible for any balance billed by the provider.** There are no benefits available for Ambulance Services, unless a patient is transported to the nearest hospital equipped and staffed to treat the condition.

## **Inpatient and outpatient day-surgery copayments**

For inpatient admissions, you are responsible for a \$100 copayment per day not to exceed \$500 per stay, plus applicable coinsurance. These copayments apply toward your calendar year inpatient copayment maximum of \$1,500 per person. Once this inpatient copayment maximum has been met, you will no longer be required to pay the \$100 inpatient copayment for the remainder of that calendar year. See page 63 for more details regarding the calendar year inpatient copayment maximum.

For outpatient day-surgeries, you will be responsible for a \$100 copayment, plus applicable coinsurance. You will be responsible for the outpatient day-surgery copayment when you receive treatment in an operating room. This copayment **does not** apply toward the calendar year inpatient copayment maximum.

## **Making the most of your benefits**

### **Steps to out-of-area benefits**

- Step 1** Call any provider (see definition of provider in Section Eight, page 101), preferably a BCBSTX ParPlan provider  
(See “ ParPlan Providers” subsection beginning in Section Six, pages 83-84).  
Tell the provider that you have HealthSelect coverage
- Step 2** See the provider.  
Show your HealthSelect ID card.  
The provider will treat you and may recommend further treatment, hospitalization, and/or surgery.
- Step 3** Precertify the treatment, if necessary. (See Section Four , pages 50-51, for a list of services and procedures that must be precertified.)
- Step 4** If you use a non-ParPlan provider, you may have to file the claim yourself. (See Section Six, pages 84-85, for instructions.)
- Step 5** You will receive an EOB from BCBSTX.

**TIP: File your BCBSTX EOB with the provider’s statement for future reference**

## **BlueCard Worldwide®**

This benefit is available to you when you travel or live outside the United States.

### **How BlueCard Worldwide® works**

When you're traveling or living outside the U.S. and require inpatient hospital care, all you need to do is follow these easy steps:

- Step 1:** Remember to carry your most current HealthSelect ID Card.
- Step 2:** Call BlueCard Access at (800) 810-BLUE (2583) to identify BlueCard Worldwide® participating hospitals. (You can use the toll-free number outside of the U.S. by using an AT&T Direct® Access Number.)
- Step 3:** Go to the nearest participating hospital in your international location and present your ID card.
- Step 4:** Call Blue Cross and/or Blue Shield for pre-certification/prior authorization, where necessary. Refer to the phone number on your ID card. It differs from the BlueCard Access number.

### **Carry your ID card abroad, and we'll take care of the rest**

By using a participating hospital, you will only need to pay for out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance). BCBSTX will take care of the rest, and will send an Explanation of Benefits to your home.

**TIP: You can search for contracting providers with BCBS plans in other states by visiting [www.bluecares.com](http://www.bluecares.com) (select Traditional/Indemnity Network)**

## Out-of-Area Benefits Summary (Under 65)

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability of amounts over the allowable. These benefits apply to participants who reside outside the state. These benefits do not apply to participants who have “*opted*” for in-area benefits based on their work county.

General Provisions	Benefits
	<i>Calendar year deductible applies to charges except as noted.</i>
Calendar year deductible	\$200 individual/\$600 family maximum
Calendar year out-of-pocket coinsurance maximum (does not include copayments)	\$800 per person
Calendar year inpatient copayment maximum (includes any inpatient copayments paid while covered as an in-area participant during the same calendar year)	\$1,500 per person
Precertification penalty deductible	\$200 per hospital admission (if not precertified)
Responsibility for precertification	Participant
Lifetime maximum benefit	None
Doctors’ and Lab Services	
Doctor office visits	Plan pays 70%, you pay 30%
Annual physicals (one per calendar year for adults and children- woman are also allowed one well-woman office visit to an OB/GYN each calendar year)	Plan pays 70%, you pay 30%
Diagnostic x-rays, mammography, injections, routine immunizations, pap smears, and lab tests	Plan pays 70%, you pay 30%
Specific immunizations for children 0-6 years old (except when performed during an office visit)	Plan pays 100%
Allergy injections and antigens	Plan pays 70%, you pay 30%

## Out-of-Area Benefits Summary (Under 65)

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability of amounts over the allowable. These benefits apply to participants who reside outside the state. These benefits do not apply to participants who have “*opted*” for *in-area benefits based on their work county*.

Doctors’ and Lab Services	Benefits
Office surgery and diagnostic procedures	Plan pays 70%, you pay 30%
Inpatient doctor visits	Plan pays 70%, you pay 30%
Outpatient surgery and anesthesia (physician charges)	Plan pays 70%, you pay 30%
Routine eye exam (one per calendar year per participant)	Plan pays 70%, you pay 30%
Maternity care	Plan pays 70%, you pay 30%
<b>Hospital Services</b>	
Inpatient hospital (semi-private room and board or intensive care unit)	After a \$100 copayment per day (\$500 max per stay), Plan pays 70%, you pay 30% (no deductible)
Other inpatient charges, including surgery and anesthesia	Plan pays 70%, you pay 30%
Outpatient facilities, including treatment room and/or pre-admission testing	After a \$100 copayment , Plan pays 70%, you pay 30%
Emergency care	Plan pays 70%, you pay 30%
<b>Extended Care Services</b>	
*Skilled nursing care in a skilled nursing facility (does not include custodial care)	Plan pays 100%; 60 days up to \$6,000 calendar year maximum (no deductible)
*Hospice care	Plan pays 70%, you pay 30%; \$18,000 lifetime maximum (o deductible)
*Home health care	Plan pays 100%; 100 visits up to \$5,000 calendar year maximum (no deductible)
**Private duty nursing	Plan pays 70%, you pay 30% (even after out-of-pocket coinsurance maximum is met); \$8,000 calendar year maximum; \$40,000 lifetime maximum

## Out-of-Area Benefits Summary (Under 65)

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability of amounts over the allowable. These benefits apply to participants who outside the state. These benefits do not apply to participants who have “opted” for in-area benefits based on their work county.

Other Medical Services	Benefits
Hearing aids (repairs not covered)	Plan pays up to \$500 per ear every three years (no deductible)
Hearing aid batteries	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for the use in your hearing aid (not subject to the \$500/three year limitation)
Diabetes supplies, other than insulin and syringes	Plan pays 70%, you pay 30%
Durable medical equipment (includes medically necessary purchase and/or rental)	Plan pays 70%, you pay 30%
Prosthetic appliances (\$10,000 maximum per occurrence)	Plan pays 70%, you pay 30%
Physical, occupational, speech therapy, and chiropractic care	Plan pays 70%, you pay 30%
Ambulance services	Plan pays 70%, you pay 30% plus charges above the allowable amount
*Home infusion therapy (HIT)	Plan pays 70%, you pay 30% if you use a BCBSTX contracting provider; Plan pays 0% and you pay 100% if you use a non-contracting provider

## Out-of-Area Benefits Summary (Under 65)

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability of amounts over the allowable. These benefits apply to participants who reside outside the state. These benefits do not apply to participants who have “opted” for in-area benefits based on their work county.

Behavioral Health	Benefits
<b>(Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)</b>	
Outpatient visits (maximum 30 visits per calendar year), including speech therapy for certain speech disorders	Plan pays 70%, you pay 30% (even after coinsurance maximum is met); maximum allowable amount \$60 per visit
*Inpatient visits (maximum 30 days per calendar year)  Inpatient copayments apply toward calendar year inpatient copayment maximum of \$1,500 per person.	After \$100 copayment per day (\$500 max per stay), Plan pays 70% for the first 15 days, you pay 30%. The next 15 days, Plan pays 50%, you pay 50%
**Intermediate care facility (maximum 60 days per calendar year)  Intermediate copayments apply toward the calendar year inpatient copayment maximum of \$1,500 per person.	After \$50 copayment per day (\$500 max per stay), Plan pays 70% for the first 30 days, you pay 30%. The next 30 days, Plan pays 50%, you pay 50%
Prescription Drugs	
At participating pharmacies	<b>Up to a 30-day supply</b> for non-maintenance drugs Copayments: \$10 for generic drugs, \$25 for preferred brand name drugs, \$40 for non-preferred brand name drugs *** <b>Effective July 1, 2003, Up to a 30-day supply for maintenance drugs</b> Copayments: \$15 for generic drugs, \$35 for preferred brand name drugs, \$55 for non-preferred brand name drugs***
At non-participating pharmacies	<b>Up to a 30-day supply</b> 60% of the lesser of: the amount you pay for the prescription, minus your copayment OR the average wholesale price of the drug, plus the dispensing fee, minus your copayment ***
Mail order pharmacy	<b>90</b> Copayments: \$30 for generic drugs, \$75 for preferred brand name drugs, \$120 for non-preferred brand name drugs ***

\*Precertification required.

\*\*Precertification required. This includes residential treatment centers for children and adolescents, crisis stabilization units, and psychiatric day treatment facilities. Each day of a hospital inpatient stay reduces by two the number of days available for psychiatric intermediate care facilities services. Each two days of intermediate care facilities services reduces by one the number of days available for hospital inpatient stays.

\*\*\*If a brand-name drug is dispensed that has a generic available, in addition to paying the generic copayment, you are also responsible for the difference between the generic and the preferred or non-preferred brand-name drug.

## What's not covered

HealthSelect covers a wide range of medical services and supplies. However, HealthSelect specifically excludes payment in certain instances. You should read the Glossary of Important Terms, Section Eight, beginning on page 91 as you read the exclusions for definitions of "Medically Necessary," "Allowable Amount," or "Covered Oral Surgery."

**TIP: If you are unsure if a specific medical service or supply is covered, call BCBSTX Customer Service at (800) 252-8039.**

## Exclusions

### HealthSelect does not cover expenses for:

- A. Services or supplies that BCBSTX determines are not medically necessary.
- B. Occupational illness or injuries sustained at work, regardless of whether they are covered by Workers' Compensation or similar state or federal programs.
- C. Charges that would not be made if you did not have health insurance, or charges that you are not legally required to pay.
- D. Services or supplies provided by a facility or hospital that has not been approved as a facility or hospital by BCBSTX, as defined by HealthSelect.
- E. Injuries sustained as a result of war or an act of war, or while on active or reserve duty in the armed forces.
- F. Charges for appointments not kept, completion of forms, or obtaining medical records.
- G. Room and board charges during a hospital admission for diagnostic or evaluative procedures, unless BCBSTX determines that inpatient status is medically necessary.
- H. Any expenses incurred for Dental Care Services, except for Covered Oral Surgery, services and supplies provided to a newborn natural child or eligible newborn grandchild which are necessary for the treatment or correction of a congenital defect, and Inpatient Hospital Expenses and Other Medical Expenses incurred for a medically necessary hospital or ambulatory (day) surgery facility admission for Dental Care Services or Covered Oral Surgery.
- I. Any services or supplies provided for the nonsurgical and/or nondiagnostic treatment of, or related services to, the temporomandibular (jaw) joint (TMJ), or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the TMJ and all adjacent or related muscles and nerves. This exclusion shall not apply to any physical therapy which is necessary as a result of TMJ surgery, as described in the fourth bullet of the definition of Covered Oral Surgery.

