

Making Your Benefits Work For You

**Employees and Retirees Under Age 65
Effective September 1, 2008**



**BlueCross BlueShield
of Texas**

HealthSelect of Texas is administered by Blue Cross and Blue Shield of Texas

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

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

The HealthSelect Benefits Book is a summary of the Master Benefit Plan Document, statutes, and administrative rules governing HealthSelect of Texas (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 control. 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, 2008 through August 31, 2009 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 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 subscriber, divorce decree showing custodial responsibility, or a court order. This will ensure confidentiality of all patient information. An authorization form can be downloaded from the HealthSelect website at www.bcbstx.com/hs

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

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; and
- How to read your Explanation of Benefits.

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

Glossary of important terms

Included in this benefits book is a section which defines frequently used terms. You should read the Glossary of Important Terms, Section Seven, beginning on page 115 for definitions of terms such as “Medically Necessary,” “Allowable Amount,” and “Covered Oral Surgery.”

This book is for active employees, retirees under age 65, and their dependents. A copy of the HealthSelect benefits book for retired employees age 65 and over may be downloaded from the ERS website at www.ers.state.tx.us, the HealthSelect website at www.bcbstx.com/hs, or call BCBSTX Customer Service at (800) 252-8039 for additional information.

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

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

If you reside in Texas and have a covered dependent who does not reside in Texas, see Section III, page 16 for additional information.

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

Your HealthSelect Medical ID Card

Your HealthSelect Medical ID Card is very important. Always carry it with you. Do not throw away your current HealthSelect Medical ID Card unless you receive a new one. Your HealthSelect Medical ID Card does not expire as long as the information printed has not changed. Your Medical ID Cards will list important information such as your subscriber number, PCP, and other important 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 a Medical 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 Medical 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 an example of 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="282 1024 527 1079">Service Description</th> <th data-bbox="537 1024 673 1079">Service Date</th> <th data-bbox="833 1024 911 1079">Amount Billed</th> <th data-bbox="966 1024 1052 1079">Not Covered</th> <th data-bbox="1263 1024 1349 1079">Covered</th> </tr> </thead> <tbody> <tr> <td colspan="5" data-bbox="282 1079 1373 1205" style="height: 60px;"></td> </tr> <tr> <td colspan="5" data-bbox="282 1205 1373 1234">Totals</td> </tr> </tbody> </table>	Service Description	Service Date	Amount Billed	Not Covered	Covered						Totals								
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Totals																			
Claim Summary																			
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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

Caremark

(888) 886-8490
P.O. Box 659541
San Antonio, TX 78265-9541

Prescription Drug Reimbursement

Caremark RxClaim
P.O. Box 52136
Phoenix, AZ 85072-2136

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 655730
Dallas, TX 75265-5730
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

Caremark Mail Service Program

(800) 875-0867
P.O. Box 659541
San Antonio, TX 78265-9541

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Section Two

The HealthSelect website

The information found in this benefits book and much more is available on the HealthSelect website. You can search for network and ParPlan physicians and providers, review your benefits, email BCBSTX Customer Service, 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 **Caremark's web site** and search for contracting pharmacies and download the latest preferred drug list. You can access the HealthSelect website through the ERS website at www.ers.state.tx.us, or directly at www.bcbstx.com/hs.

Online Provider Directories 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 HealthSelect network and 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 physicians and providers 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. 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.

BlueCompare – Physician Comparison Tool

A physician comparison tool called BlueCompare, provides you information on how a physician or professional compares to their peers with regard to affordability and Evidence Based Medicine (EBM).

The affordability measure (less, average and more) tells you how a physician or professional manages the cost of care for similar medical conditions compared to their peers.

The EBM measure tells you if a physician or professional is doing the right things for various medical conditions compared to their peers. The EBM measure uses national standards and expert boards who develop and maintain the criteria.

Affordability and EBM measures are updated monthly in Provider Finder and are only available for physicians and professionals in the HealthSelect Network (does not include ParPlan). BlueCompare results are available when conducting searches in Provider Finder, but are not available through the regional directories. Measures are not provided for hospitals and ancillary (e.g., Durable Medical Equipment Facility) providers. To compare hospitals, log in to Blue Access for Members and use the Hospital Comparison Tool.

Note: Hospital-based providers are radiologists, pathologists, anesthesiologists, neo-natologists and emergency room physicians who practice only in a hospital setting. These providers are not measured for affordability and EBM; therefore, when conducting a search for these type of providers, the affordability measure will be blank and a grey EBM ribbon will display in Provider Finder.

Hospital Comparison Tool

When your physician has recommended a surgical treatment, you can easily find and review the outcome history of procedures previously performed at hospitals using the Hospital Comparison tool found in Blue Access for Members. This tool compares how hospitals compare to one another based on particular performance factors that include:

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

To use the Hospital Comparison Tool, log in to Blue Access for Members and click on My Health and select “Compare Hospitals.”

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 Medical ID Card or print a temporary Medical ID Card
- Email BCBSTX Customer Service
- Review your year-to-date out-of-pocket maximum
- 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 Medical ID Card). Go to **www.bcbstx.com/hs**
2. Log in to Blue Access for Members
3. 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

As a HealthSelect participant if you have registered with Blue Access for Members, you have access to the Personal Health Manager, an online resource and information tool that helps you manage the health of you and your family. The Personal Health Manager gives you the capability to:

- Set up a personal health record to keep track of and manage your family's health – within one secure location. With your permission, health care providers, family members and Blue Care Advisors can access your records to facilitate care.
- Ask questions through *Ask a Nurse*, *Ask a Trainer*, *Ask a Dietician* and *Ask a Life Coach* and receive responses from experts.
- Access online content such as health and medication information, wellness tracking tools, videos and interactive tutorials.
- Receive wellness and condition-specific information via secured messaging to help you manage your health. Receive alerts for screening tests and set up reminders for medical appointments and medication refills.
- Access to online resources where you can complete the Health Risk Assessment, research symptoms, investigate treatment options or prescription drugs and their side effects, learn about nutritious meal planning and more.

Health Risk Assessment

While you are in the Personal Health Manager, complete the Health Risk Assessment, which takes approximately 10 to 15 minutes. You can complete the assessment several times throughout the year to track your progress and receive an individualized report that will provide you guidance and suggestions on the next steps to improving your health.

If you have completed an assessment prior to January 1, 2007, log in to Blue Access for Members and complete a new assessment so you can begin tracking your progress.

Please be assured your information is kept confidential and will not be released to your employer or outside entities without your authorization.

To complete a Health Risk Assessment simply:

- Go to the HealthSelect Web site at www.bcbstx.com/hs and log in to Blue Access for Members.
- Once logged in to Blue Access for Members, click on the “Personal Health Manager” logo.
- In the center of the Personal Health Manager, you’ll see a section called “Know Your Risk.” Within that section click on the link to complete the Health Risk Assessment.

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 11 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.

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

Section Three

Guide to In-Area Benefits

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

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

General Information About In-Area Coverage

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

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

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

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

If you have covered dependents who do not live in Texas

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

- Does not live with you; and
- Does not live in Texas,

then...

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

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

Once out-of-area coverage is established for your dependent, a new Medical ID Card will be issued for that dependent. This new Medical ID Card will provide out-of-area benefit information and a different group number. Your group number will continue to be 038000 and your out-of-area dependent will now have coverage under group number 038001.

Please note: Section Four, which begins on page 62, describes out-of-area benefits.

Network and Non-Network Benefits

Freedom of choice

HealthSelect covers a wide range of medical services and supplies. The amount HealthSelect will pay depends on whether you receive your medical care inside or outside the network. In general, you pay less when you use in-network providers.

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

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

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

The network saves you money

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

Your share of the cost

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

	Network	Non-Network*
Office Visit with your designated PCP (routine immunizations, injections, lab work and x-rays, done at the same time in physician's office are covered under copayment)	You pay a \$20 PCP copayment per visit	You pay 40% after deductible
Specialty Office Visit (visit with a physician other than your designated PCP)	You pay a \$30 specialty copayment per visit	You pay 40% after deductible
Coinsurance for most other services	You pay 20% up to coinsurance maximum	You pay 40% after deductible
Calendar year coinsurance maximum	\$1,000 per person per calendar year **	\$3,000 per person per calendar year **
Inpatient Medical Care **	You pay a \$100 copayment per day (\$500 max per admission) plus 20%, up to coinsurance maximum	You pay a \$100 copayment per day (\$500 max per admission) plus 40%, up to coinsurance maximum
Calendar year inpatient copayment maximum (includes inpatient copayments paid for both network and non-network benefits)	\$1,500 per person	\$1,500 per person
Hospital outpatient day-surgery	You pay a \$100 copayment plus 20%, up to coinsurance maximum	You pay a \$100 copayment plus 40%, up to coinsurance maximum
Calendar year deductible	None	\$500 per person \$1,500 per family

* Benefits are paid on the BCBSTX allowable amount.

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

TIP: If you use non-network providers, you may be responsible for charges above the allowable amount. Using ParPlan providers may limit your liability for amounts over the allowable. See Section Six, pages 108-110 for more details about BCBSTX ParPlan providers.

Allowable Amounts

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

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

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

Your Primary Care Physician

Selecting your PCP

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

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

- If you have completed a GBP Supplemental Information Form or called in your selection to BCBSTX during the grace period and then decide to change your PCP within the 60-day grace period, you must contact BCBSTX to inform them of your change in order to receive network benefits.

TIP: For information on PCPs and specialists in your area (or anywhere in Texas), visit the Provider Finder[®] found on the HealthSelect website at www.bcbstx.com/hs.

Changing your PCP

Select your PCP with care. If you or any of your covered dependents want to change PCPs after you enroll, you may do so by calling BCBSTX Customer Service at (800) 252-8039. A representative can give you the names of several PCPs in your area and take your selection by phone. You can also search for a PCP on the HealthSelect Online Provider Directory, www.bcbstx.com/hs.

TIP: It is important to establish a relationship with your PCP. Maintaining this relationship with your PCP will prevent delays when you need referrals to a specialty care provider.

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

If your PCP leaves the network

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

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

Your PCP manages your health care

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

**TIP: Your PCP may not issue a referral for behavioral health services.
See Behavioral Health Care, on page 30 of this section for more information.**

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

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

Please Note:

- An informal referral or recommendation from a physician to a specialist that has not been approved by BCBSTX, even if it is in writing will not be sufficient in order to receive network benefits.
- You do not need to wait for the referral letter to visit the network specialist.
- Simply confirm with your PCP that the referral has been approved by BCBSTX, schedule the appointment and go directly to the network specialist.
- **It is your responsibility to inform your PCP or specialist when a referral is about to expire. Your provider may then contact BCBSTX for an extension.**

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

- **Obtaining a referral does not guarantee payment. All plan limitations and exclusions still apply.**
- Charges for treatment received beyond the length of the referral period will be reimbursed at the non-network level.
- If you see a specialist (even if the specialist is in the network) without your PCP's referral, you will receive **non-network benefits**.

- At the time of the visit, you will pay a \$30 specialist office visit copayment and any applicable coinsurance amount.
- If a referral is approved by BCBSTX to a non-contracting provider (non-network and non-ParPlan), you will receive network benefits based on the **billed amount**.

Note: When you are receiving treatment through a network hospital, laboratory or other ancillary provider, what determines network benefits is who is directing your care. As long as your PCP, network OB/GYN, or specialist with a valid referral is directing your care to a network facility, you will receive network benefits. If you are not being directed by your PCP, network OB/GYN, or specialist with a valid referral, you will receive non-network benefits.

IMPORTANT!!!!

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

Direct access to obstetricians and gynecologists

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

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

Referrals for routine eye exams

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

For additional visits, or if your network provider discovers a condition requiring additional treatment, **you must have a referral from your PCP in order to receive network benefits. If you do not have a referral from your PCP, you will receive non-network benefits.**

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

TIP: You can search for network providers through the HealthSelect Online Provider Directory at www.bcbstx.com/hs.

Emphasis on preventive care

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

- Participants 18 years of age and older may receive one routine physical exam each calendar year;
- For children under age 18, HealthSelect covers more frequent visits when using the network;
- Women may receive one annual well-woman exam by a gynecologist, or a physician of family practice or internal medicine, if those services are not performed during their routine physical exam;
- Each participant may receive one routine eye exam per calendar year;
- Men age 50 and over are eligible for coverage for an annual diagnostic medical examination for prostate cancer. Men age 40 and over with a family history of prostate cancer are also eligible for this exam.
- 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. For network benefits your PCP, network OB/GYN or Specialist with a valid referral must direct your care and all care must be received at a network facility. If you receive these services at a non-contracting (non-network and non-ParPlan) facility, you will receive non-network benefits and you may be responsible for charges above the BCBSTX Allowable Amount.

Maternity and Newborn Care

Female participants are eligible for coverage for maternity care. The participant will receive network benefits when maternity care is received from a network OB/GYN or the designated PCP. Maternity care includes charges billed by the physician for pre and post natal care. See Section Seven, page 125 for a complete definition of maternity care. If maternity care is received from the designated PCP, the participant will be responsible for a one-time copayment of \$20 for physician services only. If the maternity care is with a network OB/GYN specialist, the patient will be responsible for a one-time copayment of \$30 for physician services only. Applicable copayments and coinsurance will apply for hospital charges (i.e., delivery) and other charges. See the Benefits Summary on page 38 of this section for coinsurance and copayment information for hospital charges.

