

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

### **Retired Employees Age 65 and Over Effective September 1, 2002**



**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*

**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 plan document provision, statute, or administrative rule will prevail. 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.**

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## **Section One**

### **About This Benefits Book**

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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;
- 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 Seven, beginning in Section Seven, page 55 for definitions of terms such as “Medically Necessary,” “Allowable Amount,” or “Covered Oral Surgery.”

## This book is meant for retirees age 65 and over, and their dependents

The information in this book applies only to retired employees age 65 and over, and their covered dependents. If you are an active employee or a retiree under age 65 you may download the correct version for you of the HealthSelect benefits book from the ERS website [www.ers.state.tx.us](http://www.ers.state.tx.us) or call Blue Cross and Blue Shield of Texas (BCBSTX) Customer Service at 1-800-252-8039 for more information.

## 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 and other important telephone numbers.

**TIP: If you would like additional HealthSelect ID cards, contact BCBSTX Customer Service at 1-800-252-8039.**


## 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, Missouri 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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**At-A-Glance**

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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 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, search for contracting pharmacies, download the latest preferred drug list and obtain up-to-date information regarding your HealthSelect plan. You can access the HealthSelect website through the “Health and Dental Links” on the ERS website at **www.ers.state.tx.us**.

## Online provider directory

Regional provider directories are no longer printed. This information is found on the HealthSelect website **www.bcbstx.com/hs2002**. Posting this information on line provides you with the most up-to-date information regarding BCBS ParPlan physicians and providers. The HealthSelect website is updated monthly and 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. The Online Provider Directory allows you to conduct customized searches 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 a ParPlan provider, you can contact BCBSTX Customer Service at 1-800-252-8039, 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). 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: Your BlueAccess password is mailed to the address BCBTX has on file. It is important to make sure that ERS has your most current address.**

**Section Three**  
**Guide To Benefits**  
**At-A-Glance**

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**Please remember that these topics apply to retirees age 65 or over and/or their dependents.**

## Section Three

### About your coverage

As a retiree who is age 65 or over, you are eligible for traditional medical benefits under HealthSelect. You may choose any provider you wish (see definition of provider in Section Seven, page 63).

### A word about Medicare

#### Medicare has two parts:

- Part A provides hospital insurance and covers institutional services such as hospitals, skilled nursing facilities, home health agencies and hospices.
- Part B provides medical insurance, and covers doctors' services, outpatient services and medical supplies.

Most individuals become eligible for Medicare when they reach age 65. If you have Part A, you are automatically covered for Part B unless you decline it. Medicare charges a premium for Part B coverage. It is important that you sign up for Medicare when you first become eligible, since HealthSelect will coordinate benefits with Medicare, as explained in this book.

We have added a subsection in the back of this section (Section Four, page 28) titled "Q & A Quick Reference." You may want to review this section which includes questions frequently asked by retirees, which address coordination of benefits with Medicare.

**TIP: Contact your Social Security office about enrolling in Medicare Part B.**

### Precertification of certain services

If you do not have Medicare Part A coverage, or if your Medicare benefits have been exhausted (e.g. skilled nursing facility care), HealthSelect requires precertification of certain medical services. Precertification determines, in advance, the medical necessity of the care you are to receive. 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 any benefits).

Precertification merely confirms 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;
- Failure to call for precertification as explained below on a timely basis - prior to an elective admission or within 48 hours of an emergency admission; and
- 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 a family member call for you.

### Precertification numbers to call:

In Dallas	1-972-238-7712
Within Texas	1-800-344-2354
Outside Texas	1-800-343-0125

**TIP: Precertification saves you money.**

## If you do not precertify

**If you are admitted to a hospital without precertification, you may have to pay a penalty deductible in addition to your coinsurance.** Also, benefits will not be paid for services which are not medically necessary, including room and board charges for unapproved inpatient hospital days. **If you receive any of the other services listed in Section Three, page 10 without precertification, you must pay the full cost of the services. HealthSelect will pay nothing.**

<b>Precertification</b>	Determines medical necessity for inpatient hospitalization, but is not a guarantee of payment
<b>Predetermination</b>	Determines whether services requested are eligible for benefits, prior to services being rendered

## Predetermination of benefits

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 service to be medically necessary and therefore eligible for benefits.

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

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.

## 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 1-800-252-8039 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).

## **Making the Most of Your Benefits**

### **Steps to HealthSelect benefits**

**Step 1:** Call any provider (see definition of provider in Section Seven, page 63), preferably a BCBSTX ParPlan provider (see explanation of ParPlan provider in Section Seven, page 62).  
Tell the provider that you have HealthSelect coverage.