- J. Contact lens exams, prescriptions or fittings of contact lenses or eyeglasses, and the cost of the contact lenses or eyeglasses.
- K. Treatment of myopia and other errors of refraction, orthoptics, visual training, or radial keratotomy, including related corrective vision procedures.
- L. Services or supplies for routine foot care, shoe orthotics, insoles, or shoe inserts of any type (except when prescribed for a diagnosis of, or related to, diabetes).
- M. Cosmetic, reconstructive, or plastic surgery, unless medically necessary due to accidental injury while covered under the Texas Employees Uniform Group Insurance Program, congenital defect (up to age 19), neoplastic (cancer) surgery, or following a mastectomy. Coverage is provided for surgical breast reconstruction following a mastectomy to restore or achieve breast symmetry. Surgical reconstruction of the breast on which mastectomy surgery was performed and surgical reconstruction of the breast on which mastectomy surgery has not been performed are both covered.
- N. Marriage and family therapy/counseling, self-therapy, or therapy as a part of training.
- O. Travel services and accommodations, whether or not recommended or prescribed, except ambulance services.
- P. Weight reduction programs, services, or supplies, surgeries including but not limited to Gastric Bypass or Vertical Banding, or gym memberships even if the participant has medical conditions that might be helped by weight loss; or even if prescribed by a physician.
- Q. Sterilization reversal, transsexual surgery, gender reassignment, artificial insemination services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above referenced excluded procedures.
- R. Abortion, unless the participant's life would be endangered by continuing the pregnancy, or there is a diagnosed fetal anomaly, or unless the pregnancy is caused by a criminal act such as rape or incest.
- S. Home infusion therapy treatment provided by an entity that does not contract with BCBS as a provider of home infusion therapy.
- T. Transplant procedures (including transplantation of non-human organs) or the services performed in preparation for, or in conjunction with such procedure, which BCBSTX considers to be Experimental and/or Investigational in nature; living and travel expenses of the live donor or recipient; organ donor search and acceptability testing of potential living donors; expenses related to maintenance of life for purpose of organ donation; purchase of organ or tissue; and donor expenses where donor is not a participant under the Texas Employees Uniform Group Insurance Program.
- U. Medical social services, bereavement counseling (except as part of a precertified hospice treatment plan), or vocational counseling.
- V. Items for patient convenience or comfort as determined by BCBSTX such as, but not limited to, motorized lifts, over-the-counter splints or braces, air conditioners or purifiers, humidifiers, dehumidifiers, physical fitness and/or whirlpool bath equipment, personal hygiene protection, allergen-free pillows, home air fluidized beds, mattresses, blood pressure cuffs, etc., even if recommended or prescribed by a physician or other provider.

- W. Environmental sensitivity, clinical ecology, or inpatient allergy testing or treatment. Chelation therapy except for treatment of acute metal poisoning.
- X. Services or supplies that require precertification under HealthSelect, but were not precertified.
- Y. Dietary and nutritional services (except for an inpatient nutritional assessment program provided in and by a hospital and approved by BCBSTX, or diabetic management services that are provided by a physician and approved by BCBSTX).
- Z. Prescription drugs or medicines which are covered under a separate prescription drug program with its own limitations and exclusions, as described in this book.
- AA. Any services or supplies for acupuncture.
- BB. Any services or supplies provided before the participant's effective date or after the expiration date of coverage except as provided through the extension of benefits provision as described in Section Six, page 77.
- CC. Any occupational therapy services which do not consist of traditional physical therapy modalities.
- DD. The excess of any charge greater than the allowable amount as determined by BCBSTX.
- EE. Any service or supplies provided for, in preparation for, or in conjunction with autologous or allogenic bone marrow transplant with or without high dose chemotherapy, except for those nonexperimental transplants (as determined and precertified by BCBSTX) or as may be provided by BCBSTX through Case Management as described in Section Six, page 82.
- FF. Difference between the charge for a hospital private room and semiprivate room, except when coordinating secondary benefits with Medicare Part A.
- GG. Any services or supplies for which benefits are not provided under HealthSelect, unless through Case Management or ERS-approved pilot projects.
- HH. Services or supplies provided by a person or entity who is not a provider, as defined by HealthSelect.
- II. Physical examinations conducted solely for school admission, insurance, employment, or licensure examination purposes.
- JJ. Telemedicine services provided by telephone or fax machine. Refer to Section Eight, page 103, for a definition of telemedicine.
- KK. Services, supplies and related expenses that the BCBSTX Claims Administrator determines to be experimental and/or investigational.
- LL. Services and supplies provided by an immediate family member.

## About the deductible

The “calendar year deductible” is per person. The family deductible is met when three family members have each met their individual deductible under one subscriber ID number. If more than the family deductible maximum has been taken in a calendar year, call BCBSTX Customer Service. You may be eligible for a refund. Refer to the Benefits Summary in Section Four, pages 56-59, for the amount of the individual and family deductibles.

If two or more family members are injured in the same accident, only one deductible will be applied to all eligible services resulting from the accident, for the calendar year in which the accident occurred

**TIP: Calendar year is January 1 through December 31**

## About the out-of-pocket coinsurance maximum

The “out-of-pocket coinsurance” maximum is per person per calendar year. This means that after your coinsurance share of covered services and supplies totals the out-of-pocket maximum amount in a calendar year, HealthSelect will generally pay 100% of covered charges for the rest of that calendar year. Refer to the out-of-area benefits summary in Section Four, pages 56-59.

The following expenses do not count toward the out-of-pocket coinsurance maximum:

- Your deductible;
- Inpatient and outpatient day-surgery copayments;
- Any amount over the allowable amount;
- Charges for services and supplies that are not covered or that are limited by HealthSelect;
- Room charges for a hospital stay that was not precertified; and
- Any prescription drug copayments.

## About the inpatient copayment maximum

The calendar year inpatient copayment maximum is \$1,500 per person. This maximum also includes any inpatient copayments paid while covered as an in-area participant in the same calendar year. Inpatient behavioral health and intermediate behavioral health care copayments also apply toward the \$1,500 calendar year inpatient copayment maximum. This means that after your copayments have reached the copayment maximum of \$1,500, you will no longer be responsible for inpatient copayments for the remainder of that calendar year. The calendar year inpatient copayment maximum **does not** include any copayments paid for outpatient day-surgery or prescription drugs.

## Services that are never covered at 100%

After you meet your out-of-pocket coinsurance maximum as described above, HealthSelect pays 100% for most covered services and supplies. However, there are two exceptions:

- Charges for private-duty nursing; or
- Charges for outpatient behavioral health visits.

Your share of the cost of these services does count toward the out-of-pocket coinsurance maximum. But once you reach that coinsurance maximum, you must continue to pay a portion of the cost of these two services, as shown in the benefits summary.

## Q & A Quick Reference

Questions commonly asked by out-of-area participants:

**Q. How do my deductible and coinsurance accumulate?**

A. Your deductible and coinsurance are accumulated and calculated on a calendar year basis, January 1st through December 31st of the same year. Deductible and coinsurance amounts are applied to your claims based on the date your claims are received and processed by BCBSTX, not necessarily in chronological order. Copayments paid for outpatient day surgeries or inpatient admissions do not apply toward your deductible or out-of-pocket coinsurance maximum.

**Q. Do I and all of my covered dependents have to satisfy a calendar year deductible?**

A. Once three of your family members have each individually satisfied their calendar year deductible under one subscriber ID number, the rest of your covered family members do not have to satisfy a deductible. Refer to Section Four, page 63, of this book regarding the calendar year family deductible. Copayments paid for outpatient day surgeries or inpatient admissions do not apply toward your deductible.

**Q. Do I and all of my covered dependents have to satisfy the calendar year coinsurance?**

A. Yes. Each covered family member must individually satisfy their calendar year coinsurance. Once the covered family member satisfies the calendar year coinsurance, HealthSelect will generally pay 100% of covered services and supplies, except for prescription drug copayments, for which you would still be responsible.

**Q. Does HealthSelect provide coverage for me and my covered dependents when we travel outside Texas or outside the country?**

A. Yes. HealthSelect provides coverage for medical services received outside of the state or country. Typically, however, you will have to pay for these services in full when rendered and then file a claim with BCBSTX for reimbursement. See Section Four, page 55, for information on BlueCard Worldwide®. Refer to Section Six, pages 84-85 for information on filing claims.

**Q. Whom should I contact when my address changes?**

A. Contact your benefits coordinator if you are an active employee, or contact the ERS if you are a retiree.

**Q. If I currently live out-of-area, but move during the plan year to a new residence that is in-area, what type of coverage do I and my covered dependents have?**

A. Your move to an in-area residence changes your coverage to in-area. Please contact your benefits coordinator if you are an active employee or the ERS if you are a retiree for the proper paperwork to make the necessary changes. Please note that your residential or work county determines what type of coverage is available to you.

**Q. How many ID cards are issued to HealthSelect participants?**

A. One card is issued for individual coverage, and two cards are issued for employee and spouse, employee and children, and family coverage. To receive additional cards, call BCBSTX Customer Service. Your ID card will list your name and a coverage code on the card that indicates what level of coverage you have. Coverage codes are:

101 and 102	Male/Female employee-only coverage
111	Employee and spouse coverage
119	Employee and children coverage
127	Family coverage

**Q. My physician has recommended that I pursue a certain treatment for my diagnosis. How can I be sure HealthSelect will provide benefits for the treatment?**

A. You and your physician can request a predetermination of benefits for your proposed treatment. Your physician will need to provide BCBSTX with your diagnosis and history, past treatments, and a description of the proposed treatment. Based on the information provided, BCBSTX will respond with a written determination on whether or not the proposed services are medically necessary and therefore eligible for benefits.

**Q. I have not satisfied my calendar year deductible and am receiving care in December which continues into January of the next year. Do I have to satisfy another deductible?**

A. Yes. Your deductible is calculated on a calendar year basis. Therefore, on January 1st, you would be required to meet your deductible for the new

**Q. Will my outpatient day-surgery copayments apply toward my calendar year inpatient copayment maximum?**

A. No, only inpatient copayments apply toward the \$1,500 inpatient calendar year copayment maximum. Once you have met the calendar year inpatient copayment maximum, you will no longer be required to pay for inpatient copayments for the remainder of that calendar year.

**Q. If I am discharged from an inpatient hospital stay and readmitted will I have to start over on my inpatient copayments?**

A. If you are discharged from an inpatient hospital stay and readmitted within 24 hours of that discharge date, your inpatient copayments will not start over if your original stay was five days or more. However, if your original stay was less than five days, when you are readmitted you will be required to pay copayments up to the \$500 maximum for the two admissions.

**Section Five**  
**Guide To Prescription Drug Benefits**  
**At-A-Glance**

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## Section Five

### Guide To Prescription Drug Benefits

#### About the prescription drug program

When you enroll in HealthSelect, whether you are in-area or out-of-area, you are automatically enrolled in the Prescription Drug Program (PDP). The PDP for HealthSelect participants is administered by Medco Health Solutions, Inc. (Medco Health) through its affiliates Medco Health Prescription Solutions, L.L.C., administrator of the retail pharmacy program, and Medco Health Home Delivery Pharmacy Service, administrator of the mail service pharmacy program.

Using your HealthSelect ID card, you may purchase covered drugs at participating retail pharmacies located in Texas and throughout the United States. For information on participating pharmacies, contact Medco Health Member Services at (800) 903-8345 or visit the Medco Health website through a link at [www.ers.state.tx.us](http://www.ers.state.tx.us).

You may obtain long-term (maintenance) medications through participating retail pharmacies (up to a 30-day supply) or you may order them through the mail service pharmacy program (up to a 90-day supply). Order forms and envelopes are available online at [www.medcohealth.com](http://www.medcohealth.com) or by calling (800) 473-3455.

#### What is covered

Most prescription drugs that are medically necessary and ordered by a provider are covered. Most self-administered injectable drugs are covered under the Prescription Drug Program portion of your coverage. In order to provide the most clinically effective prescription benefit, HealthSelect participates in the Preferred Prescriptions Formulary® and Prior Authorization programs administered by Medco Health.

#### The Preferred Prescriptions Formulary®

Your PDP includes a preferred brand-name drug list, which contains commonly prescribed medications that are preferred based on their clinical and cost effectiveness. When generic equivalents are not available, ask your doctor to prescribe preferred medications. Use of a preferred drug is voluntary; however, you will pay a non-preferred copayment (\$40 retail for 30-day supply, \$120 mail service for 90-day supply) if your physician does not prescribe a preferred drug.