TIP: Maternity care is also available for eligible dependent children.

Your child may go directly to a network OB/GYN for her care and receive network benefits.

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

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

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

Should the newborn remain hospitalized after the mother is released, in order to ensure that the correct benefit level is paid and 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.

As part of your coverage you can enroll in Special Beginnings[®], a Blue Care[®] Connection program for expecting mothers, which will provide you education and support throughout your pregnancy. See Section VI, page 108 for more information on Special Beginnings.

*** TIP: HealthSelect allows benefits automatically for the first 31 days for a newborn natural child if the mother or the father is either the subscriber or subscriber's spouse. A newborn must be enrolled within 30 days of birth in order for benefits to continue after the first 31 days. Newborn grandchildren are not covered automatically – if eligible, they must be added as dependents for benefits. Active employees should contact their benefits coordinator for more information. Retirees should contact ERS.**

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

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 copayments, coinsurance and if you are using a non-network provider, the annual deductible may also apply. (see Section Seven, page 126 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 Seven, page 131 for the complete definition of Telemedicine.

Durable medical equipment

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

If your PCP or specialist with a valid referral prescribes DME, utilize a network DME supplier to receive network benefits. A separate referral to the DME supplier is not required. Visit www.bcbstx.com/hs or call BCBSTX Customer Service for a list of network DME providers.

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

Please note: *Equipment designed for alleviation of pain or provision of patient comfort (i.e., motorized lift, air fluidized mattress, blood pressure cuff, cold therapy devices), 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, pages 120-121, for specific definitions of these services. Diabetes Supplies are covered in the following manner:

Insulin and syringes are covered under your prescription drug benefits (see Section Five, page 85, for information on your prescription drug benefits).

Other diabetes supplies (see Section Seven, page 120, for a complete definition) are covered under your medical benefits as Durable Medical Equipment (DME), at 80% of the BCBSTX allowable amount. However, if you use a non-contracting supplier and the charge is greater than the allowable amount, ***you will be responsible for the difference.***

If you use a DME provider who does not contract with BCBSTX, you will be required to file your claim and may be billed for amounts above the allowable. To file a claim for diabetes supplies, attach your cash register receipt, showing quantity of each item purchased, to a completed medical claim form (keeping copies for your records). Mail to BCBSTX at P.O. Box 660044, Dallas, TX 75266-0044.

If you use a DME provider who contracts with BCBSTX, you will not be required to file your claim and will not be responsible for any charges above the allowable amount. You can search for contracting DME providers through Provider Finder, **www.bcbstx.com/hs**. When conducting a customized search, DME providers are found under “Ancillary Providers.” You can also use ParPlan (see Section Seven, page 127, for a complete definition) DME providers for your diabetic supplies. To obtain names of ParPlan Providers in your area, contact Customer Service at (800) 252-8039. Once locating a DME provider, you will need to contact that provider to determine if the provider carries your supplies.

Hearing aids

HealthSelect allows a \$500 maximum benefit per hearing loss (per ear) every 36 months for hearing aids, fittings, and molds – but not repairs. If you use a network provider, the provider’s total payment is based on the BCBSTX allowable amount. BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between that benefit and the contracted BCBSTX allowable amount. If you use a non-network provider, BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between the benefit and the provider’s billed charges. In addition, hearing aid batteries are covered and are not subject to the \$500/three year limitation. Please refer to the Benefits Summary on page 38 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.

Retail Health Clinics

A Retail Health Clinic is a health care clinic located in a retail setting, such as a supermarket or pharmacy, and provides treatment of common illnesses and routine preventive health care services that can be rendered by appropriately licensed staff located in the clinic, which may include Advanced Practice Nurses, Physician Assistants, and/or Physicians.

You and your covered dependents can seek medically necessary care at a network Retail Health Clinic without a referral from your designated Primary Care Physician (PCP). You will be responsible for a \$20 Retail Health Clinic office visit copayment. If you or a covered dependent receive services or supplies at the Retail Health Clinic, but no office visit, you will be responsible for network coinsurance (20%).

If you or a covered dependent seek care at a non-network Retail Health Clinic, you will receive non-network benefits and will be responsible for the non-network deductible (\$500) and applicable non-network coinsurance (40%).

For a list of network Retail Health Clinics, visit the Online Provider Directory and search for Retail Health Clinics.

In Case of Emergency

Definition of emergency

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

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

Getting emergency care

When you or a covered dependent has an emergency, appropriate medical treatment should be obtained immediately. The How to Access Benefits chart on page 55 of this section provides the steps you should follow in receiving emergency care.

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

If you are treated by a non-contracting provider during the first 48 hours of your emergency, benefits will be paid at the network level based on the BILLED amount. (Effective April 1, 2008, ambulance services are paid on the billed amount if you receive care from a non-contracting ambulance provider.) Ambulance service is described on page 30 of this section. You will not be financially responsible for any charges that are above the allowable amount. **If treatment is received after the first 48 hours of an emergency without a referral from your PCP, you will receive non-network benefits based on the ALLOWABLE amount.** *This means you will pay 40% of the allowed amount plus the calendar year deductible if not already satisfied, and the difference between the provider's billed charges and the BCBSTX allowed amount.*

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

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

Emergency care received outside of Texas and the United States

For emergency care received outside of Texas or the United States, you will receive network benefits for the first 48 hours. For care received after the first 48 hours of the emergency, an out-of-plan referral may be requested to continue to receive network benefits. Your PCP may request this referral. For non-emergency care, benefits are paid at the non-network benefit level on the allowable amount. By using contracting providers, you will not be required to file claims and cannot be held responsible for charges above the allowable amount. See BlueCard Worldwide for information about contracting providers outside of Texas and the United States Section Six, pages 111-112.

Ambulance services (effective April 1, 2008)

HealthSelect pays benefits for Ambulance Services received at the time of an emergency and when determined to be medically necessary by BCBSTX. 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 117).

If you receive services from an ambulance provider who is not contracted (non-network and non-ParPlan) with BCBSTX, benefits will be paid on the billed amount. This means that you will not be responsible for charges above the BCBSTX allowable amount.

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

If you have been admitted to the hospital

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

If your PCP is not managing your care, you will be responsible for contacting the BCBSTX Preauthorization Department within 48 hours of your admission to get your hospital stay preauthorized. If you cannot make the call yourself, have a family member call for you. **If you do not preauthorize your stay, you will have to pay an additional penalty deductible.** Preauthorization is described on page 33 of this section.

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

- Calendar year deductible, if not previously satisfied;
- Preauthorization penalty deductible, if you did not preauthorize;
- Services and supplies that are not medically necessary;
- Your coinsurance and inpatient copayments as shown on the in-area Benefits Summary (page 38 of this section); and
- Any difference between the provider’s billed amount and the BCBSTX allowable amount, if you do not use a network or ParPlan provider.

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

Behavioral Health Care

Referrals for behavioral health services

There are separate guidelines for network treatment of behavioral health (which includes mental health, serious mental illness and substance abuse) INROADS® Behavioral Health Services can work with you directly to obtain a referral. **Your PCP is not utilized in this process.** INROADS Behavioral Health Services will refer you to a network counselor, psychologist, psychiatrist, or treatment center, and will send you a referral stating the approved time span and approved number of visits. (Please refer to definition of “Network Behavioral Health Service Provider” in Section Seven, page 125.)

Your out-of-pocket cost may vary, depending on your choice of providers, your diagnosis, and the type of treatment. If you have a referral to a **network** provider for outpatient treatment and your diagnosis is not a serious mental illness (as defined by Texas law and found in Section Seven, page 130 of this benefits book), you will be responsible for a per-visit coinsurance, subject to the outpatient visit limit.

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

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

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

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

INROADS® Behavioral Health Services telephone numbers:

In Dallas (972) 766-5201

Outside Dallas (800) 528-7264

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

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

Residential Treatment Centers and Substance Abuse Facilities

A **Residential Treatment Center (RTC)** provides treatment to children and adolescents for behavioral health problems. In order for benefits to be available, the facility must be licensed by the appropriate licensing body (see definition in Section Seven, page 130). 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 definition in Section Seven, page 131). All inpatient treatment of **Substance** abuse (chemical dependency) must be preauthorized through INROADS Behavioral Health Services.

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

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

INROADS® Behavioral Health Services telephone numbers:

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

Preauthorization

Preauthorization of certain services

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

- Inpatient hospital admissions;
- Skilled nursing care in a skilled nursing facility;
- Private-duty nursing;
- Home health care;
- Hospice care; and
- Home infusion therapy (use of a provider contracted with BCBSTX or accessible through BlueCard Worldwide is required to receive *any* benefits).

Care for behavioral health must be preauthorized through a separate process, described on page 34 of this section.

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

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

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

How to preauthorize

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

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

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

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

Preauthorization numbers to call:

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

Preauthorization of behavioral health services

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

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

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

Predetermination of benefits

As participants in HealthSelect, you and your covered dependents are entitled to a review by the BCBSTX Medical Division to determine the medical necessity of any proposed medical procedure. This process is called a **predetermination of benefits**. It will inform you in advance if BCBSTX considers the service to be medically necessary, and therefore eligible for benefits. See Section Seven, page 125 for definition of Medically Necessary.

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

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

Review 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.

Step 6: The IRO will notify you and BCBSTX of its decision.

You may also appeal a denied claim after charges have been incurred by following the normal appeal procedures under HealthSelect as described on pages 112 – 114.

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 network benefits

Step 1: Call your PCP for an appointment (unless you need care for behavioral health, as described on page 31 of this section).

Tell your PCP that you have HealthSelect coverage.

Step 2: See your PCP. You will be responsible for the \$20 PCP office visit copayment and any applicable coinsurance.

Show your HealthSelect Medical ID Card.

Your PCP will treat you, or will obtain approval from BCBSTX if a referral to a network specialist is appropriate. If you see a network specialist, you will be responsible for the \$30 specialty office visit copayment and any applicable coinsurance.

If your PCP refers you to a non-network provider, and it is approved by BCBSTX, you will still receive network benefits. **You will be referred to a non-network provider only if there are no network providers available within the network's mileage radii requirements who can treat you.**

If you need to be admitted to a hospital, your PCP will arrange your admission to a network facility.

Step 3: You will receive an EOB from BCBSTX. (See Section One, page 6 for a description of the EOB.)

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

Steps to non-network benefits

Step 1: Call any provider (see definition of provider in Section Seven, pages 128-129),

preferably a BCBSTX ParPlan provider. (See explanation of ParPlan Provider in Section Six, pages 108-110).

Tell the provider you have HealthSelect coverage.

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- Step 2:** See the provider. You will be responsible for 40% of the allowed amount, and may be responsible for amounts above the allowable that the provider charges.
Show your HealthSelect Medical 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 33 of this section for a list of services and procedures requiring preauthorization).
- Step 4:** If you use a non-ParPlan provider, you may have to file a claim form. (See Section Six, page 110 for instructions.)
- Step 5:** You will receive an EOB from BCBSTX.

If you receive services outside of Texas or the United States, see Section VI, pages 110-112 for more information on how to file your claims and BlueCard Worldwide.

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

In-Area Benefits Summary

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

General Provisions	Network	Non-Network
		<i>Calendar year deductible applies to charges except as noted.</i>
Calendar year deductible	None	\$500 individual
Calendar year out-of-pocket coinsurance maximum (does not include copayments)	\$1,000 per person (includes network and non-network coinsurance)	\$3,000 per person (does not include network coinsurance)
Calendar year inpatient copayment maximum (does not include office visit or outpatient day-surgery copayments)	\$1,500 per person (includes both network and non-network inpatient copayments)	\$1,500 per person (includes both network and non-network inpatient copayments)
Preauthorization penalty deductible	None	\$200 per hospital admission (if not preauthorized)
Responsibility for preauthorization	Provider	Participant
Lifetime maximum benefit	None	\$1,000,000
Doctors' and Lab Services		
PCP office visits (includes immunizations, injections, diagnostic x-rays and lab tests)	\$20 copayment per visit	Plan pays 60%, you pay 40%
Specialist office visits (includes immunizations, injections, diagnostic x-rays and lab tests)	\$30 copayment per visit	Plan pays 60%, you pay 40%
Retail Health Clinic	\$20 copayment per office visit. If no office visit, then 20% coinsurance.	Plan pays 60%, you pay 40%

In-Area Benefits Summary

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

Doctors' and Lab Services	Network	Non-Network
Physicals	\$20 copayment with designated PCP or \$30 copayment with a Specialists (one per calendar year for adults, periodic for children, and women are allowed one routine well-woman office visit to an OB/GYN each calendar year)	Plan pays 60%, you pay 40% (one per calendar year for adults and children, and women are also allowed one well-woman office visit to an OB/GYN each calendar year)
Diagnostic x-rays, mammography, routine immunizations and lab tests (except when performed during an office visit)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Immunizations for children 0-6 years old (except when performed during an office visit)	Plan pays 100%	Plan pays 100%
Allergy injections and antigens (when no office visit is billed)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Office surgery and procedures	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Inpatient doctor visits	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Outpatient surgery and anesthesia (physician charges)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Routine eye exam (1 per calendar year per participant)	\$30 Specialist copayment	Plan pays 60%, you pay 40%
Maternity care (doctor charges only; see Hospital Services for inpatient charges)	If care is with designated PCP; \$20 for the first office visit, then Plan pays 100% for maternity care If care is with Specialist; \$30 for the first office visit, then Plan pays 100% for maternity care	Plan pays 60%, you pay 40%

