



TAKE WELLNESS TO

heart

RETIREES 65 AND OVER

MAKING YOUR BENEFITS
WORK FOR YOU

EFFECTIVE SEPTEMBER 1, 2006



BlueCross BlueShield
of Texas

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 plan document provision, statute, or administrative rule will prevail. Although ERS intends to continue this health care plan into the future, ERS 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.
6. Required coverage for reconstructive surgery following mastectomies.

However, HIPAA permits certain governmental group health plans the right of exemption from certain provisions of this federal law. For the plan year from September 1, 2006 through August 31, 2007 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 subscriber or covered dependent (including but not limited to claims information or general membership information regarding a patient covered under HealthSelect), please be prepared to submit an authorization from the subscriber, divorce decree showing custodial responsibility, or a court order. This will ensure confidentiality of all patient information.

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

NOTICE

TO ALL PARTICIPANTS AND COVERED DEPENDENTS IN HEALTHSELECT

Effective September 1, 1998, HealthSelect began providing more comprehensive coverage for breast reconstruction in connection with a mastectomy. This notice, in accordance with the Women's Health and Cancer Rights Act of 1998, is to advise you that your health plan covers:

- reconstruction of a breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications at all stages of mastectomy, including lymphedemas.

All participants should notify their covered dependents of this expansion of coverage.

Standard copayments, coinsurance, and deductibles will apply when appropriate. Please contact your health plan administrator or the Employees Retirement System of Texas for more information.

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Section One

About This Benefits Book

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Section One

About This Benefits Book

This book is 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 Six, beginning on page 75](#) for definitions of terms such as “Medically Necessary,” “Allowable Amount,” and “Covered Oral Surgery.”

This book is intended 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 version of the HealthSelect benefits book pertaining to your age group from the HealthSelect Web site at www.bcbstx.com/hs or call Blue Cross and Blue Shield of Texas (BCBSTX) Customer Service at (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 useful telephone numbers.

Please note: Several states, including Texas, have passed Identity Theft laws to help protect the confidentiality of Social Security Numbers for state residents. Because of this, your subscriber number has been replaced with a Unique Identifier. If you do not have an ID card with a unique identifier listed for your subscriber number, please contact BCBSTX Customer Service at (800) 252-8039.

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


Easy-to-read Explanation of Benefits (EOB)

Understanding your EOB is essential to understanding your benefits. BCBSTX has an EOB form that makes it easy to locate the information that is important to you. It also provides definitions of insurance terms.

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 EOB. Remember to match up your EOB with the provider's statement, and file them together for future reference.

|  | BlueCross BlueShield of Texas P.O. Box 660044 Dallas, Texas 75266-0044 | Explanation of Claims Benefits (EOB). This is not a bill HEALTHSELECT 11-21-01 | | | | | | | | | | | | | | | | | |
|--|---|--|--|----------------------------|------------------------------------|--|--------------------------------|--|--|--|---------------|--|--|--|--|--|--|--|--|
| Name _____ Address _____ | Customer Service: 800-252-8039 | Customer Service Hours 7:00 A.M. - 7:00 P.M. C.S.T. Sunday - Saturday | | | | | | | | | | | | | | | | | |
| | | Member Name: _____ Group/ID Number: _____ Claim Number: _____ Patient Name: _____ | | | | | | | | | | | | | | | | | |
| The following shows how this claim was processed. | | | | | | | | | | | | | | | | | | | |
| Service Information | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <thead> <tr> <th data-bbox="285 1026 526 1079">Service Description</th> <th data-bbox="540 1026 675 1079">Service Date</th> <th data-bbox="829 1026 911 1079">Amount Billed</th> <th data-bbox="964 1026 1052 1079">Not Covered</th> <th data-bbox="1263 1026 1354 1052">Covered</th> </tr> </thead> <tbody> <tr> <td colspan="5" data-bbox="285 1079 1373 1205" style="height: 60px;"></td> </tr> <tr> <td colspan="5" data-bbox="285 1205 1373 1234"> Totals </td> </tr> </tbody> </table> | Service Description | Service Date | Amount Billed | Not Covered | Covered | | | | | | Totals | | | | | | | | |
| Service Description | Service Date | Amount Billed | Not Covered | Covered | | | | | | | | | | | | | | | |
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| Totals | | | | | | | | | | | | | | | | | | | |
| Claim Summary | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td data-bbox="285 1314 1373 1344">Deductions</td> </tr> <tr> <td data-bbox="285 1344 1373 1373">Applied To Your Deductible</td> </tr> <tr> <td data-bbox="285 1373 1373 1402">Amount You May Owe Provider</td> </tr> <tr> <td data-bbox="285 1402 1373 1432"></td> </tr> <tr> <td data-bbox="285 1432 1373 1461">Total Benefits Approved</td> </tr> <tr> <td data-bbox="285 1461 1373 1503"></td> </tr> </table> | | | Deductions | Applied To Your Deductible | Amount You May Owe Provider | | Total Benefits Approved | | | | | | | | | | | | |
| Deductions | | | | | | | | | | | | | | | | | | | |
| Applied To Your Deductible | | | | | | | | | | | | | | | | | | | |
| Amount You May Owe Provider | | | | | | | | | | | | | | | | | | | |
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| Total Benefits Approved | | | | | | | | | | | | | | | | | | | |
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| Benefit Payment Information | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td data-bbox="285 1556 1373 1608">TOTAL COVERED BENEFITS APPROVED FOR THIS CLAIM:</td> </tr> </table> | | | TOTAL COVERED BENEFITS APPROVED FOR THIS CLAIM: | | | | | | | | | | | | | | | | |
| TOTAL COVERED BENEFITS APPROVED FOR THIS CLAIM: | | | | | | | | | | | | | | | | | | | |