Sometimes your physician may prescribe a non-preferred drug when a preferred brand or generic alternative drug is available, including in some cases, a prescription to be dispensed as written. The Medco Health pharmacist may discuss with your physician whether a generic alternative drug might be appropriate for you. If your physician agrees, your prescription will be filled with the generic alternative drug. Let your physician know if you have any questions about a change in a prescription. Your physician always makes the final decision on your medication and you can always choose to keep the original prescription. Please note that if a brand name medication is dispensed that has a generic equivalent available, in addition to paying the generic copayment, you are also responsible for the difference in the cost between the generic and preferred or non-preferred brand name.

## Prior authorization

Some drugs are covered only if they are prescribed for treatment of a covered benefit and FDA approved for that treatment. For this reason, some medications must receive Prior Authorization before they can be covered under HealthSelect. If the prescribed medication requires this approval by Medco Health, you, your physician or your pharmacist will initiate the review process. This process typically takes two business days to complete. The patient and physician will be notified when the review process has been completed. If Medco Health does not approve your medication, you will be responsible for paying the full cost of the drug and may not appeal this denial through the appeal process.

## Quantity limitation

Selected classes of drugs covered under the prescription drug program are subject to quantity limitations. The amount of medication dispensed is limited to an amount established by nationally recognized guidelines or manufacturer's prescribing recommendations. Quantity limitations are recommended by the Medco Health Pharmacy and Therapeutics Committee and are periodically reviewed and modified. If a prescription drug exceeds the quantity limitation, you are responsible for the entire cost of the prescription drug above the quantity limitation. Your physician can request a reconsideration from Medco Health. If the reconsideration is denied, you may not appeal this denial through the appeals process.

## Retail pharmacy program

### Participating pharmacies

HealthSelect allows you to obtain up to a 30-day supply of most covered medications. Simply present your HealthSelect ID card with your prescription and your copayment. You do not have to file a claim for prescriptions electronically processed at a participating retail pharmacy.

When purchasing a non-maintenance generic medication, you will pay a \$10 copayment. If you purchase a preferred or non-preferred brand-name drug and there is no generic equivalent, you will pay a \$25 copayment for a preferred brand-name drug or a \$40 copayment for a non-preferred brand-name drug. If you purchase a brand-name drug when a generic equivalent is available, you will pay the \$10 generic drug copayment **plus** the cost difference between the brand-name and generic drug.

Beginning July 1, 2003, you may purchase a maintenance medication at a participating pharmacy, for a \$15 payment for the generic medication. If you purchase a preferred or non-preferred brand-name drug and there is no generic equivalent, you will pay a \$35 copayment for a preferred brand-name drug or a \$55 copayment for a non-preferred brand-name drug. If you purchase a brand-name drug when a generic equivalent is available, you will pay the \$15 generic drug copayment **plus** the cost difference between the brand-name and generic drug.

### Non-Participating pharmacies

If you use a non-participating pharmacy, you will have to pay the full amount and then file a claim for reimbursement. The amount of the reimbursement will be 60% of the lesser amount of the prescription minus your copayment or the average wholesale price of the drug, plus the dispensing fee, minus your copayment. Please note that if a brand name medication is dispensed that has a generic equivalent available, in addition to paying the generic copayment,

you are also responsible for the difference in the cost between the generic and preferred or non-preferred brand name.

### Steps to using non-participating pharmacies

1. You must pay 100% of the prescription price at the time of purchase.
2. Obtain a Prescription Drug Reimbursement Form by using the HealthSelect website at [www.ers.state.tx.us](http://www.ers.state.tx.us) or call Member Services at (800) 903-8345 and use Medco Health's automated ordering system.
3. Submit a completed claim form to Medco Health Prescription Solutions, L.L.C. The prescription receipt must be attached to the form. Mail form to:  
Medco Health Prescription Solutions, L.L.C  
P. O. Box 2187  
Lee's Summit, MO 64063-2187
4. You will be reimbursed within 21 days from receipt of your claim form.

### Mail service pharmacy program

You may obtain up to a 90-day supply of most long-term (maintenance) covered medications through the mail service pharmacy program. Restrictions on controlled substances may limit the days supply and number of refills allowed. If you purchase a generic drug, you will pay the \$30 generic copayment. If you purchase a preferred or non-preferred brand-name drug and there is no generic equivalent, you will pay the \$75 preferred brand-name copayment or the \$120 non-preferred brand-name copayment. If you purchase a brand-name drug when a generic equivalent is available, you will pay the \$30 generic drug copayment plus the cost difference between the brand-name and generic drug.

### With the mail service pharmacy:

- Medco Health Home Delivery Pharmacy Service fills every prescription following strict quality and safety controls.
- Licensed, registered, highly trained professionals staff Medco Health's pharmacies.
- You can order your refills directly over the internet or phone in your order toll-free.
- Consultations with a registered pharmacist are available 24 hours a day.

### Steps to ordering new prescriptions

1. Ask your doctor to prescribe a 90-day supply of your medication plus refills, if appropriate.
2. Mail your 90-day supply prescription and required copayment along with an order form in the envelope provided.

**OR**

Ask your doctor to call 1-888-EASYRX1 (1-888-327-9791) for instructions on how to fax the prescription. You will need to give your doctor your subscriber ID number, located on your ID card or on your medication container.

## Steps to refilling your medication

1. Remember to reorder on or after the refill date indicated on the refill slip or on your medication container. Or reorder when you have used 75% of your medication based on prescribed dosage.
2. Reorder online using the link to [medcohealth.com](http://medcohealth.com) through the HealthSelect website at [www.ers.state.tx.us](http://www.ers.state.tx.us). Have your HealthSelect subscriber ID number, the prescription number (it's the 12-digit number on your refill slip), and your credit card ready when you log on.

**OR**

Call 1-800-4REFILL (1-800-473-3455) and use the automated refill system. Have your subscriber ID number, refill slip with the prescription number, and credit card ready.

**OR**

Use the refill and order forms provided with your medication. Mail them with your copayment.

## Delivery of your medication

Prescription orders receive prompt attention and, after processing, are shipped from the mail service facility to you by U.S. mail or UPS and usually are delivered in 7-10 days. Your enclosed medication will include an invoice and instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages, and other important details.

## Payment for your medication

You may pay by check, money order, Visa, MasterCard, Discover/NOVUS, American Express, Diners Club, or the TexFlex Convenience Card. If you prefer to pay for all orders by credit card, consider joining the Medco Health Automated Enrollment program. Call (800) 948-8779 and you will be asked to enter your credit card number and expiration date, which will allow you to charge future orders.

## Services available through the Medco Health website

Medco Health provides several services through its website. You may access these services through the link provided at the HealthSelect website at [www.ers.state.tx.us](http://www.ers.state.tx.us) and following instructions provided to register. HealthSelect participants who register can:

- View information about the PDP;
- Check status of mail order prescriptions;
- Check and pay balances online;
- Submit inquiries to Medco Health Customer Service;
- Download mail service prescription order forms;
- Locate a retail pharmacy;
- View interactive formulary;
- Refill or renew your prescription; or
- Download prescription and payment history for use in your TexFlex Health Care Reimbursement Account.

	<b>Retail Pharmacy (30-day supply) Non-Maintenance</b>	<b>Retail Pharmacy (30-day supply) Maintenance</b>	<b>Home Delivery Pharmacy (up to a 90-day supply)</b>
Generic Medication	\$10	\$15	\$30
Preferred Brand-Name Medication	\$25	\$35	\$75
Non-Preferred Brand-Name Medication	\$40	\$55	\$120

**Your Copayment Per Prescription**

HealthSelect has a three-level copayment structure for prescription drugs. Under this structure, you pay the lowest copayment for generic drugs, a mid-level copayment for brand name medications on the preferred list, and a higher copayment for brand-name drugs that are not on the preferred list. Please remember that if a brand name medication is dispensed that has a generic equivalent available, in addition to paying the generic copayment, you are also responsible for the difference in the cost between the generic and preferred or non-preferred brand name.

**Drugs for Excluded Benefits**

Participants are responsible for the full cost of drugs which are used for treatment of excluded services and supplies under HealthSelect. The non-preferred copayment will not apply.

**Member Services** (800) 903-8345, 24 hours a day, 7 days a week

**Health management program**

Medco Health offers a variety of health management programs, known as Positive Approach Programs, that apply educational and behavioral interventions, as well as expert medical knowledge to educate participants and providers. Available health management programs include:

- Diabetes;
- Digestive Health;
- Multiple Sclerosis;
- Respiratory Disease; and
- Hepatitis C.
- Cardiovascular Programs

These programs are for education purposes and are offered to patients to help assist with and manage these conditions. Based on your prescription information, you may be invited to participate. Most programs also provide clinical support through a toll free hotline, hands-on tools, and helpful hints. Positive Approach participants may also receive follow-up phone calls from Medco Health pharmacists. These programs are voluntary and available at no cost to you.

## Exclusions

Your HealthSelect Prescription Drug Program does not cover expenses for:

- A. Drugs that do not require a prescription;
- B. Drugs that are not prescribed in writing or verbally by a provider;
- C. Durable medical equipment or devices;
- D. Administration or injection of any drugs;
- E. Vitamins, except those that require a prescription by law and have no non-prescription equivalent;
- F. Drugs dispensed in a provider's office, or while a patient is in a hospital, skilled nursing facility, or other institution, or any take-home drugs;
- G. Drugs provided by laws of the federal or local government, including Workers' Compensation;
- H. Services or supplies for which a pharmacy does not normally charge;
- I. Drugs for which a pharmacy's usual and customary charge to the public is less than or equal to the copayment;
- J. Contraceptive devices or materials (birth control pills are covered);
- K. Prescription mouthwash preparations or topical oral solutions or preparations;
- L. Investigational or experimental drugs;
- M. Refills over the number prescribed, or over the 30-day or 90-day limit under HealthSelect;
- N. Fluids, solutions, medications, or nutrients used intravenously, including intravenous or infusion therapy drugs (injectable insulin is covered);
- O. Drugs used primarily for cosmetic purposes, including but not limited to: Retin-A, Renova, Solage, Rogaine;
- P. Drugs used for weight reduction or maintenance or drugs approved by the FDA for weight loss only, even if the participant has medical conditions that might be helped by weight loss, and even though prescribed by a physician;
- Q. Drugs used to stop smoking, including but not limited to nicorette gum (nicotine polacrilex) and nicotine patches;
- R. Drugs that are obtained by unauthorized, improper, or fraudulent use of a HealthSelect ID card;
- S. Drugs whose use or intended use would be illegal or unethical;
- T. Drugs not approved by the U.S. Food and Drug Administration for any purpose other than the purpose for which FDA approval is given;
- U. Drugs used or intended to be used for treatment of a condition, sickness, disease, injury or bodily function which is not covered or for which benefits have been exhausted;
- V. Coordination of benefits claims except when required for other government programs;
- W. Homeopathic products and herbal remedies.

## Q & A Quick Reference

Questions commonly asked about the Prescription Drug Program:

### **Q. What's the difference between generic and brand-name drugs?**

- A. Generic and brand-name drugs generally contain the same active ingredients. Brand-name drugs typically are more expensive because the company which originally develops them spends a lot of money on research and testing before putting the drug on the market. The drug company makes up for some of this developmental cost in the price it charges for the drug. After a time, other drug companies are allowed to make a generic equivalent; but they generally do not have to charge as much, because all they have to do is manufacture the drug. In most cases, the research and testing have already been done.

### **Q. What is the difference between preferred brand-name and non preferred brand-name drugs?**

- A. A preferred brand-name drug is a commonly prescribed medication that has been selected based on its clinical effectiveness and safety. A non-preferred brand-name drug has therapeutic alternatives that are listed in the

Preferred Prescription Formulary Guide. The Prescription Drug Program includes a three-level copayment structure for generic, preferred brand-name, and non-preferred brand-name drugs.