In-Area Benefits Summary

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

Hospital Services	Network	Non-Network
*Inpatient hospital (semi-private room and board or intensive care unit)	After a \$100 copayment per day (\$500 max per stay), Plan pays 80%, you pay 20%	After a \$100 copayment per day (\$500 max per stay), Plan pays 60%, you pay 40%
Other inpatient charges, including surgery and anesthesia	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Outpatient facilities, including treatment room and/or pre-admission testing	Plan pays 80% , you pay 20%	Plan pays 60%, you pay 40%
Outpatient day-surgery	After a \$100 copayment, Plan pays 80%, you pay 20%	After \$100 copayment, Plan pays 60%, you pay 40%
Emergency care	After a \$100 copayment (waived if you are admitted - hospital stay of at least 24 hours; however inpatient hospital copayment will apply), Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Extended Care Services		
*Skilled nursing care in a skilled nursing facility (does not include custodial care)	Plan pays 80%, you pay 20% (60 day maximum per calendar year)	Plan pays 60%, you pay 40% (60 days/ \$4,200 maximum per calendar year)
*Hospice care	Plan pays 80%, you pay 20% (\$18,000 lifetime maximum)	Plan pays 60%, you pay 40% (\$18,000 lifetime maximum)
*Home health care	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% (100 visits up to \$3,500 calendar year maximum)
*Private duty nursing	Plan pays 80%, you pay 20% (even after out-of-pocket coinsurance is met)	Plan pays 60%, you pay 40% (even after out-of-pocket coinsurance maximum is met); \$7,000 calendar year maximum, \$35,000 lifetime maximum

In-Area Benefits Summary

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

Other Medical Services	Network	Non-Network
Hearing aids (repairs not covered)	Plan pays 100% (up to \$500 per ear every three years)	Plan pays 100% (no deductible – up to \$500 per ear every three years)
Hearing aid batteries	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for the use in your hearing aid (not subject to the \$500/three year limitation)	
Diabetes supplies, other than insulin and syringes	Plan pays 80%, you pay 20%	Plan pays 80%, you pay 20%
Durable medical equipment (includes medically necessary purchase and/or rental)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Prosthetic appliances (See definition on page 130 for additional information.)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Physical, occupational, speech therapy, and chiropractic care	Plan pays 80%, you pay 20% if no office visit, with office visit \$30 copayment plus 20%	Plan pays 60%, you pay 40%
Ambulance services	Plan pays 80%, you pay 20%	
*Home infusion therapy (HIT)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% 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 43 for excluded services)	<p>If care is with designated PCP; \$20 for office visits. For other medical services, Plan pays 80%, you pay 20%</p> <p>If care is with Specialist; \$30 for office visits. For other medical services, Plan pays 80%, you pay 20%.</p>	Plan pays 60%, you pay 40%

In-Area Benefits Summary

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

Behavioral Health (Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)		
	Network	Non-Network
Outpatient visits (maximum 30 visits per calendar year)	Plan pays 80%, you pay 20% (even after out-of-pocket coinsurance is met)	Plan pays 60%, you pay 40% (even after out-of-pocket coinsurance maximum is met); maximum allowable amount \$60 per visit
*Inpatient treatment (maximum 30 days per calendar year) Inpatient copayments apply toward calendar year inpatient copayment maximum of \$1,500 per person.	After \$100 copayment per day (\$500 max per stay), Plan pays 80% for the first 15 days, you pay 20%. The next 15 days, Plan pays 60%, you pay 40%	After \$100 copayment per day (\$500 max per stay), Plan pays 60% for the first 15 days, you pay 40%. The next 15 days, Plan pays 50%, you pay 50%
**Intermediate care facility (maximum 60 days per calendar year) Intermediate copayments apply toward the calendar year inpatient copayment maximum of \$1,500 per person.	After \$50 copayment per day (\$500 max per stay), Plan pays 80% for the first 30 days, you pay 20%. The next 30 days, Plan pays 60%, you pay 40%	After \$50 copayment per day (\$500 max per stay), Plan pays 60%, for the first 30 days, you pay 40%. The next 30 days, Plan pays 50%, you pay 50%

In-Area Benefits Summary

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

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	90-day supply Copayments: \$30 for Tier 1 drugs, \$75 for Tier 2 drugs, \$120 for Tier 3 drugs ***

*Preauthorization required

**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.

***If a brand name drug that has a generic available is dispensed, in addition to paying the generic copayment, you are also responsible for the difference in the cost between 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 Seven, beginning on page 115 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 illnesses 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.
- 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 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. Any services or supplies provided to any participant for treatment of obesity or for weight reduction, weight reduction programs, gym memberships, and surgeries, even if the participant has medical conditions which might be helped by a reduction of obesity or weight and even if prescribed by a physician. Gastric Bypass and Vertical Banding are not covered for any conditions. This exclusion does not apply to disease management or wellness programs provided through Blue Care Connection.
- Q. Sterilization reversal, transsexual surgery, gender reassignment, artificial insemination and related services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures.
- R. Abortion, unless the participant's life would be endangered by continuing the pregnancy, or there is a diagnosed fetal anomaly, or unless the pregnancy is caused by a criminal act such as rape or incest.
- S. Home infusion therapy treatment provided by an entity that does not contract with 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; and the purchase of organ or tissue. (Revised Effective January 1, 2008)

- 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, cold therapy devices, 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 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, described in this book.
- AA. Any services or supplies for acupuncture.
- BB. Any services or supplies provided before the participant's effective date or after the expiration date of coverage except as provided through extension of benefits as described in Section Six, page 100.
- 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 preauthorized by BCBSTX) or as may be provided by BCBSTX through case management as described in Section Six, page 106.
- FF. Difference between the charge for a hospital private room and semiprivate room, except when coordinating secondary benefits with Medicare Part A.

- GG. Any services or supplies for which benefits are not provided under HealthSelect, unless through case management or ERS-approved pilot projects.
- HH. Services or supplies provided by a person or entity who is not a provider, as defined by HealthSelect.
- II. Any services and/or physical examinations requested or required by a third party, including but not limited to school admissions, insurance, employment, or licensure examination purposes.
- JJ. Telemedicine services provided by telephone, fax machine or Internet.
- KK. Services, supplies and related expenses that BCBSTX determines to be experimental and/or investigational.
- LL. Services and supplies provided by an immediate family member.

Out-of-pocket coinsurance maximum (network)

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

Outpatient Day-Surgery Copayment (network and non-network)

For outpatient day-surgeries, you will be responsible for a \$100 copayment plus applicable coinsurance and if you are using non-network benefits, the annual deductible may also apply. 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.

Inpatient copayment maximum (network and non-network)

The calendar year inpatient copayment maximum is \$1,500 per person and includes inpatient copayments paid for both network and non-network inpatient stays. Inpatient behavioral health and intermediate behavioral health care copayments also apply toward the \$1,500 calendar year inpatient copayment maximum. This means that after your copayments have reached the copayment

maximum of \$1,500, you will no longer be responsible for inpatient copayments for the remainder of that calendar year. The calendar year inpatient copayment maximum does **not** include any copayments paid for office visits, emergency room treatment, outpatient day-surgery or prescription drugs.

Calendar year deductible (non-network)

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

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

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

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

There is a \$3,000 out-of-pocket coinsurance maximum for non-network benefits per person, **per calendar year**. This means that after your coinsurance share of covered services and supplies reaches the out-of-pocket maximum in a calendar year, HealthSelect will generally pay 100% of covered services and supplies for the rest of that calendar year. The following expenses do not count toward the out-of-pocket coinsurance maximum:

- Your deductible
- Any amount over the allowable amount
- Charges for services and supplies that are not covered or that are limited under HealthSelect
- Room charges for a hospital stay that was not preauthorized
- Any network coinsurance or copayment amounts
- Any outpatient day-surgery or inpatient copayment amounts
- Any prescription drug copayments

Services that are never covered at 100%

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

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

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

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

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

When you need:	Network benefits	Non-network benefits, when using a non-contracting provider:	Non-network benefits, when using a ParPlan Provider.
Office visit to your Primary Care Physician (PCP)	<ul style="list-style-type: none"> • Select a HealthSelect network PCP • Make an appointment with your PCP • You will pay a \$20 copayment for the office visit and other routine services provided during the visit (excluding surgery) 	<ul style="list-style-type: none"> • Make an appointment with any valid provider, (see Section Seven, pages 128-129, for definition) • You will pay 40% of allowable charges, after you meet your annual deductible and be responsible for any amounts above the allowable amount. • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Make an appointment with any ParPlan provider • You will pay 40% of allowable charges, after you meet your annual deductible • You are not responsible for amounts above the allowable.
Office visit to a Specialist (other than a behavioral health provider)	<ul style="list-style-type: none"> • Obtain a referral from your PCP • Confirm a referral has been approved by BCBSTX • Make an appointment with your specialist • You will pay a \$30 copayment for the office visit and other routine services provided during the visit (excluding surgery) 	<ul style="list-style-type: none"> • Make an appointment with any valid provider, (see Section Seven, pages 128-129, for definition) • You will pay 40% of the allowable amount, after you meet your deductible and be responsible for any amounts above the allowable amount. • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Make an appointment with any ParPlan provider • You will pay 40% of allowable charges, after you meet your annual deductible • You are not responsible for amounts above the allowable.

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

When you need:	Network benefits	Non-network benefits, when using a non-contracting provider :	Non-network benefits, when using a ParPlan Provider.
Retail Health Clinic	<ul style="list-style-type: none"> • No referral from your PCP is required • Seek care at any network Retail Health Clinic. • You will pay a \$20 Retail Health Clinic office visit copayment. • If no office visit, you will pay 20% network coinsurance. 	<ul style="list-style-type: none"> • Seek care at any valid provider (see Section Seven, pages 128-129, for definition). • You will pay 40% of the allowed amount, after you meet your deductible and be responsible for any amounts above the allowable amount. • File your claim with BCBSTX. 	<ul style="list-style-type: none"> • Seek care with any ParPlan Provider. • You will pay 40% of the allowable charges, after you meet your annual deductible • You are not responsible for amounts above the allowable.

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

When you need:	Network benefits	Non-network benefits, when using a non-contracting provider :	Non-network benefits, when using a ParPlan Provider
<p>Outpatient medical care by PCP</p> <p>For example: office or any other outpatient surgeries</p>	<ul style="list-style-type: none"> • Make an appointment with your PCP • If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 20% up to the coinsurance maximum. • If services are performed in the provider’s office, you will pay 20% of eligible expenses up to the coinsurance maximum 	<ul style="list-style-type: none"> • Make an appointment with any valid provider, (see Section Seven, pages 128-129, for definition) • If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 40%, after you meet your annual deductible. • If services are performed in the provider’s office, you will pay 40% after you meet your annual deductible. You will also be responsible for any amounts above the allowable amount. • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Make an appointment with any ParPlan provider • If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 40%, after you have met your deductible. • If services are performed in the provider’s office, you will pay 40%, after you meet your annual deductible. • You are not responsible for amounts above the allowable.
<p>Outpatient medical care by specialist</p> <p>For example: office or any other outpatient surgeries</p>	<ul style="list-style-type: none"> • Obtain a referral from your PCP • Confirm a referral has been approved by BCBSTX • Make an appointment with your specialist • If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 20% up to coinsurance maximum. • If services are performed in the provider’s office, you will pay 20% of eligible expenses up to the coinsurance maximum 	<ul style="list-style-type: none"> • Make an appointment with any valid provider, (see Section Seven, pages 128-129, for definition) • If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 40%, after you meet your annual deductible. • If services are performed in the provider’s office, you will pay 40% after deductible. You will also be responsible for any amounts above the allowable amount. • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Make an appointment with any ParPlan provider • If services are performed in a facility with an operating room, you will pay a \$100 copayment, plus 40%, after you have met your deductible. • If services are performed in the provider’s office, you will pay 40%, after you meet your annual deductible. • You are not responsible for amounts above the allowable.

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

When you need:	Network benefits	Non-network benefits, when using a non-contracting provider :	Non-network benefits, when using a ParPlan Provider.
Laboratory/ Radiology testing	<ul style="list-style-type: none"> Your PCP or specialist with a valid referral will send you to a HealthSelect network laboratory You will pay 20% of eligible expenses up to the coinsurance maximum 	<ul style="list-style-type: none"> Schedule an appointment with a valid provider, (see Section Seven, pages 128-129, for definition) You will pay 40% of allowable charges, after you meet your deductible and be responsible for any amounts above the allowable amount. File your claim with BCBSTX 	<ul style="list-style-type: none"> Schedule an appointment with a ParPlan provider You will pay 40% of allowable charges, after you meet your annual deductible You are not responsible for amounts above the allowable.
Routine Eye exam (one per calendar year) Does not include contact lens exam, which is not covered.	<ul style="list-style-type: none"> Schedule an appointment with a HealthSelect network optometrist or ophthalmologist You will pay \$30 copayment for the office visit 	<ul style="list-style-type: none"> Schedule an appointment with a valid provider, (see Section Seven, pages 128-129, for definition) You will pay 40% of allowable charges, after you meet your annual deductible and be responsible for any amounts above the allowable amount. File your claim with BCBSTX 	<ul style="list-style-type: none"> Schedule an appointment with a ParPlan provider You will pay 40% of the allowable amount, after you meet your annual deductible You are not responsible for amounts above the allowable.