List of frequently called phone numbers and addresses:

BCBSTX Customer Service

(800) 252-8039
P.O. Box 660044
Dallas, TX 75266-0044

TDD Phone Line for Hearing Impaired

(800) 735-2989

Coordination of Benefits

(800) 252-8039
P.O. Box 660044
Dallas, TX 75266-0044

Inpatient Hospital Admission

Extended Care Services
Home Infusion Therapy
In Dallas: (972) 238-7712
Within Texas: (800) 344-2354

Outside Texas: (800)343-0125

Evidence of Insurability

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

Employees Retirement System of Texas

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

Prescription Drug Program

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

Prescription Drug Reimbursement

Medco Health Solutions, L.L.C.
P.O. Box 14711
Lexington, KY 40512

Claims Filing Address

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

Blue Care[®] Connection

24/7 NurseLine: (888) 334-9473
Special Beginnings[®]: (800) 462-3275

GBP Forms/PCP Changes

BCBSTX Membership/Group Accounts
P.O. Box 660044
Dallas, TX 75266-0044
OR Call (800) 252-8039

Behavioral Health Services

INROADS[®] Behavioral Health Services
a Magellan Behavioral Health Company
In Dallas (972) 766-5201
Outside Dallas (800) 528-7264

Medicare Part A and B

(800) MEDICARE

Mail Order Prescription Drugs

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

Section Two

HealthSelect Website

At-A-Glance

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Section Two

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, Live Chat with a BCBSTX Customer Service Representative, review participant eligibility and claim status, view and print your Explanation of Benefits (EOB), request email notification when a claim finalizes, opt-out of paper EOBs, download claim forms and obtain up-to-date information about HealthSelect. You can also link to [Medco's website](#) and search for contracting pharmacies and download the latest preferred drug list. You can access the HealthSelect website through the "Health and Dental Links" on the ERS website at www.ers.state.tx.us, or directly at www.bcbstx.com/hs.

Online provider directory through Provider Finder[®]

[Provider Finder](#), which is located on the HealthSelect website www.bcbstx.com/hs, provides you with the most up-to-date information regarding BCBS ParPlan physicians and providers. The customized search feature through Provider Finder that is updated **daily** provides you with the most up to date information. You can also download an entire directory, which is updated twice a month. You can access Provider Finder 24 hours a day, 7 days a week.

Provider Finder gives you detailed information about the physicians and providers including: whether they are accepting new patients, board certification, hospital affiliations, where the physician attended medical school, if the physician has a website, and much more. Provider Finder allows you to conduct customized searches or download an entire directory. Provider Finder also gives you the option 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 Provider Finder is correct, some additions, deletions and changes may not be reflected. If you have any questions about Provider Finder, please contact BCBSTX Customer Service at (800) 252-8039.

Blue Access[®] for Members

As a HealthSelect participant, you have immediate, secure access to your medical claims information. Blue Access for Members is available through the HealthSelect Web site at www.bcbstx.com/hs, and lets you:

- Check the status of your claims and your claims history
- Confirm who in your family is covered under your plan
- View and print an Explanation of Benefits (EOB) for a claim
- Select the option to not receive EOBs in the mail
- Request e-mail notification of finalized claims
- Request a new or replacement ID card or print a temporary ID card
- Email BCBSTX Customer Service
- Live Chat with a BCBSTX Customer Service Representative

If you do not have a User ID and password for Blue Access for Members, you can get started by following these four easy steps:

1. Have your group and subscriber identification number ready (these can be found on the HealthSelect ID card)
2. Go to www.bcbstx.com/hs
3. [Log in to Blue Access for Members](#)
4. Create a User ID and password. Once the User ID and password are created you will have secure access to your personal information.

