



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

**Retirees Age 65 and Over  
Effective September 1, 2009**



**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

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

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

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

1. Limitations on preexisting conditions exclusions periods;
2. Special enrollment periods for individuals (and dependents) losing other coverage;
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status;
4. Standards relating to benefits for mothers and newborns;
5. Parity in the application of certain limits to mental health benefits; and
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, 2009 through August 31, 2010, the Employees Retirement System of Texas (ERS) has elected to exempt HealthSelect of Texas (HealthSelect) from HIPAA provisions 2 and 3 above. Therefore, employees and retirees who do not enroll themselves and their dependents in HealthSelect during their initial period of eligibility may be subject to evidence of insurability requirements if they wish to enroll at a later date.

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

In order for BCBSTX to receive information from or give information to anyone other than the subscriber or covered dependent (including but not limited to claims information or general membership information regarding a patient covered under HealthSelect), please be prepared to submit an authorization from the subscriber, divorce decree showing custodial responsibility, or a court order. This will ensure confidentiality of all patient information. An authorization form can be downloaded from the HealthSelect website at **[www.bcbstx.com/hs](http://www.bcbstx.com/hs)**

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

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# NOTICE

## TO ALL PARTICIPANTS AND COVERED DEPENDENTS IN HEALTHSELECT

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

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

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

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

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# Section One

## About This Benefits Book

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## Section One

### About This Benefits Book

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

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

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

### Glossary of important terms

Included in this benefits book is a section which defines frequently used terms. You should read the Glossary of Important Terms, Section Six, beginning on page 77 for definitions of terms such as “Medically Necessary,” “Allowable Amount,” and “Covered Oral Surgery.”

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

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

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## 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 and Prescription ID Cards will list important information, such as your subscriber number and useful telephone numbers.

Please note: Several states, including Texas, have passed Identity Theft laws to help protect the confidentiality of Social Security Numbers for state residents. Because of this, your subscriber number has been replaced with a Unique Identifier. If you do not have 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.

	<b>BlueCross BlueShield of Texas</b> P.O. Box 60044 Dallas, Texas 75266-0044	<b>THIS IS A DUPLICATE Explanation of Benefits (EOB). This is not a bill. EMPLOYEES RETIREMENT SYSTEM OF TEXAS</b>																
Name _____ Address _____	Customer Service: 1-800-252-8039  Customer Service Hours 7:00 a.m. to 7:00 p.m. C.S.T., Monday - Friday 9:30 a.m. to 1:30 p.m. C.S.T., Saturday																	
<b>SUMMARY</b> Total Billed: Total Benefits Approved: Amount You May Owe Provider:	<b>Claim Information</b> Member Name: Group No.: Identification No.: Claim No.: Patient Name:																	
<b>SERVICE INFORMATION</b>																		
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Total Benefits Approved																		
Amount You May Owe Provider																		
Total covered benefits approved for this claim:																		

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## 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 75265-5403

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

Outside Austin: (877) 275-4377  
Within 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 and 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  
(800) 252-8039  
P.O. Box 655730  
Dallas, TX 75265-5730

### **Behavioral Health Services**

INROADS® Behavioral Health Services  
a Magellan Behavioral Health Company  
Within Dallas: (972) 766-5201  
Outside Dallas: (800) 528-7264

### **Subrogation and Workers Compensation**

(800) 695-6475  
2329 S. MacArthur Blvd.  
Springfield, IL 62704

### **Medicare Part A and B**

(800) MEDICARE (633-4227)

### **Caremark Mail Service Program**

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

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# Section Two

## HealthSelect Website

### At-A-Glance

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## Section Two

### About the HealthSelect Website

The information found in this benefits book and much more is available on the HealthSelect website. You can search for ParPlan physicians and providers, review your benefits, email BCBSTX Customer Service, Live Chat with a BCBSTX Customer Service Representative, review participant eligibility and claim status, view and print your Explanation of Benefits (EOB), request email notification when a claim finalizes, opt-out of paper EOBs, download claim forms and obtain up-to-date information about HealthSelect. You can also link to **Caremark's website** 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](http://www.ers.state.tx.us), or directly at [www.bcbstx.com/hs](http://www.bcbstx.com/hs).