**TIP: Call 1-800-942-5270 for a ParPlan Provider Directory or visit the HealthSelect Online Provider Directory at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002).**

**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 Three, page 10 for a list of what services and procedures must be precertified).

**Step 4:** Your providers will file your claims with Medicare. If you have given BCBSTX your Medicare number, then your claims will automatically be forwarded to BCBSTX. If you have not given BCBSTX your Medicare information, you may be responsible for filing those claims with BCBSTX. Be sure to include a copy of the Medicare EOB with any claims you file with BCBSTX.

**Step 5:** Either you or your provider will receive payment, if appropriate. You will always receive an EOB from BCBSTX regardless of who files your claim.

**TIP: File your Medicare EOB, BCBSTX EOB and provider statement together 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 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 precertification/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, and coinsurance). BCBSTX will take care of the rest, and will send an Explanation of Benefits to your home.

### **Emphasis on preventive care**

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

- Participants may receive one routine physical exam each calendar year.
- Women may receive one annual well-woman exam by an obstetrician/gynecologist (OB/GYN), if those services are not performed during their routine physical.
- 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.

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

## **Routine eye exam**

- One routine eye exam per calendar year per participant is covered (subject to calendar year deductible).
- Services may be provided by either an optometrist or ophthalmologist.
- Contact lens exam is not covered.

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

- Obtain a separate precertification for the child; and
- Arrange to have the child "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. Retirees should contact the ERS for more information.**

## **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 Seven, page 62 for definition of office visit):

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

## 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 Seven, page 65 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 the provider contracts with BCBSTX, 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 the provider does not contract with BCBSTX, 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 see the Benefits Summary in Section Three, page 22 of this book for more information.

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

## 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*.

If your physician prescribes DME, simply take the prescription to any DME supplier. To reduce your out-of-pocket expenses, use a DME supplier contracting with BCBSTX. (If a non-contracting DME supplier's charge is greater than the BCBSTX allowable amount, you will be responsible for the difference).

See the Benefits Summary in Section Three, page 22 for more information. For a complete definition of DME, see Section Seven, page 59.

**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 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 Seven, page 58 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 Seven, page 58 for more information).

**Other diabetes supplies** (see Section Seven, page 58 for a complete definition) are covered under your **medical benefits as Durable Medical Equipment (DME)**, at 80% of the BCBSTX allowable amount after your deductible is met. If you use a non-contracting supplier and the charge is greater than the allowable amount, you will be responsible for the difference. You may call BCBSTX Customer Service at (800) 252-8039 for a list of **contracting DME providers** in your area. You can also search for contracting DME providers in other states 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.

If you use a contracting DME provider, you will not be required to file your claims. However, if you use a provider who does not contract with BCBSTX, you will be required to file your claim for diabetes supplies. To file your claim, 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 Medicare is your primary carrier, you will be required to use a DME Provider who contracts with Medicare. Once Medicare has processed your claim, it will be forwarded to BCBSTX for processing if you have provided BCBSTX your Medicare information.

For further clarification on your benefits for diabetes supplies, please see your Benefits Summary in Section Three, page 22.

## **Bundling**

Bundling is 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 ParPlan provider, they must “write-off” charges that bundle to other services. If the provider is not a ParPlan Provider, the participant is responsible for these bundled charges.

## **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. To limit your out-of-pocket expenses, it is recommended that you use ParPlan providers (see Section Seven, page 62 for complete definition of ParPlan). ParPlan providers can only bill you the difference between the benefit maximum (\$60) and the BCBSTX allowable amount.

**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.**

If your diagnosis is a serious mental illness as defined in Section Seven, page 64 or substance abuse as defined in Section Seven, page 65, you will not be subject to the 30-outpatient visit maximum or the \$60 benefit maximum per visit. Your treatment will be covered as any other illness or injury.

## **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.

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

In Dallas	1-972-766-5201
Outside Dallas	1-800-528-7264

## **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 Seven, page 64 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 Seven, page 65 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.

**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.

## **In Case of Emergency**

### **Definition of emergency**

HealthSelect defines an emergency as 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.

### **Getting emergency care**

In an emergency situation that is not life or limb threatening, you should call your doctor before you visit the 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.

### **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 Seven, page 56).

**TIP: Call 1-800-344-2354 for precertification.**

### **If you have been admitted to the 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 Three, page 10 of this book.

## Benefits Summary

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability for amounts over the allowable.