Blue Access for Members is available seven days a week, all day, except during the hours of 3:00 a.m. through 6:00 a.m.

If you cannot log into Blue Access for Members, the Internet Help Desk is ready to assist you. Call toll-free at (888) 706-0583 between 7 a.m. and 10 p.m. (CT) Monday through Friday and 7 a.m. to 3:30 p.m. Saturday.

Personal Health Manager

Through [Blue Access for Members](#), you have access to the Personal Health Manager. The Personal Health Manager gives you access to:

- Set up a personal health record to keep track of and manage your family's health information
- Ask registered nurses, your Blue Care Advisors, health-related questions through "Ask a Nurse"
- Request nutrition, fitness and weight loss advice from a team of certified personal trainers with "Ask a Trainer"

- You also have access to trained life skills coaches who are online daily to offer motivation through "Ask a Coach"
- Access online health content such as health and medication information, wellness tracking tools, videos and interactive tutorials
- Receive targeted wellness and condition-specific information
- Complete the Health Risk Assessment, research symptoms, investigate treatment options or prescription drugs and their side effects, learn about nutritious meal planning and more

Making Informed Decisions before Surgery is Scheduled

When your physician has recommended a surgical treatment, you can now easily find and review the outcome history of procedures previously performed at hospitals using "Health Share*." For example, if you're having bypass surgery, you can review a hospital's performance based on factors such as:

- Mortality
- Length of stay
- Complications
- Number of procedures performed
- Cost

To review hospital outcome data, log on to [Blue Access for Members](#) and click on "Compare Hospitals."

Email BCBSTX Customer Service

Have you ever had questions for BCBSTX Customer Service and were unable to call during business hours? Now you can email BCBSTX Customer Service your questions and comments when you become a registered user through [Blue Access for Members®](#). Your emails are secure when emailing BCBSTX Customer Service through Blue Access for Members, which allows BCBSTX Customer Service to respond to your inquiry via email. Be assured that your email inquiry will be responded to within 24 hours of receipt.

Live Chat with BCBSTX Customer Service

As a HealthSelect participant you have the option to communicate with BCBSTX Customer Service Representatives about your HealthSelect benefits through a feature known as Live Chat. Live Chat gives you the option of communicating with a BCBSTX Customer Service Representative through a feature similar to "instant messaging."

To communicate with a BCBSTX Customer Service Representative using Live Chat, you must be a registered user through [Blue Access for Members](#). This ensures that your information and privacy are protected. If you are not a registered user with Blue Access for Members, please refer to page 10, above, for instructions on how to become a registered user.

Once you have become a registered user with Blue Access for Members, you can communicate with BCBSTX Customer Service Representatives using Live Chat Monday through Friday 8 a.m. – 5 p.m. (CT). Live Chat is not available on Saturdays, Sundays or holidays.

Downloading PDFs for the Visually Impaired

Adobe Reader 7 has a feature for visually impaired persons that will read the PDF out loud. You can download the latest version of Adobe Reader by visiting www.adobe.com and click on the button "Get Adobe Reader". This program is free from Adobe and can also be linked from the HealthSelect website, www.bcbstx.com/hs.

Once you have downloaded [Adobe Reader 7](#), when opening a PDF, go to "View", "Read Out Loud", and select "Read This Page Only" or "Read To End of Document". The PDF will then be read out loud.

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 Six, page 87](#)).

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 in Section V, pages 61-66](#).

We have added a subsection in the back of this section ([page 40 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.

If you are a Grandfathered Retiree

As a "Grandfathered Retiree," (you retired and turned 65 prior to September 1, 1992) you are not required to purchase Medicare Part B. HealthSelect is your primary plan for Part B services and Medicare primary for Part A services. As your primary plan, HealthSelect pays 70% of the allowable amount for eligible services after you have met your calendar year HealthSelect deductible. See the [Benefits Summary which begins on page 30](#) of this section for more details regarding deductible, coinsurance and copayment amounts.

Return-to-work retirees

Retirees who return to active employment at a state agency or higher education institution will have the option to enroll as active employees. For more information on [return-to-work retirees, refer to Section Five, page 55](#).

If you cover any dependents who are under age 65

If you cover any dependents who are under age 65 that do not have Medicare, they will have traditional medical care with HealthSelect. If your covered dependent does not have coverage with any other insurance plan, HealthSelect will be their primary insurance. This means that for eligible services, HealthSelect will pay 70% of the allowable amount once the calendar year deductible has been satisfied. See the [Benefits Summary on page 30](#) of this section for more details regarding deductible, coinsurance and copayment amounts.