### Online provider directory through Provider Finder<sup>®</sup>

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

Provider Finder gives you detailed information about the physicians and providers, including:

- Whether they are accepting new patients;
- Board certification;
- Hospital affiliations;
- Where the physician attended medical school;
- If the physician has a website; and
- Much more.

Provider Finder allows you to conduct customized searches or download an entire directory. Provider Finder also gives you the option to email your search results to a family member, your physician, or anyone with a valid email address.

Although every attempt has been made to ensure that Provider Finder is correct, some additions, deletions, and changes may not be reflected. If you have any questions about Provider Finder, please contact BCBSTX Customer Service at (800) 252-8039.

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## Blue Access<sup>®</sup> 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 website at [www.bcbstx.com/hs](http://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 email notification of finalized claims
- Request a new or replacement Medical ID Card or print a temporary Medical ID Card
- Email BCBSTX Customer Service
- Live Chat with a BCBSTX Customer Service Representative

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

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

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

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

## Personal Health Manager

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-Dietitian*, 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.

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

To complete a Health Risk Assessment simply:

- Go to the HealthSelect website at [www.bcbstx.com/hs](http://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.

## BlueCompare – Provider Comparison Tool

A tool called BlueCompare provides you information on:

- Affordability and performance measures for hospitals; and
- How physicians or other professionals compare to their peers with regard to Evidence Based Medicine (EBM).

BlueCompare for Hospitals measures general acute care hospitals, not specialty hospitals like children’s, mental health, or rehabilitation facilities.

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 EBM.

BlueCompare results are available when conducting online searches in Provider Finder.

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## Care Comparison Tool

Care Comparison allows you to review and compare total treatment costs, both professional and facility combined, for procedures performed at the following facilities:

- Hospitals;
- Ambulatory surgery centers; and
- Free-standing radiology centers, including inpatient and outpatient services.

You can also use the Care Comparison tool to help you rank facilities based on the factors important to you.

To use Care Comparison, go to the HealthSelect website at [www.bcbstx.com/hs](http://www.bcbstx.com/hs), log in to Blue Access for Members, then select “Tools” under the “My Health” tab.

## 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 7 a.m. – 10 p.m. (CT). Live Chat is not available on Saturdays, Sundays or holidays.

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## Downloading PDFs for the Visually Impaired

Adobe® Reader® 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](http://www.adobe.com) and clicking 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](http://www.bcbstx.com/hs).

Once you have downloaded Adobe Reader, 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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**Section Three**  
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Please remember that these topics apply to retirees age 65 or over and/or their dependents.

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## Section Three

### About your coverage

As a retiree who is age 65 or over, you are eligible for traditional medical benefits under HealthSelect. You may choose any provider you wish (see definition of provider in Section Six, pages 89-90).

### A word about Medicare

#### Medicare has two parts:

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

Most individuals become eligible for Medicare when they reach age 65. Typically, if you have Part A, you are automatically covered for Part B, unless you decline it. However, you may not be automatically enrolled in Medicare Part A and B at age 65 and it is your responsibility to verify whether or not you are enrolled. Medicare charges a premium for Part B coverage. It is important that you sign up for Medicare when you first become eligible, since HealthSelect will coordinate benefits with Medicare, as explained in this book in Section Five, pages 63-68.

**Please note:** If you are eligible for Medicare, HealthSelect will coordinate and pay benefits as the secondary payer. You can be eligible for Medicare Part A and B and still not receive a Social Security Benefit.

If you are not eligible for Social Security Benefits at age 65, then you are **not** automatically enrolled. Medicare also does not send you enrollment material prior to turning 65. It is recommended that you contact the Social Security Office prior to your 65 birthday to ensure you enroll during your enrollment period and avoid paying a premium penalty with Medicare and higher out-of-pocket costs as HealthSelect will always coordinate benefits assuming you have Medicare, paying only secondary benefits.

We have added a subsection in the back of this section (page 43 titled "Q & A Quick Reference"). You may want to review this section which includes questions frequently asked by retirees, which address coordination of benefits with Medicare.