General Provisions	Benefits
<i>Calendar year deductible applies to charges except as noted.</i>	
Calendar year deductible (\$100 Medicare deductible counts toward this amount).	\$200 individual/\$600 family maximum
Calendar year out-of-pocket coinsurance maximum (does not include copayments)	\$800 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 80%, you pay 20%
Annual physicals (one per calendar year for adults and children-women are also allowed one well-woman office visit to an OB/GYN each calendar year)	Plan pays 80%, you pay 20%
Diagnostic x-rays, mammography, injections, routine immunizations, pap smears, and lab tests	Plan pays 80%, you pay 20%
Specific immunizations for children 0-6 years old (except when performed during an office visit)	Plan pays 100%
Allergy injections and antigens	Plan pays 80%, you pay 20%
Office surgery and diagnostic procedures	Plan pays 80%, you pay 20%

## Benefits Summary

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability for amounts over the allowable.

<b>Doctors' and Lab Services</b>	<b>Benefits</b>
Inpatient doctor visits	Plan pays 80%, you pay 20%
Outpatient surgery and anesthesia	Plan pays 80%, you pay 20%
Routine eye exam (one per calendar year per participant)	Plan pays 80%, you pay 20%
Maternity care	Plan pays 80%, you pay 20%
<b>Hospital Services</b>	
Inpatient hospital (semi-private room and board or intensive care unit)	Plan pays 80%, you pay 20% (no deductible)
Other inpatient charges, including surgery and anesthesia	Plan pays 80%, you pay 20%
Outpatient facilities, including pre-admission testing and/or treatment room	Plan pays 80%, you pay 20%
Emergency care	Plan pays 80%, you pay 20%
<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 80%, you pay 20%; \$18,000 lifetime maximum (no deductible)
*Home health care	Plan pays 100%; 100 visits up to \$5,000 calendar year maximum (no deductible)
***Private duty nursing	Plan pays 80%, you pay 20% (even after out-of-pocket coinsurance maximum is met); \$8,000 calendar year maximum; \$40,000 lifetime maximum

## Benefits Summary

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability for amounts over the allowable.

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 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%
Durable medical equipment (includes medically necessary purchase and/or rental)	Plan pays 80%, you pay 20%
Prosthetic appliances (\$10,000 maximum per occurrence)	Plan pays 80%, you pay 20%
Physical, occupational, speech therapy, and chiropractic care	Plan pays 80%, you pay 20%
Ambulance services	Plan pays 80%, you pay 20%
*Home infusion therapy (HIT)	Plan pays 80%, you pay 20% 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>	
<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 80%, you pay 20% (even after coinsurance maximum is met); maximum allowable amount \$60 per visit

## Benefits Summary

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability for amounts over the allowable.

Behavioral Health	Benefits
<b>(Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)</b>	
*Inpatient visits (maximum 30 days per calendar year)	First 15 days, Plan pays 80%, you pay 20%; Next 15 days, Plan pays 60%, you pay 40%
**Intermediate care facility (maximum 60 days per calendar year)	First 30 days, Plan pays 80%, you pay 20%; Next 30 days, Plan pays 60%, you pay 40%
Prescription Drugs	
At participating pharmacies	<b>Up to a 30-day supply</b> Copayments: \$5 for generic drugs, \$20 for preferred brand-name drugs, \$35 for non-preferred brand-name drugs
At non-participating pharmacies	<b>Up to a 30-day supply</b> 70% 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>Up to a 30-day supply</b> Copayments: \$5 for generic drugs, \$20 for preferred brand-name drugs, \$35 for non-preferred brand-name drugs
	<b>Up to a 90-day supply</b> Copayments: \$10 for generic drugs, \$40 for preferred brand-name drugs, \$70 for non-preferred brand-name drugs

\*Precertification required unless you have Medicare Part A benefits.

\*\*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.

\*\*\* Precertification required.

**TIP: If you are unsure if a specific medical service or supply is covered, call BCBSTX Customer Service at 1-800-252-8039.**

## 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 Seven, beginning in Section Seven, page 55 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 1-800-252-8039.**

## 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.

**TIP: Extraction of wisdom teeth is not covered. Check with ERS about available dental plans.**

- 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 two weeks before 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, 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 extension of benefits as described in Section Five, page 42.
- 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 Five, page 46.
- 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 provided through Case Management or ERS-approved pilot programs.

- 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 deductible**

The deductible is per person 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 maximum family deductible has been taken in a calendar year, call BCBSTX Customer Service because you may be eligible for a refund. Refer to the Benefits Summary in Section Three, pages 20-23 for the amount of the individual and family deductibles.

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

If two or more members of your family 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.