If you have a dependent that is under the age 65 who wishes to continue with in-area benefits, you can contact BCBSTX to make arrangements for the dependent to continue with in-area benefits. Once in-area coverage is established for your dependent, a new ID card will be issued for that dependent. This new ID card will provide in-area benefits information and a different group number. Your group number will continue to be 038000 and your in-area dependent will now have coverage under group number 038001.

Calendar year 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 on page 30](#) of this section 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 61-66 of this book for an explanation of coordination of benefits with Medicare](#).

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 on page 30](#) of this section for the out-of-pocket maximum amount. The following expenses do not count toward the out-of-pocket coinsurance maximum:

- Your deductible;
- Outpatient day-surgery and inpatient copayments;
- 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.

Inpatient copayments

For inpatient admissions, you are responsible for a \$100 copayment per day not to exceed \$500 per stay, plus applicable coinsurance. Inpatient hospital, inpatient behavioral health, and intermediate behavioral health care copayments all apply toward the \$1,500 per person calendar year inpatient copayment maximum. After your copayments have reached the copayment maximum of \$1,500, you will no longer be responsible for inpatient copayments for the remainder of that calendar year.

Once this inpatient copayment maximum has been met, you will no longer be required to pay the \$100 inpatient copayment for the remainder of that calendar year. The calendar year inpatient copayment maximum does **not** include any copayments paid for outpatient day-surgery or prescription drugs.

Outpatient day-surgery copayments

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

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.

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) or a physician of family practice or internal medicine, 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.
- Your medical condition or age may require regular preventive testing or services such as a mammography or bone density screening. HealthSelect allows coverage for medically necessary testing and services.

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 preauthorization 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 [preauthorization](#) for the child; and
- Arrange to have the child "admitted" to the hospital in his or her own name for treatment by a physician or other provider for the non-routine services.

If the mother is a covered participant, she will be responsible for inpatient copayments of \$100 per day, not to exceed \$500 per stay, in addition to any applicable coinsurance. If applicable, these copayments will be coordinated with Medicare and the mother may have an out-of-pocket expense. A separate inpatient copayment will not be charged for the baby unless the baby's stay exceeds the mother's or unless the mother is not a covered participant on the HealthSelect plan. Applicable coinsurance will be charged for the baby. See the [Benefits Summary on page 32](#) of this section for more details regarding deductibles, coinsurance and copayments.

***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 as a dependent to your coverage to continue to receive benefits. Newborn grandchildren are not covered automatically — if eligible, they must be added as a dependent to your coverage for benefits. Retirees should contact ERS for more information.**

Childhood immunizations for dependents

For children newborn through 6 years of age, the following immunizations are covered at 100%. However, if an office visit or other service is performed during the same visit, you will be responsible for applicable coinsurance and deductible amounts (see Section Six, [page 85 for definition of Office Visit](#)):

- Diphtheria;
- Haemophilus influenzae type B;
- Hepatitis B;
- Measles/Mumps;

- Pertussis (whooping cough);
- Polio;
- Rubella;
- Tetanus;
- Varicella (chicken pox); and
- Rotovirus.

Infertility services

As a HealthSelect participant you may be eligible for infertility services which may include, diagnostic laboratory and x-ray procedures, therapeutic injections and surgical treatment necessary for the diagnosis and treatment of involuntary infertility. Covered services **do not** include sterilization reversal, transsexual surgery, gender reassignment, artificial insemination and related services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures.

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 Six, [page 89 for the complete definition of Telemedicine](#).

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 Six, [pages 80-81 for specific definitions of these services](#).

Diabetes supplies are covered in the following manner:

Insulin and syringes are covered under your [prescription drug benefits \(see Section Four, page 43, for more information\)](#).

Other diabetes supplies (see Section Six, [page 80 for a complete definition](#)) are covered under your **medical benefits** as [Durable Medical Equipment \(DME\)](#), at 70% 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 Provider Finder “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 on page 34](#) of this section.

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, utilize 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 on page 34](#) of this section for more information. For a complete definition of [DME](#), see [Section Six, page 81](#).

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.**

Hearing aids

HealthSelect allows a \$500 maximum benefit for 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 on page 34](#) of this section for more information.

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

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 Six, page 77](#)).

If you have been admitted to the hospital

If you have been admitted to the hospital from the emergency room, and have exhausted your Medicare Part A benefits, you must call the [BCBSTX Preauthorization Department](#) within 48 hours of your admission to get your hospital stay preauthorized. If you cannot make the call yourself, have your doctor or a family member call for you. **If you do not get your stay preauthorized, you will have to pay an [additional penalty deductible](#).** [Preauthorization is described on page 24](#) of this section.