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

When you need:	Network benefits	Non-network benefits, when using a non-contracting provider :	Non-network benefits, when using a ParPlan Provider.
Well-Woman exam (one per calendar year)	<ul style="list-style-type: none"> • Schedule an appointment with a HealthSelect network OB/GYN or your designated PCP • You will pay \$20 copayment for the office visit with your designated PCP or a \$30 specialty office visit copayment with a visit to a network OB/GYN specialist 	<ul style="list-style-type: none"> • Schedule an appointment with a valid provider, (see Section Seven, pages 128-129, for definition) • You will pay 40% of the allowable amount, after you meet your deductible and be responsible for any amounts above the allowable amount. • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Schedule an appointment with a ParPlan provider • You will pay 40% of the allowable amount, after you meet your annual deductible • You are not responsible for amounts above the allowable.
Durable Medical Equipment (DME)	<ul style="list-style-type: none"> • Your PCP or specialist with a valid referral will give you a prescription • Take the prescription to a network DME facility • You will pay 20% of eligible expenses up to the coinsurance maximum 	<ul style="list-style-type: none"> • Take your prescription to a DME provider, (see Section Seven, page 121, for description) • You will pay 40% of allowable charges, after you meet your annual deductible and be responsible for any amounts above the allowable amount. • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Schedule an appointment with a ParPlan provider • You will pay 40% of allowable charges, after you meet your annual deductible • You are not responsible for amounts above the allowable.

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

When you need:	Network benefits	Non-network benefits, when using a non-contracting provider :	Non-network benefits, when using a ParPlan Provider.
<p>Inpatient Medical</p> <p>Only covers semi-private room</p> <p>Both network and non-network inpatient copayments apply toward your calendar year inpatient copayment maximum of \$1,500 per person</p>	<ul style="list-style-type: none"> • Your PCP will obtain preauthorization • Schedule your inpatient surgery in a HealthSelect network hospital • After a \$100 copayment per day (\$500 max per stay), you will pay 20% of eligible expenses up to the coinsurance maximum 	<ul style="list-style-type: none"> • You are responsible for obtaining preauthorization • After a \$100 copayment per day (\$500 max per stay), you will pay at least 40% after you meet your annual deductible. • You will be responsible for amounts above the allowable amount. • If you do not obtain preauthorization, you will pay an additional preauthorization penalty as well as any ineligible services • File your claim with BCBSTX 	<ul style="list-style-type: none"> • You are responsible for obtaining preauthorization • After a \$100 copayment per day (\$500 max per stay), you will pay 40%, after you have meet your annual deductible. • If you do not obtain preauthorization, you will pay an additional preauthorization penalty as well as any ineligible services • You are not responsible for amounts above the allowable.
<p>Outpatient Behavioral health care (excludes serious mental illness and substance abuse which is treated as any other illness)</p> <p>There is a 30-outpatient visit maximum per calendar year (network and non-network combined)</p>	<ul style="list-style-type: none"> • Contact INROADS Behavioral Health Services for a referral • Make an appointment with your specialist • You will pay 20% of eligible expenses (even after the coinsurance maximum has been met) 	<ul style="list-style-type: none"> • Schedule an appointment with a valid provider, (see Section Seven, pages 128-129, for definition) • You will pay 40% of the maximum allowable (\$60), once the annual deductible has been met and be responsible for any amounts above the allowable amount. • You will pay coinsurance (40%) even after your coinsurance maximum has been satisfied • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Make an appointment with any ParPlan provider • You will pay 40% of the maximum allowable (\$60), once the annual deductible has been met • You will pay coinsurance (40%) even after your coinsurance maximum has been satisfied. • You are not responsible for amounts above the allowable

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

When you need:	Network benefits	Non-network benefits, when using a non-contracting provider :	Non-network benefits, when using a ParPlan Provider.
<p>Inpatient Behavioral Health Care</p> <p>(excludes serious mental illness or substance abuse which is treated as any other illness)</p> <p>There is a 30-day inpatient maximum per calendar year (network and non-network combined)</p> <p>Inpatient copayments apply toward your calendar year inpatient copayment maximum of \$1,500 per person.</p>	<ul style="list-style-type: none"> • Contact INROADS Behavioral Health Services to verify preauthorization has been obtained • After you pay a \$100 copayment per day (\$500 max per stay), you will pay 20% for the first 15 days. The next 15 days, you will pay 40% 	<ul style="list-style-type: none"> • Schedule an appointment with a valid provider, (see Section Seven, pages 128-129, for definition) • You are responsible for preauthorization, contact INROADS Behavioral Health Services • After you pay a \$100 copayment per day (\$500 max per stay), you will pay at least 40% for the first 15 days, after you meet your annual deductible. The next 15 days, you will pay at least 50%, after you meet your annual deductible. • You will be responsible for any amounts above the allowable. • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Schedule an appointment with a ParPlan provider • You are responsible for preauthorization, contact INROADS Behavioral Health Services • After you pay a \$100 copayment per day (\$500 max per stay), you will pay 40% for the first 15 days, after you meet your annual deductible. The next 15 days, you will pay 50%, after you meet your annual deductible. • You are not responsible for amounts above the allowable.

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

When you need:	Network benefits	Non-network benefits, when using a non-contracting provider :	Non-network benefits, when using a ParPlan Provider.
<p>Intermediate Behavioral Health Care</p> <p>(excludes serious mental illness or substance abuse which is treated as any other illness)</p> <p>There is a 60-day intermediate care maximum per calendar year (network and non-network combined)</p> <p>Intermediate care copayments apply toward your calendar year inpatient copayment maximum of \$1,500 per person.</p>	<ul style="list-style-type: none"> • Contact INROADS Behavioral Health Services to verify preauthorization has been obtained • After you pay a \$50 copayment per day (\$500 max per stay), you will pay 20% for the first 30 days. The next 30 days, you will pay 40% 	<ul style="list-style-type: none"> • Schedule an appointment with a valid provider, (see Section Seven, pages 128-129, for definition) • You are responsible for preauthorization, contact INROADS Behavioral Health Services • After you pay a \$50 copayment per day (\$500 max per stay), you will pay at least 40% for the first 30 days, after you meet your annual deductible. The next 30 days, you will pay at least 50%, after you meet your annual deductible. • You will be responsible for any amounts above the allowable. • File your claim with BCBSTX 	<ul style="list-style-type: none"> • Schedule an appointment with a ParPlan provider • You are responsible for preauthorization, contact INROADS Behavioral Health Services • After you pay a \$50 copayment per day (\$500 max per stay), you will pay 40% for the first 30 days, after you meet your annual deductible. The next 30 days, you will pay 50%, after you meet your annual deductible. • You are not responsible for amounts above the allowable.

How to Access Benefits

Benefits are paid on BCBSTX “allowable amounts” (see Section Three, page 19). Using a HealthSelect network provider or a ParPlan provider can protect you from liability for amounts over the allowable. If you use a non-contracting provider, you can also be billed for services determined to be not medically necessary by BCBSTX.

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

Q & A Quick Reference

Questions commonly asked by in-area participants:

1. **I’m sick and I call my PCP. The nurse says the doctor can’t see me for two weeks. What do I do?**
 Request an appointment with your PCP’s backup. Every PCP is required to have one or more backup PCPs. If you are not able to obtain the names and telephone numbers of the backup PCPs, call BCBSTX Customer Service at (800) 252-8039. You will be responsible for a \$20 PCP office visit copayment when you see your PCP’s backup.

2. **My PCP sent me to another network physician for care, but when I received an EOB from BCBSTX, it stated that I had received non-network benefits. Why?**
Your PCP may have forgotten to contact BCBSTX to set up the referral. If you ever receive a confusing EOB from BCBSTX, call BCBSTX Customer Service at (800) 252-8039 to investigate and correct any problems with your claims.
3. **Can I choose whether I'm in-area or out-of-area?**
No. As a HealthSelect participant, you have in-area coverage if you reside in Texas; otherwise you have out-of-area coverage. If you live in-area, you are designated in-area for purposes of determining benefit levels. One exception is during summer enrollment: If you live out-of-area, but work in-area, you may choose in-area coverage. You will have in-area coverage for the entire plan year, as long as your place of employment remains in-area. See pages 16-17 of this section for information on changing a dependent's address with BCBSTX, to change their coverage.
4. **Are all in-area network services available for a copayment?**
No. While you pay a copayment for office visits to a network provider, other services are paid differently. For example, you are responsible for coinsurance for expenses for routine x-rays, immunizations, and lab tests, except when performed and billed by the same provider during the office visit. When these services are performed and billed by your physician during an office visit, you pay only a copayment for the service and the visit. Refer to the Benefits Summary on page 38 of this section for more information.
5. **Can network copayments be used to satisfy the out-of-pocket coinsurance maximum?**
No, copayments do not apply to your coinsurance maximum.
6. **What is coinsurance? Once I satisfy my network out-of-pocket coinsurance maximum, do I still have to make copayments?**
Coinsurance means the percentage you pay for services such as allergy injections, hospital care, etc. detailed on pages 38-42 of this section. Even after the out-of-pocket coinsurance maximum is met, you must pay copayments.
7. **Can I choose a PCP from another network area, or another network city?**
Yes. You may select any network PCP. Be sure you notify BCBSTX of your selection by calling BCBSTX Customer Service, or by completing the GBP Supplemental Information Form and mailing it to BCBSTX.
8. **Am I covered when traveling out of the network areas, particularly out of state and out of the country?**
Yes, however, in most cases you will receive non-network benefits, unless you have an emergency. If you obtain emergency medical care, please refer to pages 28-30 of this section. For non-emergency medical care, contact your PCP before receiving medical care. See Section Six pages 111-112 for information on BlueCard Worldwide.

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9. **As an in-area participant, is there a deductible to satisfy when I use network providers?**

No, deductibles apply only when you receive non-network benefits.

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

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

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

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

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

12. **How many Medical ID Cards are issued to HealthSelect participants?**

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

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

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

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

Contact BCBSTX Customer Service at (800) 252-8039 with any dependent address changes. See pages 16-17 of this section for more information.

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

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

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

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

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

18. **If I am discharged from an inpatient hospital stay and readmitted will I have to start over on my inpatient copayments?**
If you are discharged from an inpatient hospital stay and readmitted within 24 hours of that discharge date, your inpatient copayments will not start over if your original stay was five days or more.

However, if your original stay was less than five days, and you are readmitted within 24 hours of that original admission, copayments paid in the original admission will be counted and you will not be required to pay more than the \$500 copayment maximum for the two admissions combined.

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

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

The \$50 prescription drug plan year deductible is accumulated and calculated on a plan year basis, September 1 through August 31. Each covered participant will be required to pay this prescription drug deductible before any prescription drug copayments apply. Any deductible amounts paid for medical services **do not** apply toward your prescription drug plan year deductible.

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Out-of-Area Benefits
At-A-Glance

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

Section Four

Guide To Out-of-Area Benefits

About Out-of-Area Benefits

You and your covered dependents have out-of-area coverage if you reside out of the state of Texas, or if you are over 65 with Medicare as the primary payor. If you have out-of-area coverage, HealthSelect offers you traditional medical benefits. You can choose any valid provider (see definition of provider in Section Seven, pages 128-129). If you use BCBSTX ParPlan providers, you will not have to file claims and you cannot be billed for amounts which exceed the allowable amount, because ParPlan providers have agreed to accept the BCBSTX allowable amount as payment in full.

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

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

Allowable Amounts

All claim payments are based on the BCBSTX **allowable amounts**. If you use a ParPlan provider (a provider who contracts with BCBSTX) you will not be responsible for the difference between the provider’s billed charge and the BCBSTX allowable amount. See Section Seven, page 127 for definition of ParPlan Provider. If you use a non-ParPlan provider, you will be responsible for charges over the BCBSTX allowable amount.

ParPlan Providers

If you see a ParPlan provider, you pay your coinsurance percentage of the allowable amount after meeting your deductible; HealthSelect pays the remaining percentage, and the provider accepts the two amounts as payment in full. You will not be billed any additional amounts unless the services are not covered, in which case, you will be responsible for the charges. See Section Six, pages 108-110 for additional information about ParPlan providers. ParPlan providers have also agreed to:

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

Calendar year deductible

The “**calendar year deductible**” is per person. The family deductible is met when three family members have each met their individual deductible under one subscriber ID number. If more than the family deductible maximum has been taken in a calendar year, call BCBSTX Customer Service. You may be eligible for a refund. Refer to the Benefits Summary, which begins on page 77 of this section, for the amount of the individual and family deductibles.

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

TIP: Calendar year is January 1 through December 31

Inpatient and outpatient day-surgery copayments

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

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

Inpatient copayment maximum

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

Out-of-pocket coinsurance maximum

The “out-of-pocket coinsurance” maximum is per person per calendar year. This means that after your coinsurance share of covered services and supplies totals the out-of-pocket maximum amount in a calendar year, HealthSelect will generally pay 100% of covered charges for the rest of that calendar year. Refer to the out-of-area Benefits Summary, which begins on page 77 of this section.

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

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

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

Emphasis on preventive care

HealthSelect is designed to encourage preventive care:

- Participants may receive one routine physical exam each calendar year;
- Women may receive one annual well-woman exam by an OB/GYN, or a physician of family practice or internal medicine, if those services are not performed during their routine physical exam; and
- Men age 50 and over are eligible for coverage for an annual diagnostic medical examination for prostate cancer. Men age 40 and over with a family history of prostate cancer are also eligible for this exam.
- 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. If you receive these services at a non-ParPlan facility you may be responsible for charges above the BCBSTX Allowable Amount.