If you have Medicare, HealthSelect will coordinate your benefits so that most of your expenses are covered. See Section Five, pages 43-45 of this book for an explanation of coordination of benefits with Medicare.

## **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 Benefits Summary in Section Three, page 20 for the out-of-pocket maximum amount. 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; and
- 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. 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

**Q. My EOB was sent to the wrong address. What should I do?**

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

**Q. I have Medicare Part B for my primary coverage, and HealthSelect for my secondary coverage. Do I have to satisfy both the Medicare Part B deductible and HealthSelect deductible?**

A. Yes. However, the amounts that are applied toward your Medicare deductible are also applied toward your HealthSelect deductible.

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

A. Yes, benefits are available for medically necessary eligible services. You may have to pay for these services in full when rendered and then file a claim with BCBSTX. See Section Three, page 14 for information on “BlueCard Worldwide®.”

If you have Medicare and the services are performed in the U.S., most providers are required to file your claims with Medicare.

**Q. Does HealthSelect cover services that Medicare doesn't?**

A. Yes. Some services that are not covered by Medicare are covered by HealthSelect - for example, hearing aids and prescription drugs. For more specific information, refer to the Benefits Summary in Section Three, pages 20-23 of this book, or contact BCBSTX Customer Service at 1-800-252-8039.

**Q. Is HealthSelect a Medicare supplemental policy?**

A. No, HealthSelect is not a Medicare supplement. It is a comprehensive medical plan which coordinates benefits with Medicare.

**Q. If I have Medicare Part A, am I still required to precertify with BCBSTX?**

A. No, unless you are receiving private-duty nursing services, home infusion therapy, or your Medicare benefits have been exhausted. Please refer to Section Three, page 10 of this benefits book for more details on BCBSTX precertification requirements.

**Q. Aren't my claims automatically transferred from Medicare to BCBSTX?**

A. Yes, if you have supplied BCBSTX with your Medicare HIC number, effective date, and type of coverage (Part A and/or Part B). If your Medicare claims are not being transferred, please contact BCBSTX Customer Service to ensure they have your Medicare information.

**Q. I retired before September 1, 1992 and I don't have Medicare Part B coverage. Why do my EOBs from BCBSTX state they need an EOB from Medicare to process my claim?**

A. BCBSTX may not have accurate information regarding your Medicare coverage. Please call BCBSTX Customer Service and provide them with your Medicare Part A number and effective date.

**Q. I retired after September 1, 1992. Why does HealthSelect require that I purchase Medicare Part B?**

A. HealthSelect requires those employees who retired and became 65 on or after September 1, 1992, to purchase Medicare Part B. (If it is not purchased, HealthSelect does not pay for those services which would have been paid by Medicare Part B.) Unlike many public sector employers and private companies, retirees have health insurance made available to them by the State of Texas, and the State of Texas continues to pay 100% of the premium. If Medicare were not paying primary benefits, the cost of HealthSelect premiums would increase, requiring either increased funding from the Texas Legislature, payment of a share of the premium by retirees, or a decrease in the benefits offered to retirees.

**TIP: Contact your local Social Security office about enrolling in Medicare Part B.**

# **Guide To Prescription Drug Benefits**

## **Section Four**

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## **Section Four**

### **Guide To Prescription Drug Benefits**

#### **About the prescription drug program**

When you enroll in HealthSelect, you are automatically enrolled in the Prescription Drug Program (PDP). The PDP for HealthSelect participants is administered by 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 a participating pharmacy for the copayments specified in the Summary of Benefits. Many pharmacies in Texas participate. You may also use your HealthSelect ID card at any Medco Health Prescription Solutions, L.L.C. pharmacy, located throughout the United States. For information on participating pharmacies, contact Medco Health Member Services at 1-800-903-8345 or visit the Medco Health website at [www.ers.state.tx.us](http://www.ers.state.tx.us).

#### **How the prescription drug program works for you**

When filling a prescription at a participating pharmacy, simply present the card to the pharmacist along with your prescription, pay your copayment, and the pharmacist will take care of the rest. Copayment amounts are explained later in this section.

If you use a non-participating pharmacy, you will have to pay the full amount and then file a claim for reimbursement. Instructions on filing a claim and benefit amounts are explained later in this section.

#### **What is covered**

Most prescription drugs that are medically necessary and ordered by a provider, including oral contraceptives, are covered. 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 now 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. By asking your doctor to prescribe preferred medications, you can help control rising health care costs while maintaining high-quality care. Use of a preferred drug is voluntary; however, you will pay a non-preferred copayment (\$35 retail for 30-day supply, \$70 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 prescription. Your physician always makes the final decision on your medication and you can always choose to keep the original prescription.