TIP: Call (800) 344-2354 for preauthorization.

Behavioral Health Services

HealthSelect covers services for the treatment of behavioral health (which includes mental health, serious mental illness and substance abuse). You are eligible for 30-outpatient visits per calendar year. There is a \$60 maximum benefit allowable for each outpatient visit and you can be responsible for any amounts over this maximum, in addition to any applicable coinsurance and deductible amounts. To limit your out-of-pocket expenses, it is recommended that you use ParPlan providers (see Section Five, [pages 68-69, for complete description of ParPlan](#)). ParPlan providers can only bill you the difference between the benefit maximum (\$60) and the [BCBSTX allowable amount](#).

If your diagnosis is a [serious mental illness as defined in Section Six, page 88](#) or [substance abuse as defined in Section Six, page 89](#), 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.

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 Six, [page 88 for a complete definition of RTC](#)). Care received at RTCs must be [preauthorized through INROADS Behavioral Health Services](#).

Inpatient treatment of [substance abuse](#) (chemical dependency) must be provided in a **Substance Abuse Facility** (see Section Six, [page 88 for a complete definition of a substance abuse facility](#)). All inpatient treatment of substance abuse (chemical dependency) must be preauthorized through INROADS Behavioral Health Services. For inpatient or intermediate care, you will be responsible for a copayment per day in addition to applicable coinsurance. Please see the [Benefits Summary on pages 35-36](#) of this section for more details regarding copayments and coinsurance.

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

Preauthorization

Preauthorization 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 preauthorization of certain medical services. Preauthorization 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;
- Inpatient behavioral health admissions;
- Intermediate care facilities;
- Hospice care; and
- Home infusion therapy. (Use of a provider contracted with BCBSTX or accessible through [BlueCard Worldwide](#) is required to receive any benefits).

Preauthorization 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 preauthorization 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 preauthorize

You are responsible for ensuring that your treatment has been preauthorized by BCBSTX. If you cannot make the call yourself, have your doctor or a family member call for you.

Preauthorization numbers to call:

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

TIP: Preauthorization saves you money.

If you do not preauthorize

If you are admitted to a hospital without preauthorization, 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 on this page without preauthorization, you must pay the full cost of the services. HealthSelect will pay nothing.**

| | |
|-------------------------|--|
| Preauthorization | Determines medical necessity for certain care and services including inpatient hospitalization, but is not a guarantee of payment |
| Predetermination | Determines whether services requested are eligible for benefits, prior to services being rendered, but is not a guarantee of payment |

Preauthorization of behavioral health services

You are responsible for obtaining preauthorization for certain behavioral health services. If the preauthorization 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 preauthorization:

- 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 preauthorization:

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

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 steps under HealthSelect for seeking review by an IRO.

Steps for seeking a review by an IRO

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

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

Reminder: The Independent Review Organization (IRO) process, is **NOT available for** [contract exclusions](#) (for example, [Experimental/Investigational](#) procedures).

BlueCard Worldwide®

This benefit is available to you when you travel or live outside of Texas or the United States. This program allows you and your covered dependents to receive the benefit of discounts that other Blue Cross and/or Blue Shield Plans have negotiated with participating providers of that state or country. Remember, in order for you to benefit from these discounts, the participating providers must file your claims for you.

For information on contracting providers and hospitals outside Texas or the United States,

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

How BlueCard Worldwide works

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

- File your claims; and
- Not bill you the difference between what they bill and their negotiated rate.

When you're traveling or living outside of Texas or the United States and require medical care, all you need to do is follow these easy steps:

- Step 1:** Remember to carry your most current HealthSelect ID Card.
- Step 2:** Call BlueCard Access at (800) 810-BLUE (2583) to identify participating providers and 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 provider or hospital in your location and present your ID card.
- Step 4:** If necessary, call Blue Cross and/or Blue Shield for preauthorization of inpatient admissions. Refer to your ID card for the phone number for preauthorization. It differs from the BlueCard Access number.
- Step 5:** Your provider or hospital will file your claims for you and you will be required to pay any applicable deductibles, copayments or coinsurance.

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.

Making the Most of Your Benefits

Steps to HealthSelect benefits

Step 1: Call any provider (see definition of [provider in Section Six, page 87](#)), preferably a BCBSTX ParPlan provider (see explanation of [ParPlan provider in Section Five, pages 68-69](#)).
Tell the provider that you have HealthSelect coverage.

TIP: Call (800) 942-5270 for a ParPlan Provider Directory or visit the HealthSelect Online Provider Directory at www.bcbstx.com/hs.

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: Preauthorize the treatment if necessary (see [page 24 of this section for a list of what services and procedures must be preauthorized](#)).