**TIP: Contact your Social Security office about enrolling in Medicare Part B prior to your 65 birthday.**

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## **If you are a Grandfathered Retiree**

As a “Grandfathered Retiree,” (you retired and turned 65 prior to September 1, 1992) you are not required to purchase Medicare Part B. HealthSelect is your primary plan for Part B services and Medicare primary for Part A services. As your primary plan, HealthSelect pays 70% of the allowable amount for eligible services after you have met your calendar year HealthSelect deductible. See the Benefits Summary which begins on page 31 of this section for more details regarding deductible, coinsurance and copayment amounts.

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

Retirees who return to active employment at a state agency or certain higher education institutions will have the option to enroll as active employees. For more information on return-to-work retirees, refer to Section Five, page 57.

## **If you cover any dependents who are under age 65**

If you cover any dependents who are under age 65 that do not have Medicare, they will have traditional medical care coverage with HealthSelect. If your covered dependent does not have coverage with any other insurance plan, HealthSelect will be their primary insurance. This means that for eligible services, HealthSelect will pay 70% of the allowable amount once the calendar year deductible has been satisfied. See the Benefits Summary which begins on page 31 of this section for more details regarding deductible, coinsurance and copayment amounts.

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

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## Calendar year deductible

The deductible is per person per calendar year. The family deductible is met when three family members have each met their individual deductible under one subscriber ID number. If more than the maximum family deductible has been taken in a calendar year, call BCBSTX Customer Service because you may be eligible for a refund. Refer to the Benefits Summary on page 31 of this section for the amount of the individual and family deductibles.

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

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

If you have Medicare, HealthSelect will coordinate your benefits so that most of your expenses are covered. See Section Five, pages 63-68 of this book for an explanation of coordination of benefits with Medicare.

## Out-of-pocket coinsurance maximum

The out-of-pocket coinsurance maximum is per person per calendar year. This means that after your coinsurance share of covered services and supplies totals the out-of-pocket maximum amount in a calendar year, HealthSelect will generally pay 100% of covered charges for the rest of that calendar year. Refer to the Benefits Summary on page 31 of this section for the out-of-pocket maximum amount. The following expenses do not count toward the out-of-pocket coinsurance maximum:

- Your deductible;
- Outpatient day-surgery and inpatient copayments;
- Any amount over the allowable amount;
- Charges for services and supplies that are not covered or that are limited under HealthSelect; and
- Any prescription drug copayments.

## Inpatient copayments

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

Once this inpatient copayment maximum has been met, you will no longer be required to pay the \$100 inpatient copayment for the remainder of that calendar year. The calendar year inpatient

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copayment maximum does **not** include any copayments paid for outpatient day-surgery or prescription drugs.

## Outpatient day-surgery copayments

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

## Services that are never covered at 100%

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

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

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

## Emphasis on preventive care

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

- Participants may receive one routine physical exam each calendar year.
- Women may receive one annual well-woman exam by an obstetrician/gynecologist (OB/GYN) or a physician of family practice or internal medicine, if those services are not performed during their routine physical.
- Men age 50 and over are eligible for coverage for an annual diagnostic medical examination for prostate cancer. Men age 40 and over with a family history of prostate cancer are also eligible for this exam.
- Your medical condition or age may require regular preventive testing or services such as a mammography or bone density screening. HealthSelect allows coverage for medically necessary testing and services.

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

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## Routine eye exam

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

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

## Maternity and newborn care

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

The newborn child's hospitalization is covered under the preauthorization for the mother's hospital stay. If the newborn remains hospitalized after the mother is released, in order to ensure that a penalty is not applied, the participant should:

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

If the mother is a covered participant, she will be responsible for inpatient copayments of \$100 per day, not to exceed \$500 per stay, in addition to any applicable coinsurance. If applicable, these copayments will be coordinated with Medicare and the mother may have an out-of-pocket expense. A separate inpatient copayment will not be charged for the baby unless the baby's stay exceeds the mother's or unless the mother is not a covered participant on the HealthSelect plan. Applicable coinsurance will be charged for the baby. See the Benefits Summary which begins on page 31 of this section for more details regarding deductibles, coinsurance and copayments.