## **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 your medication is not approved by Medco Health, 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 once the limits are exceeded. 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**

HealthSelect allows you to obtain up to a 30-day supply of most covered medications. You may get up to four 10-cc vials of insulin and enough syringes and needles for the supply (up to 100 per prescription). Oral contraceptives are covered for up to a 90-day supply with three retail copayments.

## **Participating pharmacies**

Simply present your HealthSelect ID card with your prescription and your copayment. You do not have to file a claim for prescriptions filled at a participating retail pharmacy.

## **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 1-800-903-8345 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. The amount of the reimbursement will be 70% 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.

## Mail service pharmacy program

You may obtain up to a 90-day supply of most covered medications for one mail-order copayment, per your physician's prescription order. You may also obtain up to a 30-day supply of most covered medications through the mail service for one retail copayment. Restrictions on controlled substances may limit the days supply and number of refills allowed. With your physician's approval, generic medications will be dispensed when possible.

### 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 your medication plus refills, if appropriate.
2. Mail your 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.
2. Reorder online using 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 or Diners Club. If you prefer to pay for all orders by credit card, consider joining the Medco Health Automated Enrollment program. Call 1-800-948-8779 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 using 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 Tex Flex Health Care Reimbursement Account.

	Retail Pharmacy	Home Delivery Pharmacy	
	(30-day supply)	(30-day supply)	(up to a 90-day supply)
Generic Medication	\$5	\$5	\$10
Preferred Brand-Name Medication	\$20	\$20	\$40
Non-Preferred Brand-Name Medication	\$35	\$35	\$70

### 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.

**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** 1-800-903-8345, 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.

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 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 money. When you get a prescription, ask your provider or the pharmacist if a generic equivalent is available.

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

**A.** No, your prescription drug copayments do not apply to your calendar year 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 Five, page 48 of your benefits book for more details.

# **Section Five**

## **Important Plan Provisions**

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## Section Five

### Important Plan Provisions

#### About this section

This section contains important information about HealthSelect - coordination of benefits, how to file claims, 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 retirees and dependents

Eligibility for HealthSelect under the Texas Employees Uniform Group Insurance Program (UGIP) 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 the ERS.

**Please note:** A person who is already covered in the UGIP through the state as an employee, a retiree, or a dependent is not eligible for coverage as a dependent on your HealthSelect policy.

##### When you retire

When you retire, and are age 65 or older, you will automatically be covered by HealthSelect's traditional benefits unless you select other coverage, such as a Health Maintenance Organization (HMO). However, you should complete an enrollment form within 30 days after your retirement. The 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.

If you have any covered dependents who are under the age 65, please contact ERS Customer Benefits at 1-877-275-4377 to request In-Area coverage for those dependents. For more information regarding In-Area coverage, please refer to the HealthSelect Under 65 Benefits Book Section III, Guide to In-Area Benefits.

##### 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.

**Note: If you are age 65 or over and retired and subsequently returned to work you will remain in out-of-area coverage.**

## **Changing Your HealthSelect Coverage**

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

Contact the ERS for information on how and when you may:

- Add dependents to your coverage, including children of your covered dependents;
- Drop dependents from your coverage.

### **Evidence of insurability (EOI)**

Evidence of insurability will usually be required of any 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 summer 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 Five, page 50 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 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 the required premium payments.

## **Surviving dependents**

If you die while you and your spouse are covered by HealthSelect, your spouse may continue his or her coverage indefinitely. However, the full premium must be paid by the surviving spouse.

If you die while you and your dependent children are covered under HealthSelect, your children may continue coverage until they are no longer eligible dependents. However, your dependent children, or their legal guardians, will be responsible for the full premium.

## **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 7/1/95. All covered disabled 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; and
- 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 certification as disabled 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;
- an application for enrollment is completed within 30 days of the date the notice was mailed by ERS; and
- the COBRA premiums are paid in full.

**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 the 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 is made effective.

## **When your COBRA coverage can be terminated**

HealthSelect has the right to end this continuation coverage if:

- The 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 health plan 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 1-800-338-2227.

## **Loss of benefits due to fraud**

Improper use of the Prescription Drug Program, 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 (COB)**

### **What is coordination of benefits?**

You and your family could be covered by more than one group medical plan, including Medicare. The combination of benefits under HealthSelect, Medicare, and any other group insurance plan will never equal more than 100% of the billed charge.

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.