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.

Each state has a different Medicare carrier, and while some state Medicare carriers automatically file claims with BCBSTX, other states' carriers may require you to file the claim yourself or they require verification of your coverage directly from BCBSTX. If you need medical care in another state, save your explanation of Medicare benefits statements and contact that state's Medicare carrier and BCBSTX to ensure your claims are processed correctly.

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.

Benefits Summary

The following chart explains benefits when Medicare is your primary plan and services are covered by Medicare, if you are a Grandfathered Retiree, if your dependents are under 65 without Medicare coverage, and when services are not covered by Medicare. All benefits are paid based on the [BCBSTX allowable amount](#). Using [ParPlan providers](#) and, if you are eligible for Medicare, using providers who accept Medicare assignment will protect you from liability for amounts over the allowable.

| General Provisions | Retirees with Medicare Primary (Part A and B) when services are covered by Medicare | Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare |
|---|---|---|
| | <i>Calendar year deductible applies to charges except as noted.</i> | <i>Calendar year deductible applies to charges except as noted.</i> |
| Calendar year deductible | \$200 individual/\$600 family maximum (\$100 Medicare deductible counts toward this amount). | \$200 individual/\$600 family maximum |
| Calendar year out-of-pocket coinsurance maximum (does not include copayments) | \$1,000 per person | \$1,000 per person |
| Calendar year inpatient copayment maximum | \$1,500 per person | \$1,500 per person |
| Preauthorization penalty deductible | \$200 per hospital admission (if not preauthorized) | \$200 per hospital admission (if not preauthorized) |
| Responsibility for preauthorization | Participant | Participant |
| Lifetime maximum benefit | None | None |

Benefits Summary

The following chart explains benefits when Medicare is your primary plan and services are covered by Medicare, if you are a Grandfathered Retiree, if your dependents are under 65 without Medicare coverage, and when services are not covered by Medicare. All benefits are paid based on the [BCBSTX allowable amount](#). Using [ParPlan providers](#) and, if you are eligible for Medicare, using providers who accept Medicare assignment will protect you from liability for amounts over the allowable.

| Doctors' and Lab Services | Retirees with Medicare Primary (Part A and B) when services are covered by Medicare | Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare |
|--|--|--|
| Doctor office visits | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| 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 70%, you pay 30% Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% Plan pays 70%, you pay 30% |
| Doctors' and Lab Services | | |
| Diagnostic x-rays, mammography, injections, routine immunizations, pap smears, and lab tests | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Specific immunizations for children 0-6 years old (except when performed during an office visit) | Plan pays 100% | Plan pays 100% |
| Allergy injections and antigens | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Office surgery and procedures | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Inpatient doctor visits | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |

Benefits Summary

The following chart explains benefits when Medicare is your primary plan and services are covered by Medicare, if you are a Grandfathered Retiree, if your dependents are under 65 without Medicare coverage, and when services are not covered by Medicare. All benefits are paid based on the [BCBSTX allowable amount](#). Using [ParPlan providers](#) and, if you are eligible for Medicare, using providers who accept Medicare assignment will protect you from liability for amounts over the allowable.

| Doctors' and Lab Services | Retirees with Medicare Primary (Part A and B) when services are covered by Medicare | Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare |
|--|--|---|
| Outpatient surgery and anesthesia | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Routine eye exam (one per calendar year per participant) | Plan pays 70%, you pay 30% | Plan pays 70%, you pay 30% |
| Maternity care | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Hospital Services | | |
| *Inpatient hospital (semi-private room and board or intensive care unit) | Medicare pays 80%, HealthSelect will coordinate by paying the inpatient deductible, private room difference, and first three pints of blood, and you may be responsible for a copayment amount | <p>Grandfathered Retirees only– Medicare pays 80%, HealthSelect will coordinate by paying the inpatient deductible, private room difference, and first three pints of blood, and you may be responsible for a copayment amount</p> <p>All others – Plan pays 70%, you pay a \$100 copayment per day (\$500 maximum per stay) plus pay 30% (no deductible)</p> |
| Other inpatient charges, including surgery and anesthesia | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |

Benefits Summary

The following chart explains benefits when Medicare is your primary plan and services are covered by Medicare, if you are a Grandfathered Retiree, if your dependents are under 65 without Medicare coverage, and when services are not covered by Medicare. All benefits are paid based on the [BCBSTX allowable amount](#). Using [ParPlan providers](#) and, if you are eligible for Medicare, using providers who accept Medicare assignment will protect you from liability for amounts over the allowable.