**Q. Should I use generic drugs whenever I can?**

**A.** Yes. Doing so will save you and the HealthSelect plan. If you purchase a brand-name drug when a generic equivalent is available, Medco Health may call your doctor to see if a generic can be substituted. If so, you will receive the generic drug and will pay the lowest copayment. If you or your doctor request the brand-name drug, you will pay the generic drug copayment plus the difference in the cost between the brand-name and generic drug.

**Q. Can my prescription drug copayments be used to satisfy my calendar year medical deductible or coinsurance?**

**A.** No, your prescription drug copayments do not apply to your calendar year medical deductible or coinsurance.

**Q. Are glucometer strips (glucostrips, dextrosticks) and lancets covered?**

**A.** Yes; however, lancets and glucometer strips are considered medical expenses, not prescription drug expenses. To file a claim, attach your cash register receipt to a completed medical claim form, and mail to BCBSTX. See Section Six of your benefits book for more details.

**Section Six**  
**Important Plan Provisions**  
**At-A-Glance**

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**These topics apply to both in-area and out-of-area participants.**

## Section Six

### Important Plan Provisions

#### About this section

This section contains important information about HealthSelect coordination of benefits, what to do when your coverage ends, how to appeal a denied claim, and more.

**TIP: HealthSelect coordinates benefits with most other group policies.**

#### Eligibility

##### Eligible employees, retirees, and dependents

Eligibility for HealthSelect under the Texas Employees Uniform Group Insurance Program is determined by the Employees Retirement System of Texas (ERS). If you have a specific question about your eligibility, or eligibility of family members, contact your benefits coordinator if you are an employee, or ERS if you are a retiree.

Please note: if you are covered as a dependent and then become eligible as an employee of a State agency or institution of higher education, you cannot be covered both as a dependent and as an employee.

If you are an eligible retiree under age 65, the type of coverage you have usually depends on whether you live in a network area. Employees under age 65 who live out-of-area but select in-area as an active employee based on their work **county**, and who retired August 31, 1995 or later, will be allowed to continue to have in-area coverage upon retirement. This coverage will remain in effect until the retiree turns age 65 or notifies ERS that he or she wishes to change the election to out-of-area coverage following a residential move. Once this change is made, the retiree will not be allowed to change the election again unless their residential county changes to an in-area location.

If you are an active employee or retiree under age 65 who is determined to be disabled by Social Security, and Medicare is your primary coverage, you and all of your covered dependents have in-area coverage if you reside in an in-area location. If you have Medicare as your secondary coverage, and one of your covered dependents has Medicare as the primary coverage due to age, that dependent has out-of-area coverage regardless of where you live. However, you and your remaining family members have in-area coverage. If one of your covered dependents has Medicare primary coverage due to disability, that dependent has in-area coverage secondary to Medicare.

If you are an active employee and do not have Medicare, but your spouse has Medicare, HealthSelect will be the primary coverage, and Medicare will be the secondary coverage for your spouse.

When you retire and are age 65 or older, you will automatically be covered by HealthSelect's out-of-area benefits unless you select other coverage, such as coverage through a Health Maintenance Organization (HMO). However, you should complete an enrollment form within 30 days after your retirement. ERS or your benefits coordinator will give you the form when you apply for retirement. It also serves as an authorization to deduct your premium, if any, from your annuity check, if applicable. You may, at this time, also add your eligible dependents without having to provide evidence of insurability.

## **Changing your HealthSelect coverage**

### **Adding and dropping dependents from coverage**

Contact your benefits coordinator if you are an employee, or ERS if you are a retiree, for information regarding how and when you may:

- Add dependents to your coverage, including children of your covered dependents;
- Drop dependents from your coverage; or
- Receive more information on when your dependents are no longer eligible for coverage;
- Contact your benefits coordinator or ERS Customer Benefits.

### **Evidence of insurability**

Evidence of insurability will usually be required of any employee, retiree, or dependent who does not enroll in HealthSelect when first eligible.

There is one exception to this rule: HealthSelect participants who do not live in an HMO service area may add dependents during an annual enrollment period without evidence of insurability.

Evidence of insurability is evidence of the condition of one's health. This means that you provide a medical history to Fort Dearborn Life (FDL) for review. You or your dependents could be denied HealthSelect coverage depending on the outcome of that review. See Section Six, page 87, for information on how to appeal a denied application.

You can download an EOI application at [www.bcbstx.com/erslife](http://www.bcbstx.com/erslife). This application should be mailed to:

Fort Dearborn Life Insurance Company  
Administrative Offices  
PO Box 655403  
Dallas, Texas 75265-5403

**To check status on your application you can call Fort Dearborn Life at (800) 451-0271, option 1**

## **When coverage ends**

### **When employee coverage ends**

Your HealthSelect coverage as an employee will end when:

- Your employment ends;
- You stop making the required premium payments, unless your employment status allows for continuation of coverage; or
- HealthSelect ends, or stops covering your employee class.

## **When retiree coverage ends**

Your HealthSelect coverage as a retiree will end when:

- You die; or
- HealthSelect ends, or stops covering your retiree class.

## **When dependent coverage ends**

A dependent's coverage will end when:

- Your coverage ends;
- He or she is no longer an eligible dependent (for example, your spouse's coverage will end if you get divorced, and a child's coverage will end if he or she gets married or reaches age 25, unless eligible as a disabled dependent); or
- You stop making premium payments for dependent coverage; or
- You remove your dependent from your health coverage.

## **Surviving dependents**

If you die while you, your spouse and/or dependent children are covered by HealthSelect, and you have at least 10 years of service credit under your retirement plan (ERS, TRS, or ORP), your spouse and/or your children may continue their coverage. Your spouse may continue indefinitely. Your children may continue until they are no longer eligible dependents. However, they will be responsible for the full premium.

## **Extension of benefits**

Benefits may be extended under certain circumstances. If HealthSelect coverage ends for the entire group, and you or a covered dependent are totally disabled at the time, treatment of the condition causing the disability will be covered for up to 90 days after HealthSelect ends. This extension will not apply if HealthSelect is administered by another carrier chosen by ERS, and if those benefits are equivalent to or greater than the current HealthSelect carrier.

## **Continuation of Coverage (COBRA)**

The Consolidated Omnibus Budget Reconciliation Act, or COBRA, provides continuation medical coverage for employees and covered dependents who lose their group medical coverage.

Any eligible individual electing to continue coverage must pay the full premium rates plus an additional 2% administrative fee.

## How long COBRA coverage lasts

You and/or your eligible dependents may continue coverage through COBRA for up to 18 months if:

- Your coverage ends because your employment ends - including retirement with less than 10 years of service - unless you are terminated for gross misconduct;
- You have completed the maximum period of leave without pay; or
- You are an employee of a higher education institution and your work hours reduce to below 50% time.

If you or a covered dependent is certified under Title II or XVI by the Social Security Administration (SSA) to be disabled on or before your termination of employment or within 60 days after the termination date, the disabled individual may continue COBRA coverage for up to a total of 29 months.

In accordance with HIPAA, individuals covered by COBRA may be eligible for up to 29 months of continuation coverage if any covered individual is certified by the SSA to have been disabled before or during the first 60 days of continuation coverage, provided the original 18 month continuation period began on or after July 1, 1995. All covered individuals may continue coverage for up to 29 months or until Medicare entitlement begins, whichever comes first. The premium increases to 150% of the premium charged for active employees.

Your spouse and/or dependent step-children may continue coverage through COBRA for up to 36 months if their coverage ends because of a divorce. Dependent children who turn age 25 or marry, and other than natural children who move out of the household, also may receive 36 months. Your spouse and/or any dependent children may continue coverage for up to 36 months if their coverage ends because of your death.

If you are a former employee's dependent continuing UGIP coverage under COBRA based on an 18-month qualifying event referenced above, you have the right to extend your coverage for a total continuation period of up to 36 months if you lose eligible-dependent status under the rules of the UGIP, provided you were covered as a dependent at the time of the initial qualifying event. In addition, a COBRA participant's newborn child or newly adopted child acquired on or after the initial qualifying event also has a right to extend their coverage. Qualifying events which occur during the initial 18 months of continuation coverage that entitle covered dependents to the additional continuation period are:

- Death of the former employee who covered you as a dependent
- Divorce of the former employee who covered you as a dependent
- Your marriage or attainment of age 25
- If you are other than a natural child of the former employee who covered you as a dependent and you move out of the former employee's household
- Former employee who covered you as a dependent begins receiving Medicare benefits.

Children who enroll in COBRA due to losing UGIP eligibility as a dependent when reaching age 25, getting married, or losing disability certification may continue enrollment in the UGIP (not under COBRA) upon expiration of the 36 months of COBRA coverage provided:

- the child is unmarried;
- the child is 25 years of age or older; and
- an application for enrollment is completed and COBRA premiums are paid in full within 105 days of the date the notice was mailed by ERS.

**UGIP coverage ceases when the child marries.**

## Applying for COBRA

When your group coverage ends, you or your covered dependents have 105 days to elect continuation coverage through COBRA and pay the initial premium. You, your spouse, or dependent child must notify your benefits coordinator if you are an employee, or ERS if you are a retiree, within 60 days of a divorce, or when a child no longer qualifies for dependent coverage. ERS will provide you with information on your COBRA rights after your benefits coordinator has entered the correct event (such as termination of coverage or divorce) into ERS OnLine. Coverage will be made retroactive to the date of the qualifying event; however the COBRA election form and all back premiums must be received at ERS before coverage will be reinstated.

## When your COBRA coverage can be terminated

HealthSelect has the right to end this continuation coverage if:

- ERS stops providing medical coverage for all employees;
- You (or your spouse or child) do not pay premiums within 30 days of the due date;
- You (or your spouse or child) become covered under Medicare;
- You (or your spouse or child) extend coverage due to a disability, and the SSA determines that the disability no longer exists;
- You (or your spouse or child) become covered under another group health care plan that does not have a clause limiting coverage for preexisting conditions in accordance with HIPAA; or
- Your (or your spouse's or child's) period of eligibility has expired.

**Note: An individual who had Medicare prior to COBRA may continue to receive both Medicare and COBRA benefits.**

## Conversion privilege

When your COBRA coverage ends because the maximum time limit (18, 29, or 36 months) has expired, you may apply to BCBSTX for an individual health insurance contract covering you and/or your covered dependents. You may do this without providing evidence of insurability, if your application is received within 31 days of the last day of your COBRA coverage.

Credit will be allowed for time earned under your HealthSelect coverage toward the waiting periods for pre-existing conditions under the individual contract. Benefits for treatment of a pre-existing condition are not available under the conversion contract until you have held continuous Blue Cross and Blue Shield coverage (group coverage plus conversion contract) for at least 12 months.

For additional information or an application, call BCBSTX Individual Health Department at (800) 338-2227.

## Loss of benefits due to fraud

Improper use of the Prescription Drug Program, your HealthSelect ID card or filing a fraudulent claim will result in higher costs for everyone. Therefore, the HealthSelect Master Benefit Plan Document sets forth penalties for fraudulent behavior. You or a covered dependent could lose your HealthSelect coverage for up to five years for fraudulent use of

HealthSelect (for instance, using your HealthSelect ID card before the effective date or after your coverage ends).

## Coordination of Benefits

### What is coordination of benefits?

You and your family could have coverage under other **group** medical plans, in addition to your HealthSelect coverage. The Coordination of Benefits (COB) provision is designed to eliminate duplicate payments for the same medical expenses.

HealthSelect does not coordinate with individual policies - only with other group policies. This means that in coordinating benefits, HealthSelect does not consider benefits you receive through any individual medical policy you may have.

### How does COB work?

Under a COB provision, the plan that pays first is called the Primary Plan. The Secondary Plan typically makes up the difference between the Primary Plan's benefit and the covered charge. When one plan does not have a COB provision, that plan is always considered Primary, and always pays first.