As part of your coverage you can enroll in Special Beginnings<sup>®</sup>, a Blue Care Connection<sup>®</sup> program for expecting mothers, which will provide you education and support throughout your pregnancy. See Section Five, page 70 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. However, for a newborn to be eligible for HealthSelect coverage and for benefits to continue after the first 31 days, the newborn must be enrolled within 30 days of birth. If the newborn is not enrolled within 30 days of birth, the newborn will not be eligible for coverage until the next open enrollment period. Newborn grandchildren are not covered automatically – if eligible, they must be added as dependents for benefits. Retirees should contact ERS for more information.**

## **Childhood immunizations for dependents**

The following childhood immunizations are covered at 100% for children until the child turns six years of age:

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

If an office visit or other service is performed during the same visit as the immunization, 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 Six, page 87 for definition of Office Visit).

## **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.

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## Telemedicine

HealthSelect covers medically necessary services provided through telemedicine. Telemedicine includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. Refer to Section Six, page 92 for the complete definition of Telemedicine.

## Diabetic management services

Diabetic management services include Diabetes Equipment, Diabetes Supplies, and Diabetes Self-Management Training Programs, which are rendered by or at the direction of a physician. See Section Six, pages 82-83 for specific definitions of these services.

### **Diabetes supplies are covered in the following manner:**

**Insulin and syringes** are covered under your prescription drug benefits (see Section Four, pages 45-54, for more information on your prescription drug benefits).

**Other diabetes supplies** (see Section Six, pages 82-83 for a complete definition) are covered under your medical benefits as Durable Medical Equipment (DME), at 70% of the BCBSTX allowable amount after your deductible is met. However, if you use a non-contracting supplier and the charge is greater than the allowable amount, **you will be responsible for the difference.** You may call BCBSTX Customer Service at (800) 252-8039 for a list of contracting DME providers in your area. You can also search for contracting DME providers in other states through Provider Finder “Out-of-State Providers.” When conducting a search in another state, you must select the “Traditional/Indemnity Network.” Once locating a DME provider, you will need to contact that provider to determine if they carry your supplies.

If you use a ParPlan DME provider, you will not be required to file your claims. However, if you use a non-ParPlan provider, you will be required to file your claim for diabetes supplies. To file your claim, attach your cash register receipt, showing quantity of each item purchased, to a completed medical claim form (keeping copies for your records). Mail to:

BCBSTX  
P.O. Box 660044  
Dallas, TX 75266-0044

**If Medicare is your primary carrier, you will be required to use a DME Provider who contracts with Medicare. Once Medicare has processed your claim, it will be forwarded to BCBSTX for processing if you have provided BCBSTX your Medicare information.**

For further clarification on your benefits for diabetes supplies, please see your Benefits Summary on page 35 of this section.

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## Durable medical equipment

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

If your physician prescribes DME, utilize any DME supplier. To reduce your out-of-pocket expenses, use a ParPlan DME supplier. (If a non-ParPlan DME supplier's charge is greater than the BCBSTX allowable amount, you will be responsible for the difference). See the Benefits Summary on page 35 of this section for more information. For a complete definition of DME, see Section Six, page 83.

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

## Hearing aids

HealthSelect allows a \$500 maximum benefit for hearing loss (per ear) every 36 months for hearing aids, fittings, and molds – **but not repairs**. If the provider is a ParPlan provider with BCBSTX, the provider's total payment is based on the BCBSTX allowable amount. BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between that benefit and the contracted BCBSTX allowable amount. If the provider is not a ParPlan provider with BCBSTX, BCBSTX will pay up to a \$500 maximum benefit, and you will be responsible for the difference between the benefit and the provider's billed charges. In addition, hearing aid batteries are covered and are not subject to the \$500/three year limitation. Please see the Benefits Summary on page 35 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, that 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.

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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**

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

1. Placing the participant's health in serious jeopardy;
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**

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

### **Ambulance services**

HealthSelect pays benefits for Ambulance Services received at the time of an emergency and when determined to be medically necessary by BCBSTX. There are no benefits available for Ambulance Services unless a patient is transported to the nearest hospital equipped and staffed to treat the condition. (See definition of "Ambulance Services" in Section Six, page 79).

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

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## If you have been admitted to the hospital

If you have been admitted to the hospital from the emergency room, and have exhausted your Medicare Part A benefits, you must call the BCBSTX Preauthorization Department within 48 hours of your admission to get your hospital stay preauthorized. If you cannot make the call yourself, have your doctor or a family member call for you. **If you do not get your stay preauthorized, you will have to pay an additional penalty deductible.** Preauthorization is described on page 26 of this section.