## COB with Medicare

If you are a retiree who is eligible for Medicare, your HealthSelect benefits will be coordinated with Medicare. If your spouse is eligible for Medicare, his or her HealthSelect benefits will be coordinated with Medicare in the same manner as yours. Please note, if your spouse has group health insurance through active employment, that carrier would be primary for both of you. Medicare would be secondary for you and HealthSelect would be tertiary. If your spouse has group health insurance through retirement, Medicare would be primary for your spouse, the other carrier secondary, and HealthSelect tertiary. The following chart shows which coverage is primary and which is secondary when Medicare and HealthSelect are involved.

**TIP: Always present both your Medicare card and your HealthSelect ID card when receiving medical services.**

### Primary vs. Secondary Coverage for Retirees:

If you are retired and are at least age 65	And your Medicare Coverage is			Then HealthSelect will be:
	Parts A & B	Part A only	Part B only	
On or before 08/31/92	X			Secondary for all medical care
On or before 08/31/92		X		Secondary for hospitals and facilities, primary for all other medical expenses
On or before 08/31/92			X	Primary for hospitals and facilities, secondary for all other medical expenses
On or after 09/01/92	X			Secondary for all medical care
On or after 09/01/92		X		Secondary for all medical care
On or after 09/01/92			X	Primary for hospitals and facilities, secondary for all other medical expenses

## How claims are coordinated with Medicare as the primary payer

Medicare Part A has a deductible for each "benefit period." A new benefit period begins when you have been out of a hospital (as an inpatient) or skilled nursing facility for at least 60 consecutive days. Your benefit plan with HealthSelect pays that deductible amount and the "blood deductible" (a charge excluded by Medicare, for the first three pints of blood for transfusions). Additionally, in the event the Medicare Reserve Days are used and no more Medicare benefits are available during a particular hospital stay, HealthSelect would become your primary insurance for the services that Part A usually pays. **In the absence of Medicare benefits, precertification is required, or a penalty will be applied.**

Medicare Part B, which applies to outpatient services, has a calendar year deductible. Your HealthSelect plan has a deductible for outpatient services as well. Please note that the amounts applied toward your Medicare deductible are also applied toward your 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%. There may be exceptions to this percentage 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.

**TIP: Using physicians who accept Medicare assignment limits your liability for amounts over the Medicare allowable.**

**TIP: Over age 65 retirees with Medicare may have a patient cost share (for example, when Medicare does not cover the service and HealthSelect pays primary, or when charges do not meet the deductible).**

## If you do not sign up for Medicare

If you retired on or after September 1, 1992, or you reached age 65 after that date, regardless of when you retired, Medicare Part B is recommended. If you do not have Medicare Part B, you will be considered the primary payer and HealthSelect will be secondary. **This means HealthSelect will pay 20% of the allowable amount; you will be responsible for the remaining charges.**

## Return-to-work retirees

If you are retired from a State agency or institution of higher education and have returned to work for a State agency or institution of higher education, your HealthSelect coverage may be primary to your Medicare coverage. For additional information, contact your employer's benefits coordinator if you are a TRS or ORP retiree, or the ERS if you are a state retiree.

**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, Medicare secondary, and HealthSelect tertiary.**

## If you are not eligible for Medicare

If you are not eligible for Medicare Part A (because you or your spouse did not contribute to Social Security), HealthSelect will be considered the primary payer for inpatient facility claims (unless you have other insurance coverage as a result of your or your spouse's employment). If you are not eligible for Medicare Part B (because you or your spouse did not contribute to Social Security), HealthSelect will be considered the secondary payer for outpatient services. Even though you may not have paid into the Social Security fund, you may still purchase Part B from the Social Security Administration. Please contact your nearest Social Security office for information about how to enroll in Medicare Part B.

## Retirees with Medicare Part A & B

When Medicare is your primary insurance, you may use any valid provider. If the physician accepts Medicare assignment, and your deductible with both Medicare and HealthSelect have been satisfied, most services that are eligible expenses under both plans will be covered at 100%. If the physicians do not accept Medicare assignment, they must still file your claims to Medicare and are limited to charging no more than 115% of the Medicare approved charge (“Medicare’s limiting charge”). In that case, HealthSelect would likely pay the difference between Medicare’s payment and the limiting charge. In the event that the physician has a ParPlan contract with BCBSTX, HealthSelect would pay up to the BCBSTX allowed amount and you would be held harmless on additional amounts.