Routine eye exam

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

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. If the mother is not preauthorized or is not covered under HealthSelect, the newborn will need his or her own preauthorization to receive benefits.

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

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

- A separate preauthorization for the child is obtained; and
- The child is "admitted" to the hospital in his or her 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. A newborn must be enrolled within 30 days of birth in order for benefits to continue after the first 31 days. Newborn grandchildren are not covered automatically – if eligible, they must be added as dependents for benefits. Active employees should contact their benefits coordinator for more information.**

Retirees should contact ERS.

Childhood immunizations for dependents

For newborn through 6 years of age, the following ten childhood immunizations are covered at 100%. However, if an office visit or other services are performed during the same visit, you will be responsible for applicable copayments, coinsurance and deductible (see Section Seven, page 126 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.

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

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 Seven, page 131, for the complete definition of Telemedicine.

Durable medical equipment

Durable Medical Equipment (DME), which consists of therapeutic supplies and rehabilitative equipment required for therapeutic use, is covered under HealthSelect when medically necessary.

If you use a DME provider who does not contract with Blue Cross and Blue Shield, you will be required to file your claim and may be billed for amounts above the allowable.

If you use a DME provider who contracts with Blue Cross and Blue Shield you will not be required to file your claim and will not be responsible for any charges above the allowable amount. You can search for contracting DME providers through Provider Finder, "Ancillaries." 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.

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, pages 120-121 for specific definitions of these services. Diabetes Supplies are covered in the following manner:

Insulin and syringes are covered under your prescription drug benefits (see Section Five, page 84, for information about your Prescription Drug Program).

Other diabetes supplies (see Section Seven, page 120 for a complete definition) are covered under your medical benefits as Durable Medical Equipment (DME), at 70% of the allowable amount. If you use a non-contracting supplier and the charge is greater than the allowable amount, you will be responsible for the difference.

If you use a DME provider who does not contract with BCBSTX, you will be required to file your claim and may be billed for amounts above the allowable. To file a claim for diabetes supplies, attach your cash register receipt, showing quantity of each item purchased, to a completed medical claim form (keeping copies for your records). Mail to BCBSTX at P.O. Box 660044, Dallas, TX 75266-0044. See Section Six, page 110 for more information.

If you use a DME provider who contracts with BCBSTX, you will not be required to file your claim and will not be responsible for any charges above the allowable amount. You can search for contracting DME providers through Provider Finder, “Ancillaries.” 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.

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 you use a ParPlan provider, the provider’s total payment is based on the BCBSTX allowable amount. BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between that benefit and the contracted BCBSTX allowable amount. If you use a **non-ParPlan provider**, BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between the benefit and the provider’s billed charges. In addition, hearing aid batteries are covered and are not subject to the \$500/three year limitation. Please refer to the Benefits Summary, on page 77 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.

Retail Health Clinics

A Retail Health Clinic is a health care clinic located in a retail setting, such as a supermarket or pharmacy, and provides treatment of common illnesses and routine preventive health care services that can be rendered by appropriately licensed staff located in the clinic, which may include Advanced Practice Nurses, Physician Assistants, and/or Physicians.

You and your covered dependents can seek medically necessary care at a ParPlan Retail Health Clinic and you will be responsible for your calendar year deductible (\$200) and coinsurance (30%).

If you or a covered dependent seek care at a non-ParPlan Retail Health Clinic, you may be responsible for charges above the BCBS allowable amount and be required to file your claim.

In Case of Emergency

Definition of emergency

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

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

Getting emergency care

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

Ambulance services

HealthSelect pays benefits for Ambulance Services received at the time of an emergency and when determined to be medically necessary by BCBSTX. There are no benefits available for Ambulance Services, unless a patient is transported to the nearest hospital equipped and staffed to treat the condition.

If you receive services from an ambulance provider who is not contracted with BCBS, benefits will be paid on the billed amount. This means that you will not be responsible for charges above the BCBS allowable amount.

TIP: For Preauthorization call (800) 344-2354.

If you have been admitted to a hospital

If you have been admitted to the hospital from the emergency room, you must call the BCBSTX 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 72 of this section.

Behavioral Health Care

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 may be responsible for any amounts over this maximum in addition to any applicable coinsurance or deductible. To limit your out of pocket expenses, it is recommended that you use ParPlan providers (see Section Six, pages 108-110, 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 by Texas state law (definition found on Section Seven, page 130) you will not be subject to the 30-outpatient visit maximum or the \$60 benefit maximum per visit. Your coverage will be treated as any other illness or injury.

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

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 130, 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 Seven, page 131, 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, which begins on page 77, for more details regarding copayments and coinsurance.

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

Call INROADS Behavioral Health Services for preauthorization:

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

Preauthorization

Preauthorization of certain services

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

- Hospital admissions;
- Skilled nursing care in a skilled nursing facility;
- Private-duty nursing;
- Home health care;
- Intermediate care facilities;

- Hospice care; and
- Home infusion therapy (Use of a provider contracted with BCBSTX or accessible through BlueCard Worldwide is required to receive any benefits.)

TIP: Call (800) 344-2354 for preauthorization

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

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

How to 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 family member call for you.

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

Preauthorization numbers to call:

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

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 services to be medically necessary and therefore eligible for benefits. To have a predetermination of benefits conducted, ask your physician to provide BCBSTX a letter of medical necessity and any pertinent medical records. After a decision is made, you and your physician will be notified in writing.

Review by an Independent Review Organization (IRO)

Even if a life-threatening condition is **not** involved, if BCBSTX initially determines that the health care services proposed are not medically necessary, and this adverse determination is upheld at the highest level of review at BCBSTX, you may seek review by an independent review organization (IRO). If you have a **life-threatening** condition, you are entitled to an immediate review by an IRO rather than having to follow the normal 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.
- Step 6:** The IRO will notify you and BCBSTX of its decision.

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 for out-of-area benefits

- Step 1** Call any provider (see definition of provider in Section Seven, pages 128-129), preferably a BCBSTX ParPlan provider (See “ParPlan Providers” subsection beginning in Section Six, pages 108-110). Tell the provider that you have HealthSelect coverage
- Step 2** See the provider.
Show your HealthSelect Medical 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 72 of this section for a list of services and procedures that must be preauthorized).
- Step 4** If you use a non-ParPlan provider, you may have to file the claim yourself. (See Section Six, page 110, for instructions.)
- Step 5** You will receive an Explanation of Benefits (EOB) from BCBSTX.

If you receive services outside of Texas or the United States, see Section VI, pages 111-112 for more information on how to file your claims and BlueCard Worldwide.

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

Out-of-Area Benefits Summary (Under 65)

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

General Provisions	Benefits
	<i>Calendar year deductible applies to charges except as noted.</i>
Calendar year deductible	\$200 individual/\$600 family maximum
Calendar year out-of-pocket coinsurance maximum (does not include copayments)	\$1,000 per person
Calendar year inpatient copayment maximum (includes any inpatient copayments paid while covered as an in-area participant during the same calendar year)	\$1,500 per person
Preauthorization penalty deductible	\$200 per hospital admission (if not preauthorized)
Responsibility for preauthorization	Participant
Lifetime maximum benefit	None
Doctors' and Lab Services	
Doctor office visits	Plan pays 70%, you pay 30%
Retail Health Clinic	Plan pays 70%, you pay 30%
Annual physicals (one per calendar year for adults and children; woman are also allowed one well-woman office visit to an OB/GYN each calendar year)	Plan pays 70%, you pay 30%
Diagnostic x-rays, mammography, injections, routine immunizations, pap smears, and lab tests	Plan pays 70%, you pay 30%
Specific immunizations for children 0-6 years old (except when performed during an office visit)	Plan pays 100%

Out-of-Area Benefits Summary (Under 65)

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

Doctors' and Lab Services	Benefits
Allergy injections and antigens	Plan pays 70%, you pay 30%
Office surgery and procedures	Plan pays 70%, you pay 30%
Inpatient doctor visits	Plan pays 70%, you pay 30%
Outpatient surgery and anesthesia (physician charges)	Plan pays 70%, you pay 30%
Routine eye exam (one per calendar year per participant)	Plan pays 70%, you pay 30%
Maternity care	Plan pays 70%, you pay 30%
Hospital Services	
*Inpatient hospital (semi-private room and board or intensive care unit)	After a \$100 copayment per day (\$500 max per stay), Plan pays 70%, you pay 30% (no deductible)
Other inpatient charges, including surgery and anesthesia	Plan pays 70%, you pay 30%
Outpatient facilities, including treatment room and/or pre-admission testing	Plan pays 70%, you pay 30%
Outpatient day-surgery	After a \$100 copayment, Plan pays 70%, you pay 30%
Emergency care	Plan pays 70%, you pay 30%
Extended Care Services	
*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)

Out-of-Area Benefits Summary (Under 65)

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

Extended Care Services	Benefits
*Hospice care	Plan pays 70%, you pay 30%; \$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 70%, you pay 30% (even after out-of-pocket coinsurance maximum is met); \$8,000 calendar year maximum; \$40,000 lifetime maximum
Other Medical Services	
Hearing aids (repairs not covered)	Plan pays up to \$500 per ear every three years (no deductible)
Hearing aid batteries	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for the use in your hearing aid (not subject to the \$500 per ear/three year limitation)
Diabetes supplies, other than insulin and syringes	Plan pays 70%, you pay 30%
Durable medical equipment (includes medically necessary purchase and/or rental)	Plan pays 70%, you pay 30%
Prosthetic appliances (See definition on page 130 for additional information.)	Plan pays 70%, you pay 30%
Physical, occupational, speech therapy, and chiropractic care	Plan pays 70%, you pay 30%
Ambulance services	Plan pays 70%, you pay 30%

Out-of-Area Benefits Summary (Under 65)

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

Other Medical Services	Benefits
*Home infusion therapy (HIT)	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 79 for excluded services)	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)	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 calendar year inpatient copayment maximum of \$1,500 per person.	After \$100 copayment per day (\$500 max per stay), Plan pays 70% for the first 15 days, you pay 30%. The next 15 days, Plan pays 50%, you pay 50%
**Intermediate care facility (maximum 60 days per calendar year) Intermediate copayments apply toward the calendar year inpatient copayment maximum of \$1,500 per person.	After \$50 copayment per day (\$500 max per stay), Plan pays 70% for the first 30 days, you pay 30%. The next 30 days, Plan pays 50%, you pay 50%

Out-of-Area Benefits Summary (Under 65)

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

Prescription Drugs	Benefits
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	90-day supply Copayments: \$30 for Tier 1 drugs, \$75 for Tier 2 drugs, \$120 for Tier 3 drugs ***

*Preauthorization required.

**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.

***If a brand name drug that has a generic available is dispensed, in addition to paying the generic copayment, you are also responsible for the difference in the cost between 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 Seven, beginning on page 115 as you read the exclusions for definitions of "Medically Necessary," "Allowable Amount," or "Covered Oral Surgery."

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

Exclusions

HealthSelect does not cover expenses for:

- A. Services or supplies that BCBSTX determines are not medically necessary.
- B. Occupational illnesses 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.
- 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 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. Any services or supplies provided to any participant for treatment of obesity or for weight reduction, weight reduction programs, gym memberships, and surgeries, even if the participant has medical conditions which might be helped by a reduction of obesity or weight and even if prescribed by a physician. Gastric Bypass and Vertical Banding are not covered for any conditions. This exclusion does not apply to disease management or wellness programs provided through Blue Care Connection.
- Q. Sterilization reversal, transsexual surgery, gender reassignment, artificial insemination and related services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures.
- R. Abortion, unless the participant's life would be endangered by continuing the pregnancy, or there is a diagnosed fetal anomaly, or unless the pregnancy is caused by a criminal act such as rape or incest.
- S. Home infusion therapy treatment provided by an entity that does not contract with 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; and the purchase of organ or tissue. (Revised Effective January 1, 2008)

- 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, cold therapy devices, 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 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, described in this book.
- AA. Any services or supplies for acupuncture.
- BB. Any services or supplies provided before the participant's effective date or after the expiration date of coverage except as provided through extension of benefits as described in Section Six, page 99.
- 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 preauthorized by BCBSTX) or as may be provided by BCBSTX through case management as described in Section Six, page 106.
- FF. Difference between the charge for a hospital private room and semiprivate room, except when coordinating secondary benefits with Medicare Part A.

- GG. Any services or supplies for which benefits are not provided under HealthSelect, unless through case management or ERS-approved pilot projects.
- HH. Services or supplies provided by a person or entity who is not a provider, as defined by HealthSelect.
- II. Any services and/or physical examinations requested or required by a third party, including but not limited to school admissions, insurance, employment, or licensure examination purposes.
- JJ. Telemedicine services provided by telephone, fax machine or Internet.
- KK. Services, supplies and related expenses that BCBSTX determines to be experimental and/or investigational.
- LL. Services and supplies provided by an immediate family member.