| Hospital Services | Retirees with Medicare Primary (Part A and B) when services are covered by Medicare | Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare |
|--|--|--|
| Outpatient facilities, including treatment room and pre-admission testing | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Outpatient day-surgery | Medicare pays 80%, HealthSelect will coordinate paying secondary and you may be responsible for a copayment amount | Plan pays 70%, you pay a \$100 copayment, plus 30% |
| Emergency care | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Extended Care Services | | |
| *Skilled nursing care in a skilled nursing facility (does not include custodial care) | Medicare pays primary, HealthSelect will coordinate paying secondary up to maximum of 60 days or \$6,000 per calendar year | Plan pays 100%; 60 days up to \$6,000 calendar year maximum (no deductible) |
| *Hospice care | Medicare pays primary, HealthSelect will coordinate paying secondary up to \$18,000 lifetime maximum | Plan pays 70%, you pay 30%; \$18,000 lifetime maximum (no deductible) |
| *Home health care | Medicare pays primary, HealthSelect will coordinate paying secondary up to maximum of 100 visits or \$5,000 per calendar year | Plan pays 100%; 100 visits up to \$5,000 calendar year maximum (no deductible) |
| ***Private duty nursing | Medicare pays primary, HealthSelect will coordinate paying secondary up to maximums of \$8,000 per calendar year and \$40,000 lifetime maximum | Plan pays 70%, you pay 30% (even after out-of-pocket coinsurance maximum is met); \$8,000 calendar year maximum; \$40,000 lifetime maximum |

Benefits Summary

The following chart explains benefits when Medicare is your primary plan and services are covered by Medicare, if you are a Grandfathered Retiree, if your dependents are under 65 without Medicare coverage, and when services are not covered by Medicare. All benefits are paid based on the [BCBSTX allowable amount](#). Using [ParPlan providers](#) and, if you are eligible for Medicare, using providers who accept Medicare assignment will protect you from liability for amounts over the allowable.

| Other Medical Services | Retirees with Medicare Primary (Part A and B) when services are covered by Medicare | Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare |
|---|--|--|
| Hearing aids (repairs not covered) | Plan pays up to \$500 per ear every three years (no deductible)- | 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) | 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 | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Durable medical equipment (includes medically necessary purchase and/or rental) | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Prosthetic appliances (\$10,000 maximum per occurrence) | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Physical, occupational, speech therapy, and chiropractic care | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Ambulance services | Medicare pays 80%, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% plus charges above the allowable |

Benefits Summary

The following chart explains benefits when Medicare is your primary plan and services are covered by Medicare, if you are a Grandfathered Retiree, if your dependents are under 65 without Medicare coverage, and when services are not covered by Medicare. All benefits are paid based on the [BCBSTX allowable amount](#). Using [ParPlan providers](#) and, if you are eligible for Medicare, using providers who accept Medicare assignment will protect you from liability for amounts over the allowable.

| Other Medical Services | Retirees with Medicare Primary (Part A and B) when services are covered by Medicare | Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare |
|--|---|---|
| ***Home infusion therapy (HIT) | Medicare pays primary, HealthSelect will coordinate paying secondary. You must use a provider contracted with BCBSTX or accessible through BlueCard Worldwide to receive any coverage from HealthSelect | Plan pays 70%, you pay 30% if you use a provider contracted with BCBSTX or accessible through BlueCard Worldwide; Plan pays 0% and you pay 100% if you use a non-contracting provider |
| Infertility Services (see “Exclusion Q” on page 38 for excluded services) | Medicare pays primary, HealthSelect will coordinate paying secondary | Plan pays 70%, you pay 30% |
| Behavioral Health (Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness) | | |
| Outpatient visits (maximum 30 visits per calendar year) | Medicare pays primary, HealthSelect will coordinate paying secondary; maximum allowable amount \$60 per visit | Plan pays 70%, you pay 30% (even after coinsurance maximum is met); maximum allowable amount \$60 per visit |
| *Inpatient treatment (maximum 30 days per calendar year) Inpatient copayments apply toward the calendar year inpatient copayment maximum. | Medicare pays primary, HealthSelect will coordinate paying secondary and you may be responsible for a copayment amount | After you pay a \$100 copayment per day (\$500 maximum per stay), Plan pays 70% for the first 15 days and you pay 30%; The next 15 days the Plan pays 50%, you pay 50% |

Benefits Summary

The following chart explains benefits when Medicare is your primary plan and services are covered by Medicare, if you are a Grandfathered Retiree, if your dependents are under 65 without Medicare coverage, and when services are not covered by Medicare. All benefits are paid based on the [BCBSTX allowable amount](#). Using [ParPlan providers](#) and, if you are eligible for Medicare, using providers who accept Medicare assignment will protect you from liability for amounts over the allowable.