### Coordinating benefits between husband and wife

When both plans have a COB provision, the following chart shows how the Primary Plan is determined for your spouse. Separate rules apply to determining which plan is Primary for children, as explained later.

If the participant is:	...and the other plan is sponsored by:	...and expenses are for:	...then HealthSelect is:
The husband	Wife's employer	Husband	Primary
The husband	Wife's employer	Wife	Secondary
The wife	Husband's employer	Husband	Secondary
The wife	Husband's employer	Wife	Primary

### Coordination of benefits for children

For children's coverage, the plan of the parent whose birthday falls earlier in the calendar year will be the Primary Plan.

When parents are divorced or separated, the plan of the parent with custody of the child(ren) is usually Primary, unless the non-custodial parent has been assigned financial responsibility for the children's health care.

If none of these rules apply, the plan which has covered the patient longer will be Primary. Your benefits coordinator or BCBSTX can help you determine which plan is Primary in your situation.

## **When you become eligible for Medicare**

If you are still actively working for an agency or institution of higher education that participates in the Texas Employees Uniform Group Insurance Program (UGIP) when you become eligible for Medicare at age 65, your HealthSelect coverage continues and pays benefits first and Medicare pays second. Once you retire, Medicare pays first and HealthSelect pays second. At that time, you and your dependents will have out-of-area coverage.

When you are eligible for Medicare, the combination of benefits under HealthSelect, Medicare, and any other group insurance plan will never equal more than 100% of the billed charge.

Please note: You can delay purchasing Medicare Part B when you reach age 65, if you are still actively employed at that time by an agency or institution of higher education that participates in the UGIP.

If you are an active employee who is covering a spouse age 65 or over in the UGIP who has not purchased Medicare Part B, your spouse will not need to purchase Medicare Part B until you retire.

When you retire, both you and your spouse should purchase Medicare Part B if you are both age 65 or older. If you do not sign up for Medicare Part B when you retire, you will be considered the primary payer, and HealthSelect will be secondary. This means that HealthSelect will pay 20% of the allowable amount; you will be responsible for the remaining charges.

## **Disabled retirees under age 65**

If you are considered to be disabled by the Social Security Administration (SSA), you are eligible for Medicare Part A and B. Because you are Medicare eligible, when you retire from the State, regardless of your age, Medicare will be the primary payer and HealthSelect will coordinate to pay secondary benefits. Upon retirement, if you do not sign up for Medicare Part B, you will be considered the primary payer and HealthSelect will be secondary. This means that HealthSelect will only pay 20% of the allowable amount and you will be responsible for the remaining charges.

As a disabled retiree under age 65 residing in Texas, you and your covered dependents will retain in-area benefits. Once you turn 65, your coverage will be moved to out-of-area. If you are age 65 or older, please refer to the HealthSelect benefits book for Retirees Age 65 and Over.

With in-area coverage, you have a choice of network or non-network level of benefits as described in Section Three of this benefits book. With Medicare as your primary plan, benefits will be coordinated between Medicare and HealthSelect. The following is a description of how your benefits will coordinate with Medicare when you use network or non-network benefits.

**If you use Network benefits**, your PCP is directing your care. As your primary insurance, Medicare will pay 80% of eligible charges after you meet the Medicare Part B deductible of \$100 per calendar year. As your secondary plan, HealthSelect plan will coordinate paying the remaining balance. You will not be responsible for this Medicare Part B deductible if you follow network guidelines with HealthSelect and will only be charged your copayments or applicable coinsurance until the \$100 Medicare deductible has been satisfied. Once the Medicare deductible is satisfied, Medicare will generally pay 80% of eligible charges and HealthSelect will pay the remaining balance. When claims are coordinated between Medicare and HealthSelect, you may have out of pocket expenses for office visits, inpatient and outpatient day-surgery copayments. In most cases, between Medicare and HealthSelect, your patient share will be zero. There may be exceptions of how benefits are coordinated if the provider of services does not accept Medicare assignment, or if it is a service that Medicare does not cover, but HealthSelect does cover.

**If you use Non-Network benefits**, you have not selected a PCP or are not obtaining referrals. With Non-Network benefits, you will have a \$500 calendar year deductible before benefits are payable by HealthSelect. Please note that any amounts applied toward your Medicare deductible as well as any percentages paid by Medicare, after the Medicare deductible has been satisfied, apply toward your \$500 calendar year non-network HealthSelect deductible. When the HealthSelect deductible has been met, the plan coordinates with Medicare and pays secondary benefits. In most cases, that means paying 20% of Medicare's eligible charges after Medicare has paid 80%. When claims are coordinated between Medicare and HealthSelect, you may have an out of pocket expense for office visit, inpatient and outpatient day-surgery copayments. In most cases, once the deductibles have been satisfied, between Medicare and HealthSelect, your patient share will be zero. There may be exceptions to this if the provider of services does not accept Medicare assignment, or if it is a service that Medicare does not cover, but HealthSelect does cover.

## **Return-to-work retirees**

Retirees who return to active employment at a state agency or higher education institution must notify ERS in writing of the dates of employment. ERS will send a letter to BCBSTX. For more information, State retirees should contact ERS. TRS or ORP retirees should contact their employer's benefits coordinator.

**TIP: If you are retired from another employer and are now actively employed with the State of Texas, HealthSelect is generally primary and the other group plan secondary.**

**TIP: If you are retired from State of Texas or higher education employment and now employed elsewhere, your new employer's group plan, if offered, is generally primary and HealthSelect secondary.**

## **Payments by another party**

When another party is or may be responsible for payment of your medical bills because of a sickness or injury to you (expenses related to an auto accident, for example), HealthSelect will still pay your benefits. However, HealthSelect is subrogated to all rights of recovery that you may have to the extent of benefits provided. The claims administrator also has the right to initiate legal proceedings in your name and to recover payment made on your behalf for which a third party is or may be responsible. Also, if you obtain a court judgement, settlement, arbitration, award, or other monetary recovery from another party because of the injury or sickness, HealthSelect is entitled to have first priority over you or any other party to receive reimbursement from the proceeds of the recovery to extent of the benefits provided. As a HealthSelect participant, you are obligated to cooperate with HealthSelect to protect its subrogation rights by supplying all necessary information, executing all necessary documents and reimbursing HealthSelect when a recovery is made.

## **Case management**

### **What is case management?**

Case management is used by your doctor and BCBSTX to monitor your medical care and the costs associated with a severe injury or long-term illness. Case management may provide alternative benefits that would not otherwise be covered by HealthSelect, if they are cost efficient and medically effective.

## How does it work?

Case management is initiated by BCBSTX when appropriate. A case management plan is established with your provider and specifies the type and amount of care that will be covered by HealthSelect.

Once BCBSTX has given approval, you will be asked to sign the case management plan, which includes a waiver of liability. During the course of your treatment, BCBSTX will continue to work with you and your providers to make sure you receive the most appropriate care for your condition at the most reasonable cost.

Case management is administered by BCBSTX on a case-by-case basis. Treatment that is recommended for one participant may be different from treatment recommended for another participant with the same or similar medical condition. **Benefits provided through case management are not subject to appeal.**

## ParPlan providers

A ParPlan provider is a doctor or other health care provider who has signed an agreement with BCBSTX to:

- File your claims;
- Not bill you for any difference between their charge and the BCBSTX allowable amount;
- Not bill you for any bundled charges;
- Not bill you for services that are not medically necessary as determined by BCBSTX; and
- Not bill you for services that are experimental, investigational or based upon unproven treatment methodologies.

**TIP: Using ParPlan Providers may save you money.**

### **For information on ParPlan providers in Texas, either**

- Call BCBSTX Customer Service at 1-800-252-8039, **OR**
- Visit [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002) for online information.

### **For information on contracting providers with BCBS plans in other states, either**

- Call BlueCard® Worldwide at 1-800-810-BLUE, **OR**
- Visit [www.bluecares.com/healthtravel/finder.html](http://www.bluecares.com/healthtravel/finder.html) for online information (select Traditional/Indemnity Network)

## ParPlan provider advantages

If you see a ParPlan provider, you pay your coinsurance percentage of the allowable amount after meeting your deductible; HealthSelect pays the remaining percentage, and the provider accepts the two amounts as payment in full. You will not be billed any additional amounts. (You can, however, be billed for services that are not covered.) ParPlan providers also file BCBSTX claims for you.

Non-ParPlan providers, on the other hand, may bill you the difference between their charges and the allowable amount as determined by BCBSTX. This is known as “balance billing.” They may also bill you for not medically necessary services that they have provided.

A directory of ParPlan providers is available by calling the Directory Request Line at 1-800-942-5270. You can also download a list of ParPlan providers on the HealthSelect website at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002).

## ParPlan and non-ParPlan: An example

Let's look at examples of how ParPlan providers can save you money. Suppose you need outpatient surgery and BCBSTX has determined that \$2,000 is the allowable amount.

What follows are comparisons for both in-area non-network and out-of-area benefits illustrating how much you would pay with a ParPlan provider and a non-ParPlan provider, assuming that your calendar year deductible has already been met:

<b>ParPlan and Non-ParPlan: A typical example for in-area non-network benefits</b>		
Item	ParPlan	Non-ParPlan
Amount billed	\$2,500	\$2,500
Allowable amount	\$2,000	\$2,000
Your 40% coinsurance	\$800	\$800
Provider's balance of billed charge	N/A	\$500
Your total cost	\$800	\$1,300

<b>ParPlan and Non-ParPlan: A typical example for out-of-area coverage</b>		
Item	ParPlan	Non-ParPlan
Amount billed	\$2,500	\$2,500
Allowable amount	\$2,000	\$2,000
Your 30% coinsurance	\$ 600	\$ 600
Provider's balance of billed charge	N/A	\$500
Your total cost	\$ 600	\$1,100

## Filing claims

Remember: If you use a network provider, a ParPlan provider, or receive medical treatment at a BCBSTX contracting facility, you do not have to file claims. If, however, you receive care from a non-network, non-ParPlan provider, or non-contracting facility or you are filing a claim for diabetic supplies (other than insulin or syringes), you must follow these steps:

### Steps to filing claims

- Step 1** Get a claim form from your benefits coordinator if you are an employee, or call BCBSTX Customer Service at 1-800-252-8039 if you are retired. You may also download a claim form from the ERS web site at [www.ers.state.tx.us](http://www.ers.state.tx.us).
- Step 2** Fill out the claim form completely.
- Step 3** Attach your original itemized bills that show the services performed and the date, the charges, and the name of the patient.  
**If you incur medical costs outside the United States, please obtain an itemized bill that has been translated into English and U.S. currency, using the rate of exchange on the date of service.**

**Step 4** Mail the form and bills to:  
Blue Cross and Blue Shield of Texas  
P.O. Box 660044  
Dallas, TX 75266-0044

**Step 5** Payment, if appropriate, will be made to you along with an EOB. (BCBSTX must pay network providers, ParPlan providers, and facilities directly.)

**Regardless of who files the claim, you will receive an EOB from BCBSTX.**

## Claims for services received outside of Texas

When you or a covered dependent receive medical services outside the state of Texas, your claims may be filed for you through the Blue Cross and Blue Shield Inter-Plan Teleprocessing System (ITS).

ITS is a program that enables participating Blue Cross and/or Blue Shield Plans throughout the United States to exchange membership, claims, and reimbursement information electronically.

*This program also allows you and your covered dependents to receive the benefit of discounts which other Blue Cross and/or Blue Shield Plans have negotiated with the participating providers in that state. Remember, in order for you to benefit from these discounts, participating providers must file your claims for you, to the Blue Cross and/or Blue Shield Plan in the state where services were rendered.*

## ITS advantages

In their agreement with their local Blue Cross and/or Blue Shield Plan, participating providers in other states have agreed to:

- File your claims with the Blue Cross and/or Blue Shield Plan in that state; and
- Not bill you for any difference between their billed charge and their negotiated charge with their local Blue Cross and/or Blue Shield Plan.