**If you are retired and over 65, with Medicare Parts A and B, the following is a brief summary of your benefits:**

Service	Medicare Pays	HealthSelect Pays	Your Patient Responsibility
<b>Inpatient hospital</b>	All covered charges, except inpatient and blood deductibles and private room difference	Inpatient deductible, blood deductible, and private room difference	Personal items
<b>Outpatient hospital</b>	80% of allowed charges after \$100 Part B deductible met	20% of allowed charges after \$200 HealthSelect deductible met	Both deductibles (met concurrently)*; then usually \$0
<b>Physician’s services</b>	80% of allowed charges after \$100 Part B deductible met	20% of allowed charges after \$200 HealthSelect deductible met	Both deductibles (met concurrently)*; then usually \$0
<b>Routine or yearly Physical exams</b>	\$0	80% if HealthSelect deductible has been met	Up to \$200 if HealthSelect deductible has not been met, otherwise 20%
<b>Laboratory charges</b>	Most paid at 100%, if covered	If paid at 100% by Medicare, no payment. If not covered, paid at 80%	\$0, if covered by both plans 20% if only covered by HealthSelect
<b>Radiology</b>	80% of allowed charges after \$100 Part B deductible met	20% of allowed charges after \$200 HealthSelect deductible met	Both deductibles (met concurrently)*; then usually \$0
<b>Skilled nursing facility (skilled care only)</b>	100% for first 20 days, then 80% for next 80 days (for total of 100 days)	20% beginning on 21 <sup>st</sup> day, for a maximum of 60 days or \$6,000 each calendar year	\$0 for first 80 days, then 20% for last 20 days (of 100 days covered by Medicare)
<b>Durable medical equipment</b>	80% of allowed charges after \$100 Part B deductible met	20% of allowed charges after \$200 HealthSelect deductible met	Both deductibles (met concurrently)*; then usually \$0
<b>Home health Care (skilled care only)</b>	100%	\$0	\$0
<b>Hospice</b>	Usually 100%	Usually \$0	\$0
<b>Home infusion therapy</b>	\$0	80% if HealthSelect deductible has been met (must be precertified)	Up to \$200 if HealthSelect deductible has not been met, otherwise 20%

**\*\$100 calendar year Medicare deductible and \$200 calendar year HealthSelect deductible, which run concurrently for a total of \$200**

## **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 provider 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 also 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 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 services determined by BCBSTX to be not medically necessary; and
- Not bill you for services that are experimental, investigational or based upon unproven treatment methodologies.

## ParPlan Provider advantages

If you turned age 65 and retired before September 1, 1992, and you are not covered by Medicare Part B, you might want to use a ParPlan provider in order to reduce your out-of-pocket costs. If you see a ParPlan provider, you pay 20% of the allowable amount (after your deductible); HealthSelect pays 80%, and the provider accepts the two amounts as payment in full. You will not be billed any additional amounts. (You can be billed for services that are not covered.)

Non-ParPlan providers, on the other hand, may bill you any 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 they have provided.

**If you turn age 65 and retire on or after September 1, 1992, and you do not enroll for Medicare Part B, you will be the primary payer of your medical expenses. This means that HealthSelect will pay 20% of the allowable amount, after the deductible, for medical expenses, and you will be responsible for the rest. However, you can still reduce your out-of-pocket expenses by using ParPlan providers.**

A directory of ParPlan providers is available by calling the Directory Request Line at 1-800-942-5270 or downloaded from the HealthSelect website at [www.bcbstx.com/hs2002](http://www.bcbstx.com/hs2002).

**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/providers](http://www.bcbstx.com/hs2002/providers) for online information.

## ParPlan and Non-ParPlan: An example

Let’s look at an example 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 is a comparison of how much you would pay with a ParPlan provider and a non-ParPlan provider. We have assumed that HealthSelect is the primary payer of benefits. To make the example easier to follow, assume that you have already met your calendar year deductible.

<b>ParPlan and Non-ParPlan: A typical example.</b>		
<b>Item</b>	<b>Par-Plan</b>	<b>Non-ParPlan</b>
Amount billed	\$2,500	\$2,500
Allowable amount	\$2,000	\$2,000
Your 20% coinsurance	\$400	\$400
Provider’s balance of billed charge	N/A	\$500
Your total cost	\$400	\$900

## How to File Claims

### Filing claims if you have Medicare

If Medicare is your primary plan and HealthSelect is secondary, claims must be filed with Medicare first. Your provider will file your claims with Medicare for you.

When receiving medical services within Texas, your claims will automatically be coordinated between Medicare and HealthSelect if you have provided BCBSTX with your Medicare coverage information. If, however, BCBSTX does not have your Medicare information, you or your provider must file your claims to BCBSTX along with a Medicare Explanation of Benefits.