| Behavioral Health | Retirees with Medicare Primary (Part A and B) when services are covered by Medicare | Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare |
|---|---|--|
| (Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness) | | |
| **Intermediate care facility (maximum 60 days per calendar year) Intermediate care copayments apply toward the calendar year inpatient copayment maximum | Medicare pays primary, HealthSelect will coordinate paying secondary and you may be responsible for a copayment amount | After you pay a \$50 copayment per day (\$500 maximum per stay) , Plan pays 70% for the first 30 days and you pay 30%; The next 30 days the Plan pays 50%, you pay 50% |
| Prescription Drugs | | |
| Prescription Drug Plan Year Deductible | \$50 per person, per plan year (September 1 – August 31) | |
| At participating pharmacies | Up to a 30-day supply for non-maintenance drugs Copayments: \$10 for Tier 1 drugs, \$25 for Tier 2 drugs, \$40 for Tier 3 drugs **** Up to a 30-day supply for maintenance drugs Copayments: \$15 for Tier 1 drugs, \$35 for Tier 2 drugs, \$55 for Tier 3 drugs**** | |
| At non-participating pharmacies | Up to a 30-day supply 60% of the lesser of: the amount you pay for the prescription, minus your copayment OR the average wholesale price of the drug, plus the dispensing fee, minus your copayment; deductible will be subtracted if not met **** | |
| Mail order pharmacy | Up to a 90-day supply Copayments: \$30 for Tier 1 drugs, \$75 for Tier 2 drugs, \$120 for Tier 3 drugs **** | |

*[Preauthorization](#) required unless you have Medicare Part A benefits.

**Preauthorization 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.

*** Preauthorization required.

****If a brand name drug is dispensed that has a generic available, in addition to paying the generic

copayment, you are also responsible for the difference between the cost of the generic and the brand name drug.

Tier 1 – Primarily Generic drugs

Tier 2 – Mostly preferred brand name drugs

Tier 3 – Non-preferred brand name drugs and certain preferred brand name drugs

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 Six, beginning on page 75](#), for definitions of terms such as “Medically Necessary,” “Allowable Amount,” or “Covered Oral Surgery.”

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

Exclusions

HealthSelect does not cover expenses for:

- A. Services or supplies that BCBSTX determines are not [medically necessary](#).
- B. Occupational illness or injuries sustained at work, regardless of whether they are covered by Workers' Compensation or similar state or federal programs.
- C. Charges that would not be made if you did not have health insurance, or charges that you are not legally required to pay.
- D. Services or supplies provided by a facility or hospital that has not been approved by BCBSTX as a [facility](#) or [hospital](#) 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 Group Benefits Plan, 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 or gym memberships, even if the participant has medical conditions that might be helped by weight loss; or even if prescribed by a physician. Gastric Bypass and Vertical Banding will not be covered for any condition.

- 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 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 BCBSTX or accessible through [BlueCard Worldwide](#) 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 Group Benefits Program.
- U. Medical social services, bereavement counseling (except as part of a preauthorized 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, 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 [preauthorization](#) under HealthSelect, but were not preauthorized.
- 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, pages 57.](#)
- BB. Any occupational therapy services that 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 preauthorized by BCBSTX) or as may be provided by BCBSTX through [case management as described in Section Five, page 67.](#)
- 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, fax machine or Internet.
- 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.](#)

Q & A Quick Reference

1. **How many ID cards are issued to HealthSelect participants?**
One card is issued for individual coverage and if you cover any dependents, a separate card is issued for each covered dependent. To receive additional cards, call BCBSTX Customer Service.

2. **My [EOB](#) was sent to the wrong address. What should I do?**
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.

3. **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?**
Yes. However, the amounts that are applied toward your Medicare deductible are also applied toward your HealthSelect deductible.

4. **Does HealthSelect provide coverage for me and my covered dependents when we travel beyond Texas and outside the U.S.?**
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 [page 28 of this section 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.

5. **Does HealthSelect cover services that Medicare doesn't?**
Yes. Some services that are not covered by Medicare are covered by HealthSelect - for example, hearing aids. For more specific information, refer to the [Benefits Summary on pages 30-36](#) of this section, or contact BCBSTX Customer Service at (800) 252-8039.

6. **Is HealthSelect a Medicare supplemental policy?**
No, HealthSelect is not a Medicare supplement. It is a comprehensive medical plan which coordinates benefits with Medicare.

7. **If I have Medicare Part A, am I still required to preauthorize with BCBSTX?**
No, unless you are receiving private-duty nursing services, home infusion therapy, or your Medicare benefits have been exhausted. Please refer to [page 24 of this section for more details on BCBSTX preauthorization requirements](#).

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