If you see a Blue Cross and/or Blue Shield participating provider in another state, you may pay your percentage of the negotiated charge, after your deductible. *(Participating providers may request payment in full at the time of service.)* HealthSelect pays the remaining percentage, and the participating provider accepts the two amounts as payment in full. You will generally not be billed any additional amounts. *(You can be billed for services that are not covered, such as not medically necessary services.)*

In-area participants must still contact their PCP prior to receiving medical treatment. *To continue to receive network benefits for an emergency hospital admission, your PCP must be contacted within 48 hours of the admission.*

Names of participating providers are available by contacting the local Blue Cross and/or Blue Shield Plan in the state where you are receiving medical care.

**For information on contracting providers with BCBS plans in other states, either**

- Call BlueCard® Worldwide at 1-800-810-BLUE, **OR**
- Visit [www.bluecares.com/healthtravel/finder.html](http://www.bluecares.com/healthtravel/finder.html) for online information.

## Steps to utilizing ITS

**Step 1** If you are living or traveling in a state other than Texas, contact the Blue Cross and/or Blue Shield Plan in that state to obtain information on participating providers. You may contact BCBSTX Customer Service for the telephone number of the Blue Cross and/or Blue Shield Plan in the other state.

**TIP: Call BCBSTX Customer Service at (800) 252-8039.**

**Step 2** Select a physician or provider of other health care from among the names of participating providers given to you.

**Step 3** When treatment is received, show the participating provider your HealthSelect ID card. The “ZGB” prefix that is printed before your subscriber ID number will identify you as a HealthSelect participant through BCBSTX. Participating providers outside of Texas may request payment in full at the time of service.

**Step 4** The participating provider will file your claims with the Blue Cross and/or Blue Shield Plan in that state, which will contact BCBSTX to verify your eligibility and benefits. Once coverage has been confirmed, the Blue Cross and/or Blue Shield Plan in that state will pay the participating provider.

**Step 5** The participating provider will bill you for the amount determined to be the patient share, minus any amount you previously paid.

**Step 6** The Blue Cross and/or Blue Shield Plan in that state will bill BCBSTX for reimbursement.

**Step 7** You will receive an EOB from BCBSTX.

**Step 8** If you have any questions regarding these procedures or how your claims were processed, please contact BCBSTX Customer Service at 1-800-252-8039.

**TIP: File your BCBSTX EOB with provider’s statement for future reference.**

*\*All HealthSelect provisions will apply to any medical services received outside of Texas, whether or not your claims are filed utilizing ITS.*

## Claims filing deadline

**Claims must be filed within 18 months from the date services are rendered. Claims filed after the deadline will be denied and no benefits will be allowed.**

## **How to appeal a denied claim or a denied EOI application**

### **If your claim is denied**

In general, if your claim is denied, you have the right to appeal regardless of who filed the claim. However, you may not appeal a denied claim for which you or your family are not financially responsible. You may write the BCBSTX Claims Office at:

Blue Cross and Blue Shield of Texas  
P.O. Box 833988  
Richardson, TX 75083-3988  
Or call:  
(800) 252-8039

BCBSTX might need additional information to review the claim again. They will let you know if they do.

### **If your claim is still denied**

If BCBSTX continues to deny the claim, you may request information from BCBSTX at 1-800-252-8039 on how to file an appeal with ERS. You may then send a letter of explanation to ERS along with copies of correspondence between you and BCBSTX and any other information you feel is important to your case. Send this to:

Grievance Administrator  
Employees Retirement System of Texas  
P.O. Box 13207  
Austin, TX 78711-3207

Your written notice of appeal must be postmarked or received by ERS within 90 days from the date of the BCBSTX letter notifying you of your right to appeal.

### **ERS will respond**

You will receive a decision in writing from the ERS. If you are not satisfied with this decision, you may appeal the decision within ERS. The request must be in writing, and you must file it within 30 days after the date of ERS's decision letter.

### **If your EOI application is denied**

If your EOI application is denied, you will receive notification from Fort Dearborn Life. This notification will indicate that your EOI application was denied and that you have the option to request a reconsideration of the denial.

Active and Retired Employees should send their request for reconsideration of denial:

Fort Dearborn Life Insurance Company  
Administrative Offices  
PO Box 655403  
Dallas, Texas 75265-5403  
1-800-451-0271, option 1

**If your EOI application continues to be denied, Fort Dearborn Life will provide information on how to file an appeal with ERS.**

You may then send a letter of explanation to ERS along with copies of correspondence between you and Fort Dearborn Life and any other information you feel is important to your case. Send this to:

Grievance Administrator  
Employees Retirement System of Texas  
P.O. Box 13207  
Austin, TX 78711-3207

Your written notice of appeal must be postmarked or received by the ERS within 90 days from the date of the Fort Dearborn Life letter notifying you of your right to appeal.

**ERS will respond**

You will receive a decision in writing from ERS. If you are not satisfied with this decision, you may appeal the decision within ERS. The request must be in writing, and you must file it within 30 days after the date of ERS's decision letter.

**If you need help**

If you have any questions about the appeal process, or need help appealing a claim, the Customer Benefits Division of ERS will assist you. You may write or call:

Customer Benefits Division  
Employees Retirement System of Texas  
P.O. Box 13207  
Austin, TX 78711-3207

1-512-476-6431; or  
1-800-252-3645

## **Section Seven**

### **Participants' Rights and Responsibilities**

#### **At-A-Glance**

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**These topics apply to both in-area and out-of-area participants.**

## Section Seven

### Participants' Rights and Responsibilities

#### Participants' Rights

Participants have certain rights and expectations when receiving health care. At BCBSTX, we respect participants' rights and seek to contract with quality network providers who can provide the most appropriate treatment settings and treatment plans for receiving health care. Although BCBSTX cannot guarantee or anticipate the actions of contracted providers, participants have the right to expect the best possible care available and to actively participate in their treatment plans. The following is a list of participants' rights under the HealthSelect plan.

#### Participants have the right to:

1. Be satisfied with the care they receive and with their relationship with their providers. If participants are not satisfied with these aspects of their care, they have the right to change their PCP.
2. Receive adequate information from BCBSTX or from their employer to enable them to make an informed decision on their level of benefits and provider selection.
3. Be informed of available health care benefits and how to obtain these benefits.
4. Request and obtain names, qualifications, and titles of the providers who are responsible for and provide their health care.
5. Participate in the decision-making for their treatment plan.
6. Under network treatment, expect their chosen PCP or network provider to coordinate and arrange for all the care that is needed, except when they are permitted to self-refer for an annual well-woman exam, maternity care, and any OB/GYN related illness or routine eye exam.
7. Receive considerate and courteous care, with respect for personal privacy and dignity through quality network providers.
8. Express their opinions, concerns, or complaints in a constructive manner through the BCBSTX Customer Service line. If the complaint involves another department such as INROADS Behavioral Health Services, your call may need to be transferred to a representative in the appropriate department for resolution.
9. Expect and receive the highest level of customer service commitment through prompt, courteous service.
10. Appeal decisions made by BCBSTX regarding their benefits (except for case management). For a full explanation of the process for appealing determinations, please refer to the "How to Appeal a Denied Claim" section of this book in Section Six, page 87.

#### Participants' responsibilities

HealthSelect allows participants to choose a network or non-network provider each time health care is needed. To maximize HealthSelect benefits, participants should always consult their chosen PCP.

A PCP will coordinate or refer care to a specialist when necessary, to ensure that the participant receives appropriate, medically necessary care at HealthSelect's highest level of benefits, and not have to file claims.

Behavioral health care may be accessed directly by the participant's calling INROADS® Behavioral Health Services.

### **If choosing *network* benefits, participants should:**

1. Read their benefits book for information about network benefits;
2. Select a PCP from the HealthSelect Online Provider Directory found on the HealthSelect website for each family member;
3. Ensure that precertification for behavioral health services has been obtained through INROADS® Behavioral Health Services;
4. Present their personal HealthSelect ID card to a provider's office staff when care is received. This card contains important information that providers will need to see to verify eligibility and charge the appropriate copayment and coinsurance amounts. This ID card should be carried at all times;
5. Establish a relationship and share medical history with their providers to ensure that they will receive the most appropriate, medically necessary care possible;
6. Pay the appropriate copayment and/or coinsurance at the time health care services are rendered;
7. Abide by the medical decisions and treatment plan made and agreed upon with their PCP or network provider;
8. Notify their PCP within 48 hours of emergency medical treatment or hospital admission. This call may be made by the participant, a family member or spouse, or medical personnel. See the "Emergency Care" section of this benefits book for specific details; and
9. Inform BCBSTX if they have additional health care coverage provided by another carrier so that benefits may be coordinated.

### **If choosing *non-network* benefits, participants should:**

1. Read their benefits book for information about non-network benefits;
2. Be prepared, in some cases, to file their own claims and be responsible for charges above the BCBSTX allowable amount when receiving care from non-contracting providers;
3. Present their personal HealthSelect ID card to a provider's office staff when care is received. The card contains important information that providers will need to see, so participants should carry it with them at all times;
4. Precertify all inpatient admissions, home infusion therapy, extended care, and behavioral health services by calling the appropriate toll-free number;
5. Notify BCBSTX within 48 hours of an emergency medical admission. This call may be made by the participant, a family member or spouse, or medical personnel. See the "Emergency Care" section for specific details regarding network and non-network benefits in emergency situations; and
6. Inform BCBSTX if they have additional health care coverage provided by another carrier so that benefits may be coordinated.

### **If receiving *out-of-area* benefits, participants should:**

1. Read their benefits book for information about out-of-area benefits;
2. Be prepared, in some cases, to file their own claims and be responsible for charges above the BCBSTX allowable amount when receiving care from non-contracting providers;
3. Precertify all inpatient admissions, home infusion therapy, extended care, and behavioral health services by calling the appropriate toll-free number;
4. Notify BCBSTX within 48 hours of a medical emergency admission. This call may be made by the participant, a family member or spouse, or medical personnel. See the "Emergency Care" section for specific details regarding benefits in emergency situations; and
5. Inform BCBSTX if they have additional health care coverage provided by another carrier so benefits may be coordinated.

## **Section Eight**

### **Glossary of Important Terms**

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# Section Eight

## Glossary Of Important Terms

This section of your book provides definitions of important HealthSelect terms, and applies to both in-area and out-of-area participants. If you have any questions about what these terms mean or how they work, call BCBSTX Customer Service.

**Accidental Injury** - A bodily injury that results from an accident and requires a provider's care within 48 hours of the occurrence.

**Allowable Amount** - The maximum amount that will be allowed by HealthSelect for a medical service or supply. Allowable amount is determined by BCBSTX based on either charges made for the same service by providers in the same geographic area with similar training, experience, and facilities, or negotiated rates with providers who have contracted with BCBSTX.

**Ambulance Service** - Professional local ground ambulance or air ambulance transportation services to the nearest hospital, appropriately equipped and staffed for the treatment of the participant's condition.

**Behavioral Health Provider** – Providers who provide services for behavioral health care. Benefits are available only when the licensed providers are providing services and/or supplies within the scope of their license. Providers include:

- Licensed Master Social Worker-Advanced Clinical Practitioner;
- Doctor of Psychology (certified as a health service provider);
- Licensed Marriage and Family Therapist;
- Licensed Professional Counselor;
- Licensed Speech Language Pathologist;
- Licensed Chemical Dependency Counselor; and
- Licensed Psychological Associate.

Benefits are available for services by providers included in this definition only as referenced in the definition of Other Medical Expenses. Services of licensed professionals not included in this list, or not specifically listed as a provider in this book, may not be covered.

**Benefits Coordinator** - The person employed by your state agency, college, or university who can help participants enroll in various benefits plans and change coverage. Retirees should contact the ERS for assistance with coverage matters.