When receiving medical services outside of Texas, ask the provider if they will file your claim for secondary benefits directly to Blue Cross and Blue Shield of Texas after they receive Medicare's payment. If they will, simply give them your HealthSelect subscriber ID number, group number, and the following address:

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

If the provider is not willing to file for secondary benefits, you may file your claim to the same address along with a copy of the Medicare EOB for that service.

**TIP: Save copies for your records of any claims or correspondence you send.**

### Steps to filing claims without Medicare

If you do not have Medicare coverage and you receive care within Texas from a non-ParPlan provider, you may have to file your own claim. Here are the steps to follow:

**Step 1** You may get a claim form by calling BCBSTX Customer Service at 1-800-252-8039. 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 your part of 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 ParPlan providers and facilities directly.)

When you, or a covered dependent, receive medical services outside the state of Texas, **and you are not covered by Medicare**, 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 participating providers of that state. Remember, in order for you to benefit from these discounts, the participating providers must file your claims for you, to the Blue Cross and/or Blue Shield Plan in the state where services were rendered.

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)

## **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 and/or not medically necessary*).

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.

## **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 at 1-800-252-8039 for the telephone number of the Blue Cross and/or Blue Shield Plan in the other state.
- 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:

1-800-252-8039

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 the ERS. You may then send a letter of explanation to the 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 the ERS within 90 days from the date of the BCBSTX letter notifying you of your right to appeal.

## **The 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 the ERS. The request must be in writing, and you must file it within 30 days after the date of the ERS 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 the 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.

## **The 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 the ERS. The request must be in writing, and you must file it within 30 days after the date of the ERS decision letter.

## **If you need help**

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

Customer Benefits  
Employees Retirement System of Texas  
P.O. Box 13207  
Austin, TX 78711-3207  
1-512-867-7411; or  
1-877-275-4377

## **Section Six**

### **Participant's Rights and Responsibilities**

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

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## Section Six

### Participants' Rights and Responsibilities

#### Participants' Rights

Participants have certain rights and expectations when receiving health care. 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 providers.
2. Be informed of available health care benefits and how to obtain these benefits.
3. Request and obtain names, qualifications, and titles of the providers who are responsible for and provide their health care.
4. Participate in the decision-making for their treatment plan.
5. Receive considerate and courteous care, with respect for personal privacy and dignity.
6. 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.
7. Expect and receive the highest level of customer service commitment through prompt, courteous service.
8. 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 Five, page 50.

#### Participants' Responsibilities

HealthSelect allows participants to choose a provider each time health care is needed. Use of ParPlan providers will ensure that the participant receives medically appropriate, medically necessary care, at HealthSelect's highest level of benefits and not have to file claims.

#### Participants should:

1. Read their benefits book for information about their benefits.
2. Be prepared, if they do not have Medicare Part B, to file their own claims when receiving care from non-contracting providers.
3. If they do not have Medicare Part A, precertify all inpatient admissions, extended care services and home infusion therapy by calling the appropriate toll-free number.
4. 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 in Section Three, page 19 for specific details regarding emergency situations.
5. Inform BCBSTX if they have additional health care coverage provided by another carrier, so benefits may be coordinated.

## **Section Seven**

### **Glossary of Important Terms**

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

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## Section Seven

### 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 your benefits coordinator or 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 Services** - 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, change coverage, and file claims. Retirees should contact the ERS for assistance with coverage matters.

**Bundling** – The process that identifies a medical procedure that is incidental to another billed procedure and is, therefore, included in that charge and not eligible for separate benefits.

**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 prescription drugs at the time they are provided.

**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.

**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);

- 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; and
- 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 Section Three, pages 20-23 of this book and in more detail in the Master Benefit Plan Document.

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

**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.

**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 (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** - Evidence regarding the condition of a person's health that may be required by BCBSTX when you change your coverage or add dependents. This could include medical records and/or a physical examination.

**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** - 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 innovated 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.

**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 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** - Routine medical care and services provided to a pregnant woman including pre- and post-natal care and delivery (including delivery by C-section).

**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.

**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 Section Three, pages 20-23 of this 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 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 or a Doctor of Osteopathy.

**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 prescription drugs, biologicals and devices approved by the Medco Health Pharmacy and Therapeutics Committee for inclusion in the pharmacy benefit program. The preferred brand-name list is subject to change.

**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 their 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 First Nurse 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.

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

**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.

**Subscriber Identification Number (Subscriber ID)** - The subscriber ID number shown on the HealthSelect ID card which identifies the subscriber. It is usually 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.

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**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 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.**