Q & A Quick Reference

Questions commonly asked by out-of-area participants:

1. **How do deductibles and coinsurance accumulate?**

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

The \$50 prescription drug plan year deductible is accumulated and calculated on a plan year basis, September 1 through August 31. Each covered participant will be required to pay this prescription drug deductible before any prescription drug copayments apply. Any deductible amounts paid for medical services **do not** apply toward your prescription drug plan year deductible.
2. **Do I and all of my covered dependents have to satisfy a calendar year deductible?**

Once three of your family members have each individually satisfied their calendar year medical deductible under one subscriber ID number, the rest of your covered family members do not have to satisfy a medical deductible. Refer to page 64 of this section regarding the calendar year family deductible. Copayments paid for outpatient day surgeries or inpatient admissions do not apply toward the medical deductible.

The prescription drug plan year deductible is \$50 per person, per plan year, September 1 through August 31. There is not a family prescription drug plan year deductible.

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

Yes. Each covered family member must individually satisfy their calendar year coinsurance maximum before eligible charges are paid at 100% of the allowable amount for that individual for the remainder of that calendar year. After the coinsurance maximum is satisfied, you will still be required to pay outpatient and inpatient copayments, prescription drug copayments and the prescription drug plan year deductible.

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

Yes. HealthSelect provides coverage for medical services received outside of the state or country. Typically, however, you will have to pay for these services in full when rendered and then file a claim with BCBSTX for reimbursement. See Section Six, pages 111-112 for information on BlueCard Worldwide. Refer to Section Six, page 110 for information on filing claims.

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

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

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

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

7. **How many Medical ID Cards are issued to HealthSelect participants?**

One Medical ID Card is issued for individual coverage and if you cover any dependents, a separate Medical ID Card is issued for each covered dependent. To receive additional Medical ID Cards, call BCBSTX Customer Service. To receive additional Prescription ID Cards, call Caremark Customer Service.

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

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

-
9. **I have not satisfied my calendar year medical deductible and am receiving care in December which continues into January of the next year. Do I have to satisfy another deductible?**
Yes. Your medical deductible is calculated on a calendar year basis. Therefore, on January 1st, you would be required to meet your medical deductible for the new year.
10. **Will my outpatient day-surgery copayments apply toward my calendar year inpatient copayment maximum?**
No, only inpatient copayments apply toward the \$1,500 inpatient calendar year copayment maximum. Once you have met the calendar year inpatient copayment maximum, you will no longer be required to pay for inpatient copayments for the remainder of that calendar year.
11. **If I am discharged from an inpatient hospital stay and readmitted will I have to start over on my inpatient copayments?**
If you are discharged from an inpatient hospital stay and readmitted within 24 hours of that discharge date, your inpatient copayments will not start over if your original stay was five days or more.

However, if your original stay was less than five days, and you are readmitted within 24 hours of that original admission, copayments paid in the original admission will be counted and you will not be required to pay more than the \$500 copayment maximum for the two admissions combined.

Section Five
Guide for Prescription Drug Benefits
At-A-Glance

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Section Five

Guide for Prescription Drug Benefits

About the Prescription Drug Program

When you enroll in HealthSelectSM, whether you are in-area or out-of-area, you are automatically enrolled in the Prescription Drug Program (PDP). The PDP for HealthSelectSM participants is administered by Caremark Rx, L.L.C (Caremark)

Using your Caremark prescription drug ID card, you may purchase covered drugs at participating retail pharmacies located in Texas and throughout the United States. For information on participating pharmacies, contact Caremark Customer Care at (888) 886-8490 or visit the Caremark website at www.caremark.com/ers.

You may obtain medications through participating retail pharmacies (up to a 30-day supply) or you may order them through the mail service pharmacy program (up to a 90-day supply). Order forms and envelopes are available online at the Caremark website at www.caremark.com/ers or by calling (888) 886-8490. The copayments for maintenance drugs obtained at retail pharmacies are higher than the copayments for the same drugs obtained through the mail service program.

What is Covered

Most prescription drugs that are medically necessary and prescribed by a provider are covered. Most self-administered injectable drugs are covered under the PDP portion of your coverage. In order to provide the most clinically effective prescription benefit, HealthSelectSM uses the Caremark Preferred Drug List and other clinical programs (including Prior Authorization programs) administered by Caremark.

The Preferred Drug List

The PDP includes a preferred brand name drug list, which contains commonly prescribed medications that are preferred based on their clinical and cost effectiveness. When generic equivalents are not available, your physician may prescribe preferred medications.

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 Caremark pharmacist may discuss with your physician whether a generic or preferred alternative drug might be appropriate for you. If your physician agrees, your prescription will be filled with the

generic or preferred alternative drug. If you have any questions about a change in a prescription, you can speak to your physician or a Registered Pharmacist at Caremark. Your physician always makes the final decision on medications.

Prior Authorization

Some medications must receive Prior Authorization before they can be covered under the PDP. If the prescribed medication requires this approval by Caremark, you, your physician or your pharmacist will initiate the review process. This process typically takes two business days to complete depending on the response from your physician's office to Caremark. You will be notified when the review process has been completed and documentation will be sent to the physician. If the criteria are not met on your medication, you will be responsible for paying the full cost of the drug. Appeals are available through Caremark for most drugs under Prior Authorization. However, appeals are not available through ERS.

Quantity Limitation

Selected classes of drugs covered under the PDP 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 edits are reviewed by the Caremark Pharmacy and Therapeutics Committee for clinical efficacy and are periodically modified as new drugs come to market. If a prescription exceeds the quantity limitation, you are responsible for the entire cost of the prescription drug above the quantity limitation. Your prescribing physician can request reconsideration from Caremark. If the reconsideration is denied, you may not appeal this denial through the appeals process.

Compound Medications

Claims for compound medications may be submitted in two ways:

1. The participating retail pharmacy may submit the claim electronically to Caremark and receive a reimbursement reply. You will pay a copayment at the time of service if it is a covered drug.
2. If you utilize a non-network pharmacy or utilize a network pharmacy that will not file the electronic claim, you must file a direct paper claim with Caremark. You will be responsible for the total cost at the time of the purchase. After filing the direct claim with Caremark, you will be responsible for any cost differences between the pharmacy charge and the plan reimbursement.

In order for a direct claim to be processed, you must send Caremark an itemized list of ingredients with a receipt and fully completed claim form. The claim and/or receipt must include:

- The amount charged by the pharmacy
- The total volume or quantity of the compound (such as the number of capsules or the number of milligrams)
- The valid National Drug Code (NDC) for each ingredient

The claim form is available through the website at www.caremark.com/ers or by calling Caremark Customer Care at (888) 886-8490

Plan Year Deductible

A separate \$50 deductible applies to each participant and dependent. The deductible is per plan year, September 1 through August 31. The prescription copayments apply for drugs dispensed through a participating retail pharmacy or through Caremark Mail Service after your deductible has been satisfied. If your drugs are dispensed through a non-participating pharmacy, your deductible and copayments are applied according to the formula as described in the “Non-Participating pharmacies” section below.

Retail Pharmacy Program

Participating pharmacies

HealthSelectSM allows you to obtain up to a 30-day supply of most covered medications. Simply present your Caremark prescription drug ID card with your prescription. You must satisfy your \$50 plan year deductible before the applicable copayments apply. You do not have to file a claim for prescriptions electronically processed at a participating retail pharmacy.

When purchasing a Tier 1 non-maintenance generic medication at a participating pharmacy, you will pay a \$10 copayment. If you purchase a Tier 2 or Tier 3 non-maintenance brand name drug and there is no generic equivalent, you will pay a \$25 copayment for a Tier 2 non-maintenance brand name drug or a \$40 copayment for a Tier 3 non-maintenance brand name drug. If you purchase a brand name drug when a generic equivalent is available, you will pay the generic drug copayment **plus** the cost difference between the brand name and generic drug.

You may purchase maintenance medication at a participating pharmacy for a \$15 copayment for Tier 1 medication. If you purchase a Tier 2 or Tier 3 maintenance brand name drug and there is no generic equivalent, you will pay a \$35 copayment for a Tier 2 maintenance brand name drug or a \$55 copayment for a Tier 3 maintenance brand name drug. If you purchase a brand name drug when a generic equivalent is available, you will pay the generic drug copayment **plus** the cost difference between the brand name and generic drug.

Please note that if your copayment for a medication is higher than the retail price of the medication, you will pay the lesser amount.

Non-Participating pharmacies

If you use a non-participating pharmacy, you will have to pay the full amount at the time of purchase and then file a paper claim for reimbursement. The amount of the reimbursement will be 60% of the lesser amount of; 1) the cost of the drug minus your copayment; or 2) the ERS contract price of the drug, plus the dispensing fee, minus your copayment. If your plan year deductible has not been met, it will be deducted after the reimbursement described above has been calculated. Please note that if a brand name medication that has a generic equivalent available is dispensed, in addition to paying the generic copayment described above, you are also responsible for the difference in the cost between the generic and preferred or non-preferred brand name drug.

You will see a much lower out of pocket expense by using a participating pharmacy. Contact Caremark Customer Care at (888) 886-8490 for the name and location of a participating pharmacy when traveling to avoid additional non-participating pharmacy costs.

Steps to using non-participating pharmacies

1. You must pay 100% of the prescription price at the time of purchase.
2. Obtain a Prescription Claim Form by using the Caremark website at www.caremark.com/ers or call Caremark Customer Care at (888) 886-8490 to request a form.
3. Submit a completed claim form to Caremark. The prescription receipt must be attached to the form. Mail form to the address at the bottom of that form:

Caremark Claims Department
P.O. Box 52136
Phoenix, AZ 85072-2136

4. Make sure you provide all the required information on the Prescription Claim Form.
5. You will receive a reimbursement or claim response within 21 days from receipt of your claim form by Caremark.

Mail Service Pharmacy Program

You may obtain up to a 90-day supply of most long-term (maintenance) covered medications through Caremark Mail Service FDA restrictions on controlled substances may limit the days supply and number of refills allowed. You must satisfy your \$50 plan year deductible before these copayments apply. If you purchase a Tier 1 drug, you will pay the \$30 copayment for a 90-day supply. If you

purchase a Tier 2 or Tier 3 brand name drug and there is no generic equivalent, you will pay the \$75 Tier 2 brand name copayment or the \$120 Tier 3 brand name copayment for a 90-day supply. If you purchase a brand name drug when a generic equivalent is available, you will pay the generic drug copayment plus the cost difference between the brand name and generic drug. Please note that if your copayment for a medication is higher than the total cost of the medication, you will pay the lesser amount.

With the mail service pharmacy:

- Caremark Mail Service fills every prescription following strict quality and safety controls.
- Licensed, registered, highly trained professionals staff Caremark's Mail Service 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, 7 days a week

Steps to ordering new mail service prescriptions

1. Ask your doctor to prescribe a 90-day supply of your medication plus refills, if appropriate.
2. The Caremark Mail Service Order Form is required when obtaining your prescriptions by mail. Visit the Caremark website at www.caremark.com/ers or call Caremark Customer Care at (888) 886-8490 to request the order form. (An order form is also provided in your Caremark New Member Handbook.)
3. Mail your 90-day supply prescription and required copayment along with the order form in the envelope provided. If you do not have an envelope, send your prescription and copayment to

**Caremark
P.O. Box 659541
San Antonio, TX 78265-9541**

OR

Use the FastStart^R program by calling toll-free (800) 875-0867. Let the Caremark Custom Care representative know you wish to fill your prescription through mail service. Provide the information on your prescription drug ID card, the name(s) of the maintenance medication(s) you want filled, your doctor's name and phone number, and your mailing address.

Steps to refilling a mail service prescription

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 50% of your medication based on prescribed dosage.

2. Reorder online using the Caremark website at **www.caremark.com/ers**. Have your **participant ID number from your Caremark prescription drug ID card**, the prescription number (it's the 12-digit number on your refill slip), and your credit card ready when you log on.

OR

3. Call (888) 886-8490 and use the automated refill system. Have your **participant ID Number from your Caremark prescription drug ID card**, refill slip or prescription bottle with the prescription number, and credit card ready.

OR

4. Use the refill and order form and envelope provided with your medication. Mail them with your copayment.

Delivery of a mail service prescription

Prescription orders receive prompt attention and, after processing, are shipped from the mail service pharmacy to you by U.S. mail or UPS. The delivery time for your initial prescription may take 10 to 14 days. Prescription refills are usually delivered in 7 to 10 days. Your medication will include an invoice, instructions for refills, if applicable, information about the purpose of the medication, correct dosages, and other important details.

Payment for your mail service prescription

You may pay by check, money order, Visa, MasterCard, Discover American Express or your **PayFlex™ Debit Card from your Texflex Flexible Health Spending Account**.

Services available through the Caremark website

You may access these services through the website at **www.caremark.com/ers**. Following the instructions provided to register. HealthSelectSM participants who register can:

- View information about the PDP;
- Price medication at both the retail and mail service;
- Check status of mail order prescriptions;
- Submit inquiries to Caremark Customer Service;
- Download mail service prescription order forms;
- Download prescription claim forms;
- Locate a retail pharmacy;
- View the Preferred Drug List Estimate savings on drugs through the “Check Drug Cost” link;
- Refill prescriptions, or
- Download prescription and payment history for use in TexFlex Health Care Reimbursement Accounts.