**Bundling** – The process that identifies a medical procedure (i.e., lab, radiology, surgery, anesthesiology, etc.) that is incidental to another billed procedure, and is therefore included in that charge and not eligible for separate benefits. The process was developed in conjunction with physician specialists from across the country. When you use a network or ParPlan provider, they must “write-off” charges that bundle to other services. If the provider is non-network or non-ParPlan, the participant is responsible for these bundled charges.

**Calendar Year** - January 1 through December 31 of the same year.

**Claims Administrator** - Blue Cross and Blue Shield of Texas (BCBSTX), a division of Health Care Service Corporation (HCSC), a mutual legal reserve company.

**Clinical Ecology** - Treatment of allergic symptoms, **not** covered under HealthSelect. Clinical ecology includes these methods:

- Cytotoxicity testing (testing allergic reactions to food or inhalant by whether it reduces or kills white blood cells);
- Urine auto injection (injecting one's own urine into one's own body tissue);
- Skin irritation (Rinkel method);
- Sublingual provocative testing (putting drops of allergenic extracts in the mouth); or any other method not recognized as safe and effective by the American Academy of Allergists and Immunologists.

**Coinsurance** - A participant's share of covered services and supplies, not counting the deductible or copayments. It is usually a percentage of the allowable amount.

**Complications of Pregnancy** - Medical conditions that require a hospital stay before the end of the pregnancy and that are caused by the pregnancy, endanger the pregnancy, or are aggravated by the pregnancy. Complications of pregnancy include:

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;
- Missed abortion;
- Termination of pregnancy by nonelective cesarean section;
- Termination of ectopic pregnancy; and
- Spontaneous termination of pregnancy when a viable birth is not possible due to stage of fetal development.

These conditions are **not** considered complications of pregnancy:

- False labor;
- Occasional spotting;
- Morning sickness;
- Physician-prescribed bed rest;
- Hyperemesis gravidarum; and
- Preeclampsia.

**Copayment** - A flat dollar amount the participant must pay for medical services or prescription drugs at the time they are provided. The amount a participant pays for a PCP or specialty office visit within the HealthSelect network is an example of a copayment.

**Cosmetic, Reconstructive, or Plastic Surgery** - Surgery that either: Improves physical appearance, but does not correct or restore a bodily function; or is performed for psychological reasons; or restores form, but does not correct or restore a bodily function.

**Cosmetic Drug** – A drug that is used primarily to enhance appearance including but not limited to correction of skin wrinkles, skin aging and hair loss, even if the drug may have other non-cosmetic uses.

**Covered Oral Surgery** - Procedures related to the teeth and jaws that are covered by HealthSelect. Covered oral surgery is limited to:

- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors, and nonodontogenic cysts;
- Incision and drainage of cellulitis;
- Surgical procedures that involve accessory sinuses, salivary glands and ducts;
- Excision, injection, or reduction of a dislocation of the temporomandibular joint (TMJ) - (oral appliances and devices used to diagnose or treat TMJ pain disorders or dysfunction of the joint, jaw, jaw muscles and nerves are not covered); and
- Correction of damage caused by external violent accidental injury to healthy natural teeth, if the accident occurs while the participant is covered under HealthSelect. Services must be received within 24 months from the date of the accident.
- Orthognathic surgery

**No other dental services are covered under HealthSelect.**

**Covered Services and Supplies** - The allowable amount for services or supplies that are specifically covered under HealthSelect. Covered services and supplies are described in Sections III, IV and V of this book and in more detail in the Master Benefit Plan Document.

**Custodial Care** - Care that is not part of a medical treatment but that helps a sick or injured individual with the activities of daily living, such as walking, bathing, eating, and taking medication. Custodial care includes room, board, and institutional services and supplies. Expenses for these services are **not** covered under HealthSelect.

**Deductible** - The amount a participant must pay in covered medical expenses each calendar year before HealthSelect begins to pay benefits. There is no deductible for network benefits.

**Dental Care Services (although no benefits are available for dental services, the following definition is included for clarification purposes)** - The professionally recognized dental services, supplies, or appliances which are provided to a participant by a Physician or Provider, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree), and shall also include a provider who is a Doctor of Medicine or a Doctor of Osteopathy. Dental Care Services include, but are not limited to cleaning, filling of teeth, crowns (or capping), root canals, restoration, replacement or repositioning of teeth, or alteration of the alveolar or periodontium process of the maxilla and the mandible.

**Diabetic Management Services** - Diabetic Management Services include **Diabetes Equipment, Diabetes Supplies and Diabetes Self-Management Training Programs**, which are rendered by or at the direction of a Physician.

**Diabetes Equipment** is specifically defined as:

- \*Blood glucose monitors, including monitors designed to be used by blind individuals;
- \*Insulin pumps and associated appurtenances;
- \*Insulin infusion devices; and
- \*Podiatric appliances for the prevention of complications associated with diabetes

\* Covered as Durable Medical Equipment.

**Diabetes Supplies** are specifically defined as:

- \*Test strips for blood glucose monitors;
- \*Visual reading and urine tests strips;
- \*Lancets and lancet devices;
- \*\*Insulin and insulin analogs;

- \*Injection aids;
- \*\*Syringes;
- \*\*Prescriptive and nonprescriptive oral agents for controlling blood sugar levels;
- \*Glucagon emergency kits; and
- \*Alcohol wipes.

\* Covered as Durable Medical Equipment.

\*\* Covered under the Prescription Drug Program.

**Diabetes Self-Management Training Programs** are specifically defined as:

- Training provided after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;
- Additional training provided after a diagnosed significant change in symptoms or condition that requires changes in the self-management regime; and
- Periodic or episodic continuing education training as warranted by the development of new techniques and treatments for diabetes.

**Dietary and Nutritional Services** - Education, counseling, or printed material about:

- Setting, regulating, or managing a diet; or
- Assessing or managing nutrition.

**Durable Medical Equipment** - Therapeutic supplies and rehabilitative equipment required for therapeutic use, such as a wheelchair, hospital-type bed, artificial respirator, or similar equipment.

*Equipment designed for alleviation of pain or provision of patient comfort (for example, over-the-counter splints or braces, air conditioners, humidifiers, dehumidifiers, air purifiers, physical fitness and whirlpool bath equipment, personal hygiene protection, home air fluidized beds, motorized lifts, mattresses, allergen-free pillows and blood pressure cuffs) is not covered, even if prescribed by your physician.*

**Emergency** - The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his condition, sickness or injury is of such a nature that failure to get immediate medical care could reasonably result in:

1. Placing the participant's health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ; or
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Environmental Sensitivity** - Treatment of allergic symptoms by one of these methods:

- Controlled environment;
- Sanitizing the surroundings and removing toxic materials; or
- Use of special nonorganic and nonrepetitive diet techniques.

Expenses for these treatments are **not** covered under HealthSelect.

**Evidence of Insurability** - Such evidence of the condition of one's health including medical records and a physical examination, as may be required by BCBSTX for changes in existing coverage or issuance of new coverage pursuant to the Rules of the Board of Trustees of the Employees Retirement System of Texas.

**Experimental and/or Investigational** - A drug, device, equipment, facility, procedure or treatment that is not generally accepted as standard medical treatment of the condition being treated, or any such items requiring Federal or other governmental agency approval, if approval is not granted at the time services are provided.

**Extended Care Services** - Services and supplies provided by a skilled nursing facility, a home health agency, a hospice, or private-duty nurses.

**Facility** - A facility that is licensed to provide services and supplies that are covered by HealthSelect, and that is approved by BCBSTX. Facilities include:

- Alcohol or drug treatment facilities;
- Birthing centers;
- Crisis stabilization units;
- Durable medical equipment providers;
- Home health agencies;
- Home infusion therapy providers (must be contracted with BCBS);
- Hospices;
- Imaging centers;
- Independent laboratories;
- Outpatient surgical facilities;
- Prosthetic providers;
- Psychiatric day treatment facilities;
- Radiation therapy centers;
- Renal dialysis centers;
- Residential treatment centers for children and adolescents;
- Rural health clinics (must be approved by and contracted with BCBSTX);
- Skilled nursing facilities;
- Spiritual care facilities;
- Substance abuse facilities; and
- Therapeutic centers.

**Family Deductible** - Family deductible applies to non-network and out-of-area participants. Three individuals in the family must each meet a calendar year deductible under one subscriber ID number.

**FDA**- The Food and Drug Administration, the federal agency responsible for drug oversight, (i.e., approval and dispensing protocols).

**Generic Substituted Drug** – A drug manufactured and distributed after the patent of the innovator brand name drug has expired. The generic drug must have the same active ingredient, strength and dosage form as its brand name counterpart.

**Home Health Agency** - A business that provides home health care and is licensed by the Texas Department of Health. Home health agencies in other states must be licensed, approved, or certified by the appropriate agency in that state and be certified by Medicare as a supplier of home health care.

**Home Health Care** - Care provided to patients during a visit by a home health agency. The care must be necessary due to sickness or injury and provided on a part-time, periodic basis.

**Home Infusion Therapy (HIT)** - Administration of medication (including chemotherapy), fluids, or nutrition by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in a home setting. Home infusion therapy includes:

- Drugs and IV solutions;
- Pharmacy charges;
- Equipment and supplies needed to administer the therapy;
- Delivery services;
- Patient and family education; and
- Related nursing services.

**Home Infusion Therapy Provider** - A home infusion therapy provider must be duly licensed by the appropriate state agency to provide home infusion therapy and must contract with BCBS as a provider of home infusion therapy.

**Hospice** - An institution that provides care for terminally ill patients. To qualify for benefits under HealthSelect a hospice must be licensed by the state in which it is located (if the state provides licensing), approved by BCBSTX, and be certified by Medicare as a supplier of hospice care.

**Hospice Care** - Health care services that are covered by HealthSelect and that are provided by a hospice to a terminally ill patient. The services may be provided in the patient's home or in the hospice.

**Hospital** - An institution that provides 24-hour nursing services and facilities for diagnosis and major surgery. To be covered by HealthSelect, a hospital must be licensed in the state where it is located, approved by BCBSTX and be either accredited by the Joint Commission on Accreditation of Health Care Organizations or certified as a hospital provider under Medicare.

The term hospital as used in this book also includes:

- Licensed and accredited mental health hospitals;
- Military medical facilities;
- Public health hospitals; and
- Veterans Administration hospitals.

**Hospital Admission** - The period of time beginning when a patient enters a hospital and ending when he or she is discharged. The day of entry is considered part of the hospital admission, but the day of discharge is not.

**Immediate Family Member** - A person related by blood or marriage who is a spouse, parent, child, mother-in-law, father-in-law, brother, sister, brother-in-law, sister-in-law, aunt, uncle, niece, nephew, cousin, grandparent or grandchild.

**In-Area** - Geographic locations selected by ERS that are served by the HealthSelect network. Effective January 1, 2003, all Texas counties, are in-area locations.

**In-Area Benefits** - Network and non-network benefits that are available to employees and retirees under age 65 who do not have Medicare as their primary carrier, and who live in a geographic location selected as in-area by ERS served by the HealthSelect network. In-area benefits are described in Section Three of this benefits book.

**Inpatient** - You are considered an inpatient when you have been admitted to a substance abuse facility or hospital for 24 or more consecutive hours.

**Inpatient Care** - Care provided to a patient with bed accommodations in a hospital that provides 24-hour a day acute medical care or in a substance abuse facility. Inpatient care does not include a stay in a skilled nursing facility or other long-term facility.

**Inpatient Copayment Maximum** - The copayment amount that a participant must pay in a calendar year before he is no longer required to pay copayments for inpatient admissions.

**Inpatient Hospital Expense** - Charges for medically necessary services or supplies that are provided by a hospital or substance abuse facility during a hospital admission and that are ordered by a doctor or other provider. This includes the charge for a semiprivate room and other medically necessary services. It does not include the cost of a phone, TV, or any other personal items.