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

## 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 benefit plan maximum dollar amount of \$60 allowed for each outpatient visit and you can be responsible for any amounts over this maximum, in addition to any applicable coinsurance and deductible amounts. To limit your out-of-pocket expenses, it is recommended that you use ParPlan providers (see Section Five, pages 71-72, for complete description of ParPlan). ParPlan providers can only bill you the difference between the benefit maximum (\$60) and the BCBSTX allowable amount.

If your diagnosis is a serious mental illness as defined in Section Six, page 91 or substance abuse as defined in Section Six, page 91, you will not be subject to the 30-outpatient visit maximum or the \$60 benefit maximum per visit. Your treatment will be covered as any other illness or injury.

## Residential Treatment 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 Section Six, page 90 for a complete definition of RTC). Care received at RTCs must be preauthorized through INROADS<sup>®</sup> Behavioral Health Services.

Inpatient treatment of substance abuse (chemical dependency) must be provided in a Substance Abuse Facility (see Section Six, page 91 for a complete definition of a substance abuse facility). All inpatient treatment of substance abuse (chemical dependency) must be preauthorized through INROADS<sup>®</sup> 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 31 of this section for more details regarding maximum benefit allowable and coinsurance.

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# Preauthorization

## Preauthorization of certain services

If you do not have Medicare Part A coverage, or if your Medicare benefits have been exhausted (e.g. skilled nursing facility care), HealthSelect requires preauthorization of certain medical services. Preauthorization determines, in advance, the medical necessity of the care you are to receive. It is required for:

- Inpatient hospital admissions;
- Skilled nursing care in a skilled nursing care facility;
- Private-duty nursing;
- Home health care;
- Inpatient behavioral health admissions;
- Intermediate care facilities;
- Hospice care; and
- Home infusion therapy. (Use of a ParPlan provider or a provider accessible through BlueCard Worldwide is required to receive any benefits.)

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

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

## How to preauthorize

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

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## Preauthorization numbers to call:

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

**TIP: Preauthorization saves you money.**

## If you do not preauthorize

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

## 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

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## Predetermination of benefits

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

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

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

## 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 still appeal a denied claim after charges have been incurred, by following the normal appeal procedures under HealthSelect as described on page 75.

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

## Making the Most of Your Benefits

### Steps to HealthSelect benefits

**Step 1:** Call any provider (see definition of provider in Section Six, pages 89-90), preferably a BCBSTX ParPlan provider (see explanation of ParPlan provider in Section Five, pages 71-72). Tell the provider that you have HealthSelect coverage.

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

**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 26 of this section for a list of what services and procedures must be preauthorized).

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

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

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statements and contact that state's Medicare carrier and BCBSTX to ensure your claims are processed correctly.

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

**If you receive services outside of Texas or the United States, see Section Five, pages 73-74 for more information on how to file your claims and BlueCard Worldwide.**

**TIP: File your Medicare EOB, BCBSTX EOB, and provider statement together for future reference.**

## Benefits Summary

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

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

## Benefits Summary

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

<b>Doctors' and Lab Services</b>	<b>Retirees with Medicare Primary (Part A and B) when services are covered by Medicare</b>	<b>Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare</b>
Doctor office visits	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Annual physicals (one per calendar year for adults and children)	Plan pays 70%, you pay 30%	Plan pays 70%, you pay 30%
Women are also allowed one well-woman office visit to an OB/GYN each calendar year	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Retail Health Clinic	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Diagnostic x-rays, mammography, injections, routine immunizations, pap smears, and lab tests	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Specific immunizations for children 0-6 years old (except when performed during an office visit)	Plan pays 100%	Plan pays 100%
Allergy injections and antigens	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Office surgery and procedures	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Inpatient doctor visits	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%