Copayment Chart

	Tier 1: Primarily Generic drugs	Tier 2: Mostly preferred brand name drugs	Tier 3: Non-preferred brand name drugs
Deductible	\$50 per person per plan year		
Retail pharmacy non-maintenance drugs	\$10 up to a 30-day supply	\$25 up to a 30-day supply	\$40 up to a 30-day supply
Retail pharmacy maintenance drugs	\$15 up to a 30-day supply	\$35 up to a 30-day supply	\$55 up to a 30-day supply
Home delivery (mail service)	\$30 up to a 90-day supply	\$75 up to a 90-day supply	\$120 up to a 90-day supply

Please remember that if a brand name medication is dispensed that has a generic equivalent available, in addition to paying the generic copayment, you are also responsible for the difference in the cost between the generic and brand name drug.

Drugs for Excluded Benefits Participants are responsible for the full cost of drugs which are used for treatment of excluded services and supplies under HealthSelectSM.

Caremark Customer Care (888) 886-8490, 24 hours a day, 7 days a week

What is Not Covered

Exclusions

Your HealthSelectSM 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; while a patient is in a hospital, skilled nursing facility, or other institution; or any take-home drugs;
- G. Drugs provided by laws of the federal or local government, including Workers' Compensation;
- H. Services or supplies for which a pharmacy does not normally charge;
- I. Drugs for which a pharmacy's usual and customary charge to the public is less than or equal to the copayment;
- J. Contraceptive devices or materials (birth control pills are covered);
- K. Prescription mouthwash preparations or topical oral solutions or preparations;
- L. Investigational or experimental drugs;
- M. Refills over the number prescribed, or over the 30-day or 90-day limit under HealthSelectSM;
- 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, and 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 HealthSelectSM prescription drug or Medical ID Card;
- S. Drugs whose use or intended use would be illegal or unethical;
- T. Legend Drugs which are being used for purposes other than those approved by the FDA;
- 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 with other group plans except when HealthSelectSM is the secondary plan or when required for other government programs in which case ERS will coordinate benefits;
- 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 contain the same active ingredients. Brand name drugs typically are more expensive because the company that originally developed them spent a lot of money on research and testing before putting the drug on the market. The company makes up for some of this developmental cost in the price it charges for the drug. After patent expiration, other drug companies are allowed to make a generic equivalent; but they generally do not have to charge as much, since there are limited developmental costs.

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 Drug List

Q. Should I use generic drugs whenever I can?

A. Yes. Generics will save you and the HealthSelectSM plan money. If you purchase a brand name drug when a generic equivalent is available, Caremark may call your doctor to see if a generic can be substituted. If so, you will receive the generic drug and will pay the lowest copayment. If you or your doctor request the brand name drug, you will pay the Tier 1 drug copayment plus the difference in the cost between the brand name and generic drug.

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

A. No, the prescription drug deductible is separate from the medical deductible. Prescription drug copayments do not apply to your calendar year medical deductible or coinsurance.

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

A. Yes; however, lancets and glucometer strips are considered medical expenses, not prescription drug expenses. To file a claim, attach your cash register receipt to a completed medical claim form, and mail to BCBSTX. See Section Six, page 110 for more details on how to file a claim to BCBSTX.

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

Section Six

Important Plan Provisions

About this section

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

TIP: HealthSelect coordinates benefits with most other group policies.

Eligibility

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

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

If you are an eligible employee or retiree under age 65, the type of coverage you have usually depends on whether you live in a network area.

Employees under age 65 who live out-of-area but select in-area as an active employee based on their work county, will be allowed to continue to have in-area coverage upon retirement. This coverage will remain in effect until the retiree turns age 65 (see paragraph below) or notifies ERS that he or she wishes to change the election to out-of-area coverage following a residential move. Once this change is made, the retiree will not be allowed to change the election again unless their residential county changes to an in-area location.

When you retire and are age 65 or older, you will automatically be covered by HealthSelect's out-of-area coverage. Visit the HealthSelect Web site at www.bcbstx.com/hs to download the Benefits Book for retirees age 65 or older.

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.

You may elect coverage as an active employee within 30 days of your date of hire. If you do not elect active coverage during this time, you may elect coverage as an active employee during the annual summer enrollment period or, if you have a Qualifying Life Event during the plan year, you may apply for active employee coverage at that time. You may be required to provide evidence of insurability in these circumstances. Contact your Benefits Coordinator for additional information on enrollment as an active employee.

If you are under age 65 when you return to work, have elected coverage as an active employee, and you turn 65 during your active employment, you and your covered dependents may continue to have in-area coverage until you are no longer employed with a state agency or higher education institution. At that time, you will switch to out-of-area coverage.

If you are a return-to-work retiree under age 65 and are currently enrolled in HealthSelect and Medicare, you have in-area coverage. If you turn age 65 during your active employment, you and your covered dependents may continue to have in-area coverage until you are no longer employed with a state agency or higher education institution. At that time, you will switch to out-of-area coverage.

If you are a return-to-work retiree under age 65 and you elect not to have coverage as an active employee and your spouse is age 65 or older, your spouse will have out-of-area coverage and HealthSelect will be the primary coverage and Medicare will be secondary.

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

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

Changing Your HealthSelect Coverage

Adding and dropping dependents from coverage

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

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

Evidence of insurability

Evidence of insurability (EOI) will usually be required of any employee, retiree, or dependent who does not enroll in HealthSelect when first eligible. However, HealthSelect participants who do not live in an HMO service area may add dependents during summer enrollment period without EOI.

EOI is an application process in which past and present health information of an applicant is provided in order to determine eligibility for insurance coverage. This means that you provide a medical history to Fort Dearborn Life Insurance Company (FDL) for review. FDL handles EOI review for BCBSTX. You and/or your dependents could be denied HealthSelect coverage depending on the outcome of that review. See page 112 of this section for information on how to appeal a denied application.

You can download an EOI application at 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 FDL at (800) 451-0271, option 1. FDL reviews EOI applications on behalf of BCBSTX.

Participants who are approved for coverage through EOI will be subject to review of medical and pharmacy claims activity during the first 18 months of coverage to determine if the Participant misrepresented his/her medical health at the time the EOI application was submitted.

Incorrect, untrue or incomplete answers on the EOI application may result in rescission of coverage and denial of any claims and may be cause for expulsion from the Texas Employees Group Benefits Program or other sanctions.

When Coverage Ends

When employee coverage ends

Your HealthSelect coverage as an employee will end if:

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

When retiree coverage ends

Your HealthSelect coverage as a retiree will end if:

- You die;
- HealthSelect ends, or stops covering your retiree class; or
- You are expelled from the insurance program.

When dependent coverage ends

A dependent's coverage will end if:

- Your coverage ends;
- The dependent is no longer an eligible dependent unless continuation of coverage is elected (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);
- You stop making premium payments for dependent coverage;
- You remove your dependent from your health coverage; or
- You are expelled from the insurance program.

Surviving dependents

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

Extension of benefits

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

Continuation of Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act, or COBRA, provides an option to continue 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 continuation coverage lasts

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

- Your coverage ends because your employment ends - including retirement with less than 10 years of service and/or if you have 10 years of service and retire under age 65 without meeting the "Rule of 80" - 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.
- 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.

If you are a dependent covered in the GBP you may 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 GBP, provided you were covered as a dependent at the time of the initial qualifying event. Qualifying events that entitle covered dependents up to 36 months of continuation coverage are:

- Death of the employee who covered you as a dependent;
- Divorce from the employee who covered you as a dependent;
- Dependent child marries or attains age 25;
- An other than natural child of the employee who moves out of the employee's household; or
- The employee begins receiving Medicare benefits.

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, continuation coverage may be extended for up to a total of 29 months.

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

Former COBRA unmarried child

Under state law, children who initially continue coverage under COBRA due to losing GBP eligibility as a dependent when reaching age 25 may continue enrollment in the GBP upon expiration of the 36 months of COBRA coverage provided:

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

GBP coverage ceases when the child marries.

Applying for COBRA

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

When your COBRA coverage can be terminated

HealthSelect has the right to end this continuation coverage if:

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

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

Conversion privilege

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

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

For additional information or an application, call BCBSTX Direct Markets at (800) 531-4456.

Loss of benefits due to fraud or misrepresentation

Improper use of the PDP or HealthSelect plan, your HealthSelect Medical ID Card, or the filing of a misleading or fraudulent claim for benefits or application for coverage is wrong, and in some instances illegal, and may subject you or your dependents to penalties and sanctions, including loss of coverage in HealthSelect and/or the GBP. An example of a misleading or fraudulent act would be using your HealthSelect ID card before the effective date or after coverage ends, or providing misleading information or omitting information regarding your health history on an EOI form.

Coordination of Benefits

What is coordination of benefits?

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

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

How does COB work?

Under a COB provision, the plan that pays first is called the Primary Plan. The Secondary Plan typically makes up the difference between the Primary Plan's benefit and the covered charge. When one plan does not have a COB provision, that plan is always considered Primary, and always pays first. You may still be responsible for applicable deductible amounts, copayments and coinsurance.

Coordinating benefits between husband and wife

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

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

Coordination of benefits for children

For children's coverage, the plan of the parent whose birthday (month and day) falls earlier in the calendar year is the Primary Plan.

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

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

When you become eligible for Medicare

If you are still actively working for an agency or institution of higher education that participates in the Texas Employees Group Benefits Program (GBP) when you become eligible for Medicare at age 65, your HealthSelect coverage continues and is your primary plan and Medicare is the secondary plan. Once you retire, Medicare becomes the primary plan and HealthSelect becomes the secondary plan. At that time, you and your dependents will have out-of-area coverage.

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

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

If you are an active employee and do not have Medicare, but your spouse has Medicare, HealthSelect will be the primary coverage, and Medicare will be the secondary coverage for your spouse. Both you and your covered spouse will continue to have in-area coverage until you retire. If you retire prior to age 65, your spouse will have out-of-area coverage and Medicare will be his or her primary coverage. You will remain in-area with HealthSelect as your primary coverage until you turn age 65, at which time Medicare will become your primary plan and you will have out-of-area coverage.

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

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

Disabled active employees

If you are considered to be disabled by the Social Security Administration, you may become eligible for Medicare Part A and B. While you are an active employee, HealthSelect will be primary and Medicare secondary. As long as you reside in Texas, you and your covered dependents will have in-area coverage.

Upon retirement, regardless of your age, because you are eligible for Medicare, Medicare will be the primary payer and HealthSelect will coordinate to pay secondary benefits. If you did not sign up for Medicare Part B when first eligible, upon retirement, you will be in your enrollment period with Medicare and can purchase Part B, with no penalties. **If you do not purchase Part B, you will be considered the primary payer and HealthSelect will be secondary. This means that HealthSelect will only pay 20% of the allowable amount and you will be responsible for the remaining charges.**

Disabled retirees under age 65

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

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

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

If you use Network benefits, your PCP is directing your care. As your primary insurance, Medicare will generally pay 80% of eligible charges after you meet the Medicare Part B calendar year deductible. As your secondary plan, HealthSelect will coordinate benefits with Medicare. You will not be responsible for the Medicare Part B deductible if you follow network guidelines with HealthSelect and will only be charged your copayments or applicable coinsurance until the Medicare deductible has been satisfied. Once the Medicare deductible is satisfied, Medicare will generally pay 80% of eligible charges and in most cases HealthSelect will pay the remaining balance.

You may however, have out of pocket expenses for office visits, for inpatient and outpatient day-surgery copayments, for services if the provider does not accept Medicare assignment, or for services that Medicare does not cover, but HealthSelect does cover.

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

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. This means that HealthSelect has the right to be reimbursed for healthcare expenses it has paid on your behalf. 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 judgment, 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 the extent of the benefits provided. As a HealthSelect participant, you are obligated to cooperate with HealthSelect to protect its subrogation rights by supplying all necessary information, executing all necessary documents and reimbursing HealthSelect when a recovery is made.

Case Management

What is case management?

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

How does it work?

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

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

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

Blue Care[®] Connection

Blue Care Connection is the Disease Management and Wellness program offered to HealthSelect participants as part of your coverage. Blue Care Connection simplifies the coordination of your health care benefits, educates and empowers you to make informed choices, supports wellness by aiding your understanding of preventive care guidelines, personal risk assessments and preventive screenings. These services are provided to you at no additional cost.

Wellness Programs

Wellness programs, an important part of Blue Care Connection, include targeted mailings regarding key preventive screenings and disease-specific immunizations based on your age, sex, or identified gap in care. Reminders include birthday cards to women 40 and over and men 50 and over to help remind you to take good care of yourself, eat healthy food and get the medical tests that are recommended for your age.

24/7 NurseLine

With the 24/7 NurseLine, you have access to caring, experienced nurses who understand your health concerns and are available to you twenty-four hours a day, seven days a week, even on holidays. This convenient information and support resource is available at no out-of-pocket expense to you. The 24/7 NurseLine is available toll-free at (888) 334-9473.

If you want to get basic information on a topic from the audio library, just call the 24/7 NurseLine and choose a topic from more than 500 pre-recorded health messages such as; kicking the smoking habit, ways to get a good nights sleep and getting a grip on stress.

Personal Health Manager

As part of Blue Care Connection, you have access to the Personal Health Manager, an online tool available through Blue Access for Members. The Personal Health Manager is discussed in more detail on pages 12-13.

Disease Management

Blue Care Connection includes disease management programs designed for those who have been diagnosed with conditions such as asthma, diabetes, congestive heart failure or coronary artery disease, to name a few. When selected to participate in one of the voluntary programs, you will receive helpful information about your condition and possibly contacted by a Blue Care Advisor. If you have any questions or would like to inquire about enrolling in a disease management program, call toll-free (800) 462-3275.