**Intermediate Care Facility** - A type of psychiatric care facility, which includes residential treatment centers for children and adolescents, crisis stabilization units and psychiatric day treatment centers. Treatment in these facilities requires precertification.

**Maternity Care** - Medical care and services provided to a pregnant woman. For network benefits, maternity care includes diagnosis of pregnancy and pre- and post-natal care and delivery (including delivery by C-section). Doctor office visits are covered at 100% after the initial office visit copayment. The 100% coverage does not include complications of pregnancy, sonograms, stress tests, amniocentesis, lab fees, tubal ligation, circumcision, assistant surgeon fees, anesthesiologist fees and inpatient hospital expenses. Network benefits for these services are paid according to the benefits summary in Section Three, pages 26-29.

**Medically Necessary (Medical Necessity)** - Services and supplies are considered medically necessary if they:

- Are essential to and consistent with the diagnosis or treatment of a specific illness or injury;
- Meet generally accepted standards of medical practice in the U.S.;
- Are not primarily for the convenience of the patient, doctor, or hospital;
- Represent the most cost-efficient treatment of the condition that is safe and effective; and
- Are not experimental or investigational.

The recommendation of a doctor or other health care provider does not automatically make a given service or supply medically necessary.

**BCBSTX will determine whether a service or supply is medically necessary, considering views of the medical community, guidelines and practices of Medicare and Medicaid, and peer review literature.**

**Mental Illness** - Mental disease, disorder or condition as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) III-R, or any other diagnostic coding system as used by BCBSTX, whether or not the cause of the disease, disorder or condition is physical, chemical, or mental in nature or origin.

**Network** – The HealthSelect network of providers that have been established by BCBSTX and approved to provide services for HealthSelect participants.

**Network Behavioral Health Service Provider** – The HealthSelect network of providers that has been established by BCBSTX and approved to provide behavioral health services for HealthSelect participants. Providers who have entered into this agreement with BCBSTX are required to obtain the appropriate referral and precertification authorization. Providers failing to obtain the required authorization are not eligible to receive benefits reimbursement and cannot bill the patient for any unauthorized services. Benefits are available only when the licensed providers are providing services and/or supplies within the scope of their license. Providers include:

- Licensed Master Social Worker-Advanced Clinical Practitioner;
- Doctor of Psychology (certified as a health service provider);

- Licensed Marriage and Family Therapist;
- Licensed Professional Counselor;
- Licensed Speech Language Pathologist;
- Licensed Chemical Dependency Counselor; and
- Licensed Psychological Associate.

Benefits are available for services by providers included in this definition only as referenced in the definition of Other Medical Expenses. Services of licensed professionals not included in this list, or not specifically listed as a provider in this book, may not be covered.

**Network Benefits** - Benefits for services and supplies provided by:

- A network primary care physician (PCP);
- A network specialty care provider if referred by the PCP and approved by BCBSTX;
- A provider referred by INROADS Behavioral Health Services.
- A non-network provider if referred by your PCP and approved by BCBSTX.

Network benefits apply only to employees, retirees under age 65 who do not have Medicare as their primary carrier, and covered dependents who live or work within a network service area, and have in-area coverage.

**Non-Network Benefits** - Benefits available under HealthSelect for services and supplies that are not provided or referred by a network PCP. Non-network benefits apply only to employees, retirees under age 65, and covered dependents who live or work within a network service area, have in-area coverage, and do not have Medicare as their primary carrier.

**Non-Network Provider** - Doctors, hospitals, and other providers (as defined in Section Eight, page 101) who do not belong to the HealthSelect network serving employees, retirees under age 65, and covered dependents, in counties designated as in-area by ERS.

**Non-Preferred Brand Name Drug** – Designated prescription drugs available at a higher copayment than Preferred brand name drugs. All new drugs will be designated as Non-preferred until reviewed by the Pharmacy and Therapeutics Committee.

**Office Visit** - A visit performed by a physician for a covered service, in which the reimbursement for the charge is not included in any other procedure already considered for benefits.

**Other Medical Expenses** - Charges for medically necessary services or supplies that are ordered by a doctor or other provider, and that are not considered inpatient expenses or extended care expenses. Covered services and supplies are shown in Sections III and IV of this book.

**Out-of-Area** - Geographic locations that are not served by a BCBSTX network.

**Out-of-Area Benefits** - HealthSelect benefits that are available to employees and retirees who live outside of a network service area or who are age 65 or older and have Medicare as their primary carrier. Out-of-area benefits are described in Section Four of this benefits book.

**Out-of-Pocket Coinsurance Maximum** - The amount that a participant must pay in a calendar year (excluding copayments) before HealthSelect pays 100% of remaining covered expenses (up to the allowable amount).

**Outpatient Care** - Care that is ordered by a doctor and provided in a hospital (as defined in this section), with a stay of less than 24 hours.

**ParPlan Provider** - A physician or other provider who has signed an agreement with BCBSTX agreeing to the following:

- Accept the BCBSTX allowable amount;
- File claims for patients covered by BCBSTX; and
- Not bill participants for services determined by BCBSTX to be not medically necessary, or experimental and investigational.

**Participant** - A person who is covered under HealthSelect.

**Participating (Network) Pharmacy** – An independent Pharmacy or chain of Pharmacies that have contracted with Medco Health Prescription Solutions, L.L.C. to provide Pharmacy services to participants.

**Physician** - A person who is licensed as a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

**Plan Year** - The period from September 1st through August 31st.

**Precertification** - Advance approval that is required from BCBSTX. Precertification determines the medical necessity of the care a participant receives. It is required for:

- Inpatient hospital admissions;
- Skilled nursing care in a skilled nursing facility;
- Private-duty nursing;
- Home health care;
- Intermediate care facilities;
- Hospice care; and
- Home infusion therapy (use of a BCBS contracting provider is required to receive benefits).

**Predetermination** - A review by BCBSTX of proposed services and supplies to determine medical necessity and the availability of benefits under HealthSelect, prior to services and supplies being provided.

Predeterminations do not guarantee payment.

**Preferred Brand Name Drug** – Medications recommended by the Pharmacy and Therapeutics Committee as acceptable based on efficiency, safety and cost.

**Preferred Brand Name List** – A list of preferred drugs, biologicals and devices approved by Medco Health Pharmacy and Therapeutics Committee for inclusion in the pharmacy benefit program. The preferred brand name list is subject to change.

**Primary Care Physician** - A doctor who has entered into an agreement with BCBSTX to provide health care services to employees and retirees under the terms of HealthSelect. Primary Care Physicians (PCPs) either provide care themselves or refer the patient to a specialist.

**Private-Duty Nursing** - Services of a private-duty nurse in a patient's home, that are not part of a hospice or home health care visit. Private-duty nursing in a hospital or other medical facility is not covered under HealthSelect.

**Prosthetic Appliances** - Artificial devices which replace body parts, including arms, legs, and eyes. Dental appliances, wigs and cataract lenses are not considered prosthetic appliances.

**Provider** - A facility, hospital, physician (as defined in this glossary), or other professional that is licensed to provide services and supplies within the scope of its license. Benefits are available for services provided by providers included in this definition only as referenced in the definition of Other Medical Expenses. Providers also include:

- Licensed Audiologist;
- Licensed Master Social Work-Advanced Clinical Practitioner;
- Doctor of Chiropractic;
- Doctor of Dentistry;
- Doctor of Optometry;
- Doctor of Podiatry;
- Doctor in Psychology (certified as a health service provider);
- Licensed Hearing Aid Fitter and Dispenser;
- Licensed Dietitian;
- Licensed Marriage and Family Therapist;
- Licensed Professional Counselor;
- Licensed Speech Language Pathologist;
- Licensed Psychological Associate;
- Licensed Chemical Dependency Counselor;
- Spiritual Care Provider (for example, a Christian Science practitioner);
- Therapeutic Optometrist;
- Registered Nurse First Assistant;
- Certified Surgical Assistant (**effective January 1, 2003**);
- Physician's Assistant\*; and
- Advanced Nurse Practitioner\*.

\*PAs & ANPs must be supervised by an M.D. or D.O. for network benefits and they must be employed by a network PCP or specialist.

**Services of licensed professionals not included in this list as a provider may not be covered.**

**Referrals** - For in-area participants to receive network benefits, a referral must be approved by BCBSTX before you receive specialty medical care from a provider other than your PCP except for those services rendered by specialists that do not require a referral. Your PCP will do this for you by contacting BCBSTX referral department by telephone or fax.

All approved referrals are set up for a specific number of days or visits. A referral does not guarantee payment. If you are seeking care for pregnancy, an annual well-woman exam, or gynecological services, you may go directly to a network OB/GYN for network benefits. Refer to Section Three, page 16 for further instructions on direct access to OB/GYNs.

**Residential Treatment Center for Children and Adolescents** – A child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Association of Psychiatric Services for Children and is approved by the Claims Administrator as a residential treatment center for the provision of certain categories of Mental Illness Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

**Routine Eye Exam** - An eye examination by a Doctor of Ophthalmology or a Doctor of Optometry which, when within the scope of their license, includes such services as:

- External examination of the eye and its structure;
- Determination of refractive status; and
- Glaucoma screening test.

**It does not include a contact lens exam.**

**Routine Foot Care** - Hygienic and preventive maintenance care of the foot, including the cutting or removal of corns or callouses, nail trimming (including mycotic nails), and self-care, such as soaking of the feet. Routine foot care also includes any services performed in the absence of localized illness, injury, or symptoms involving the feet, and any treatment of a fungal (mycotic) infection, except under certain circumstances. Routine foot care is not covered under HealthSelect, except when provided for a diagnosis of, or related to, diabetes.

**Rural Health Clinic** - A medical clinic in generally rural or medically underserved areas of Texas, engaged in providing primary ambulatory care under the direction of a physician. The clinic must comply with all applicable federal, state, and local requirements and be approved by and contracted with BCBSTX as a rural health clinic.

**Serious Mental Illness** - Mental health conditions that HealthSelect covers at the same benefit levels as any other illness or injury. Serious mental illness as defined by Texas law is:

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (mixed, manic, and depressive);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive)
- Pervasive developmental disorders;
- Hypomanic disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence

**Skilled Nursing Facility** - A facility that primarily provides skilled nursing services and other therapeutic services on an inpatient basis. It is one type of nursing home providing specialized care. (Custodial care is not covered.) It must also be:

- Licensed according to state law;
- Medicare- and Medicaid-eligible;
- Approved by the state Department of Health as a provider of inpatient nursing care; and
- Approved by BCBSTX as a skilled nursing facility.

**Specialist** - A physician or health care professional who has executed an agreement with BCBSTX for the provision of specialty care services to employees and retirees under the terms of HealthSelect.

**Subscriber Identification Number (Subscriber ID)** - The subscriber ID number shown on the HealthSelect ID card which identifies the subscriber. It is usually the employee's or the retiree's social security number preceded by the letters ZGB.

**Substance Abuse** - Abuse of, dependence on, or addiction to alcohol or a controlled substance.

**Substance Abuse Facility** - An institution located in the State of Texas which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a physician and is also:

1. Affiliated with a hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
3. Licensed, certified, or approved as a chemical abuse dependency treatment program or center by any agency of the State of Texas having legal authority to so license, certify or approve.

Any Substance Abuse Facility located outside the State of Texas shall be licensed, certified, or approved as a chemical abuse treatment center by the appropriate agency of the state in which it is located and be accredited as such an institution

by the JCAHO.

**Telemedicine** - The use of interactive audio, video or other electronic media (excluding telephones or fax machines) to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

**This book is a summary of the Master Benefit Plan Document, statutes, and administrative rules governing HealthSelect. In case of conflict between the provisions of this book and the plan document, statutes, or administrative rules, the appropriate document, statute, or rule will prevail. Although ERS intends to continue our health care plan into the future, the agency reserves the right, at all times, to change, suspend, or end the plan**