Blue Care Advisor

The Blue Care Advisor, a registered nurse, will be your personal telephone coach to provide guidance for at-risk participants or those with chronic conditions. The Blue Care Advisor works with you and your physician to reinforce treatment compliance, simplifies benefits coordination and acts as your single point of contact at BCBSTX.

Special Beginnings®

Special Beginnings helps expectant mothers and their babies get off to a healthy start by providing prenatal and postnatal health education, pregnancy risk assessment, educational materials and follow-up monitoring from pregnancy to six weeks after delivery. The Special Beginnings Program provides prenatal risk assessment education and coordinates with the patient's physician to provide case management services to help reduce the chance of low birth-weight infants and/or premature delivery. The program is available at no additional cost. Call toll-free (800) 462-3275 to enroll or ask questions.

Once enrolled in Special Beginnings, you will receive:

- A pregnancy risk assessment to determine the risk level of the pregnancy and follow-up monitoring calls, if needed.
- A welcome packet.
- Pregnancy-related, post-pregnancy and well-child educational materials on a variety of topics.

- Personal telephone contact with an experienced obstetrical nurse during pregnancy through six weeks after delivery.
- Immunization schedules that help remind parents to make doctor's appointments for their babies.

Blue CareLink

Blue CareLink is the BCBSTX integrated medical and disability management program that seeks to identify injured or ill participants in order to both optimize health benefits, and minimize or possibly prevent disability.

Participants with designated diagnoses or who are undergoing certain procedures are contacted by a Disability Case Manager who coordinates care with all involved physicians and providers to promote timely assessment and referral for required medical, surgical, and/or rehabilitative services. In addition, participants are provided supportive coaching to ensure compliance and progression with the individualized physician plan of treatment.

ParPlan Providers

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

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

TIP: Using ParPlan providers may save you money.

For information on ParPlan providers in Texas, either

- Call BCBSTX Customer Service at (800) 252-8039, **OR**
- Visit **www.bcbstx.com/hs** for online information.

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

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

ParPlan provider advantages

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

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

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

ParPlan and non-ParPlan: An example

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

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

ParPlan and Non-ParPlan: A typical example for in-area non-network benefits:

Item	ParPlan	Non-ParPlan
Amount billed	\$2,500	\$2,500
Allowable amount	\$2,000	\$2,000
Your 40% coinsurance	\$800	\$800
Provider’s balance of billed charge	N/A	\$500
Your total cost	\$800	\$1,300

ParPlan and Non-ParPlan: A typical example for out-of-area coverage:

Item	ParPlan	Non-ParPlan
Amount billed	\$2,500	\$2,500
Allowable amount	\$2,000	\$2,000
Your 30% coinsurance	\$ 600	\$600
Provider's balance of billed charge	N/A	\$500
Your total cost	\$ 600	\$1,100

How to File a Claim

Remember: If you use a network provider, a ParPlan provider, or receive medical treatment at a BCBSTX contracting facility, you do not have to file claims. If, however, you receive care from a non-network, non-ParPlan provider, or non-contracting facility or you are filing a claim for diabetic supplies (other than insulin or syringes which are a covered benefit under your Prescription Drug Program described in Section Five, page 84), you must follow these steps:

Steps to filing claims

- Step 1** You may get a claim form by calling BCBSTX Customer Service at (800)252-8039. You may also download a claim form from the HealthSelect Web site at www.bcbstx.com/hs/forms.htm.
- Step 2** Fill out the claim form completely.
- Step 3** Attach your original itemized bills that show the services performed and the date, the charges, and the name of the patient.
If you incur medical costs outside the United States, please obtain an itemized bill that has been translated into English and U.S. currency, using the rate of exchange on the date of service. See information below for more information about BlueCard Worldwide and receiving services outside the United States.
- 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 and an EOB provided. (BCBSTX must pay network providers, ParPlan providers, and facilities directly.)

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

Claims for Services Received Outside of Texas

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 Medical 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 Medical ID Card.
- Step 4:** If necessary, call Blue Cross and/or Blue Shield for preauthorization of inpatient admissions. Refer to your Medical 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.

If you receive services outside the United States from a provider who does not contract with Blue Cross and/or Blue Shield, you will be required to pay for services up-front and file your claim for processing. All receipts and documentation must be converted into United States currency and translated into English when submitted to BCBSTX.

BlueCard Worldwide offers a service, free of charge to HealthSelect participants, to translate the receipts and other documentation into English and convert currency into United States dollars. To submit your claim to BlueCard Worldwide, simply complete the BlueCard Worldwide claim form, attach all receipts and documentation and send to:

BlueCard Worldwide Service Center
PO BOX 72017
Richmond, VA 23255-2017

You claim will be translated into English and converted to United States currency and forwarded to BCBSTX for processing. **Be sure to keep copies of all information that you submit to BlueCard Worldwide or BCBSTX.**

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 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 660044
Dallas, TX 75266-0044
Or call:
(800) 252-8039

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

If your claim is still denied

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

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

Your written notice of appeal must be postmarked or received by ERS within 90 days from the date of the BCBSTX letter notifying you of your right to appeal. You will receive a decision in writing from ERS.

If your EOI application is denied

If your EOI application is denied, you will receive notification from Fort Dearborn Life Insurance Company (FDL). FDL, a company affiliated with BCBSTX, handles medical underwriting on behalf of BCBSTX. This notification will indicate that your EOI application was denied and that you have the option to request a reconsideration of the denial.

You should send your request for reconsideration of denial to:

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

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

You may then send a letter of explanation to ERS along with copies of correspondence between you and FDL 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 FDL letter notifying you of your right to appeal. You will receive a decision in writing from ERS.

If you need help

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

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

(512) 867-7711; or
(877) 275-4377

Section Seven

Glossary of Important Terms

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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 BCBSTX Customer Service at (800) 252-8039.

A

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. In some cases, allowable amounts may be set in relation to Medicare or other government program benefits.

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

B

Behavioral Health Care – The treatment of mental disease, disorder or condition as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) IV, 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.

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 Chemical Dependency Counselor; and
- Licensed Psychological Associate.

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

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

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

C

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 the allowable amount paid for covered services and supplies, not counting the deductible or copayments. It is usually a percentage of the allowable amount.

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

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;

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

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

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

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

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

Cosmetic, Reconstructive, or Plastic Surgery - Surgery that either: improves physical appearance, but does not correct or restore a bodily function; or 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); and
- Correction of damage caused by external violent accidental injury to healthy natural teeth, if the accident occurs while the participant is covered under HealthSelect. Services must be received within 24 months from the date of the accident.
- Orthognathic surgery.

No other dental services are covered under HealthSelect.

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

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

D

Deductible – The dollar amount of covered services and supplies that must be incurred by a participant each calendar year before benefits under the plan will be available. Only the allowable amount of covered services and supplies will apply to the deductible. There is no deductible for network benefits.

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

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

Diabetes Equipment is specifically defined as:

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

* Covered as Durable Medical Equipment.

Diabetes Supplies are specifically defined as:

- *Test strips for blood glucose monitors;
- *Visual reading and urine tests strips;
- *Lancets and lancet devices;
- **Insulin and insulin analogs;
- *Injection aids;
- **Syringes;
- **Prescriptive and nonprescriptive oral agents for controlling blood sugar levels;

- *Glucagon emergency kits; and
- *Alcohol wipes.

* Covered as Durable Medical Equipment.

** Covered under the Prescription Drug Program.

Diabetes Self-Management Training Programs are specifically defined as:

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

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

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

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

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

E

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

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

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

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

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

Evidence of Insurability - Such evidence of the condition of one's health including medical records and a physical examination, as may be required by Fort Dearborn Life Insurance Company, acting on behalf of BCBSTX, to evaluate one's health status when one applies for changes in existing coverage or issuance of new coverage, when evidence of insurability is required by the Rules of the Board of Trustees of ERS.

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.

F

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 BCBSTX or accessible through BlueCard Worldwide);
- 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 or accessible through BlueCard Worldwide);
- Skilled nursing facilities;
- Spiritual care facilities;
- Substance abuse facilities; and
- Therapeutic centers.

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

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

G

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

H

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 provider that is duly licensed by the appropriate state agency to provide home infusion therapy and contracts with BCBSTX or is accessible through BlueCard Worldwide.

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.

I

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

In-Area - Geographic locations selected by ERS that are served by the HealthSelect network. All Texas counties are in-area.

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

Infertility Services – The diagnosis and treatment of involuntary infertility. These services may include diagnostic laboratory and x-ray procedures, therapeutic injections and surgical treatment. See Exclusion Q, in Sections Three and Four, for excluded services.

Inpatient - A person admitted to a hospital or substance abuse facility 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 care facility.

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

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

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

M

Maternity Care - Medical care and services provided to a pregnant woman. For network benefits, maternity care includes diagnosis of pregnancy and pre- and post-natal care and delivery (including delivery by C-section). Physician office visits are covered at 100% after the initial office visit copayment. The 100% coverage does not include complications of pregnancy, sonograms, stress tests, amniocentesis, lab fees, tubal ligation, circumcision, assistant surgeon fees, anesthesiologist fees and inpatient hospital expenses. Network benefits for these services are paid according to the Benefits Summary in Section Three, page 38.

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, physician, 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 physician 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.

N

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

Network Behavioral Health Service Provider – The HealthSelect network of providers that has been established by BCBSTX and approved to provide behavioral health services for HealthSelect participants. Providers who have entered into this agreement with BCBSTX are required to obtain the

appropriate referral and preauthorization. Providers failing to obtain the required authorization are not eligible to receive benefits reimbursement and cannot bill the patient for any unauthorized services. Benefits are available only when the licensed providers are providing services and/or supplies within the scope of their license. Providers include:

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

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

Network Benefits - Benefits for services and supplies provided by:

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

Network benefits apply only to employees, retirees under age 65 and covered dependents who live or work in the state of Texas and have in-area coverage.

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

Non-Network Provider - Doctors, hospitals, and other providers (as defined on pages 129-130 of this section) who do not belong to the HealthSelect network serving employees, retirees under age 65, and covered dependents in the state of Texas.

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

O

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 physician or other provider, and that are not considered inpatient expenses or extended care expenses. Covered services and supplies are shown in Sections III and IV of this book.

Out-of-Area - Geographic locations outside the state of Texas.

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

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

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

P

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

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 to be 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 Caremark to provide pharmacy services to participants.

Pharmacy and Therapeutics (P&T) Committee - A committee of independent members consisting of nationally recognized physicians, clinical pharmacists or other medical professionals whose purpose is to develop the formulary, prescribing guidelines, coverage criteria and drug utilization review interventions. The P&T Committee meets quarterly or more often if needed to review information on safety and efficacy of each drug considered for inclusion or exclusion from the preferred and non-preferred brand name drug lists.

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

Plan Year – The 12-month period from September 1st through August 31st.

Preauthorization - Advance approval (but not a guarantee of payment) that is required from BCBSTX. Preauthorization is a predetermination of 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 provider contracted with BCBSTX or accessible through BlueCard Worldwide to receive benefits).

Predetermination - A review by BCBSTX Medical Division 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 Drug List – A list of preferred drugs, biologicals and devices approved by the Pharmacy and Therapeutics Committee for inclusion in the pharmacy benefit program. The preferred brand name list is subject to change.

Prescription Drug Plan Year Deductible – The amount each participant must pay per plan year in covered prescription drug expenses before any prescription drug copayments apply.

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

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

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

TIP: Some prosthetic appliances may not be eligible for coverage because they may be considered experimental and investigational. You should request a predetermination of benefits for prosthetic appliances to ensure coverage is available.

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

Providers also include:

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

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

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

R

Referrals - For in-area participants to receive network benefits, a referral must be approved by BCBSTX before you receive specialty medical care from a provider other than your PCP except for those services rendered by specialists that do not require a referral. PCPs will contact the BCBSTX Referral Department by telephone or fax to obtain the approval of a referral. ***An informal referral or recommendation from a physician to a specialist that has not been approved by BCBSTX, even if it is in writing will not be sufficient in order to receive network benefits.***

All approved referrals are set up for a specific number of days or visits. A referral does not guarantee payment. If you are seeking care for pregnancy, an annual well-woman exam, or gynecological services, you may go directly to a network OB/GYN for network benefits. Refer to Section Three, page 22 for further instructions on direct access to OB/GYNs.

Retail Health Clinic – A health care clinic located in a retail setting, such as a supermarket or pharmacy, which provides treatment of common illnesses and routine preventive health care services that can be rendered by appropriately licensed staff located in the clinic, which may include Advanced Practice Nurses, Physician Assistants, and/or Physicians.

Residential Treatment Center for Children and Adolescents (RTC) – 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 Behavioral Health 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.

S

Serious Mental Illness - Mental health conditions that HealthSelect covers at the same benefit levels as any other illness or injury and as defined by Texas law to include the following:

- 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 (SNF) - 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, even if provided in a SNF, is not covered by HealthSelect. It must also be:

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

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

Subscriber Identification Number (Subscriber ID) - The unique number shown on the HealthSelect Medical ID Card which identifies the subscriber.

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 must 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 to be eligible to provide services covered by HealthSelect.

T

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

This book is a summary of the Master Benefit Plan Document, statutes, and administrative rules governing HealthSelect. In case of conflict between the provisions of this book and the plan document, statutes, or administrative rules, the plan document, statute, or 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.