## Benefits Summary

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

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

## Benefits Summary

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

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

## Benefits Summary

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

Other Medical Services	Retirees with Medicare Primary (Part A and B) when services are covered by Medicare	Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare
Hearing aids (repairs not covered)	Plan pays up to \$500 per ear every three years (no deductible)	Plan pays up to \$500 per ear every three years (no deductible)
Hearing aid batteries	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for use in your hearing aid (not subject to the \$500/three year limitation)	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for use in your hearing aid (not subject to the \$500/three year limitation)
Diabetes supplies, other than insulin and syringes	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Durable medical equipment (includes medically necessary purchase and/or rental)	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Prosthetic appliances (See definition on page 89 for additional information.)	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Physical, occupational, speech therapy, and chiropractic care	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Ambulance services	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%

## Benefits Summary

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

Other Medical Services	Retirees with Medicare Primary (Part A and B) when services are covered by Medicare	Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare
***Home infusion therapy (HIT)	Medicare pays primary, HealthSelect will coordinate paying secondary. You must use a ParPlan provider BCBSTX or a provider accessible through BlueCard Worldwide to receive any coverage from HealthSelect	Plan pays 70%, you pay 30% if you use a ParPlan provider or a provider accessible through BlueCard Worldwide; Plan pays 0% and you pay 100% if you use a non-ParPlan or non-contracting provider
Infertility Services (see "Exclusion Q" on page 40 for excluded services)	Medicare pays primary, HealthSelect will coordinate paying secondary.	Plan pays 70%, you pay 30%
<b>Behavioral Health</b> (Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)		
Outpatient visits (maximum 30 visits per calendar year)	Medicare pays primary, HealthSelect will coordinate paying secondary; maximum allowable amount \$60 per visit	Plan pays 70%, you pay 30% (even after coinsurance maximum is met); maximum allowable amount \$60 per visit
*Inpatient treatment (maximum 30 days per calendar year)  Inpatient copayments apply toward the calendar year inpatient copayment maximum.	Medicare pays primary, HealthSelect will coordinate paying secondary and you may be responsible for a copayment amount	After you pay a \$100 copayment per day (\$500 maximum per stay), Plan pays 70% for the first 15 days and you pay 30%; The next 15 days the Plan pays 50%, you pay 50%

## Benefits Summary

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

<b>Behavioral Health</b>  <b>(Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)</b>	<b>Retirees with Medicare Primary (Part A and B) when services are covered by Medicare</b>	<b>Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare</b>
<p>**Intermediate care facility (maximum 60 days per calendar year)</p> <p>Intermediate care copayments apply toward the calendar year inpatient copayment maximum</p>	<p>Medicare pays primary, HealthSelect will coordinate paying secondary and you may be responsible for a copayment amount</p>	<p>After you pay a \$50 copayment per day (\$500 maximum per stay), Plan pays 70% for the first 30 days and you pay 30%; The next 30 days the Plan pays 50%, you pay 50%</p>

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

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

\*\*\*Preauthorization required.

## Benefits Summary

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

<b>Prescription Drugs</b>	
Prescription Drug Plan Year Deductible	\$50 per person, per plan year (September 1 – August 31)
At participating pharmacies	<b>Up to a 30-day supply</b> for non-maintenance drugs Copayments: \$10 for Tier 1 drugs, \$25 for Tier 2 drugs, \$40 for Tier 3 drugs **** <b>Up to a 30-day supply for maintenance drugs</b> Copayments: \$15 for Tier 1 drugs, \$35 for Tier 2 drugs, \$55 for Tier 3 drugs****
At non-participating pharmacies	<b>Up to a 30-day supply</b> 60% of the remaining balance of the lesser of: 1) the usual and customary price of the drug minus your deductible (if not met) and your copayment; <b>OR</b> 2) the ERS contract price of the drug minus your deductible (if not met) and your copayment. ****
Mail order pharmacy	<b>Up to a 90-day supply</b> Copayments: \$30 for Tier 1 drugs, \$75 for Tier 2 drugs, \$120 for Tier 3 drugs ****

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

Tier 1 – Primarily Generic drugs

Tier 2 – Mostly preferred brand name drugs

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

## What’s not covered

HealthSelect covers a wide range of medical services and supplies. However, HealthSelect specifically excludes payment in certain instances. You should read the Glossary of Important Terms, Section Six, beginning on page 77, 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.**

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## Exclusions

### HealthSelect does not cover expenses for:

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

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

- I. Any services or supplies provided for the non-surgical and/or non-diagnostic treatment of or related services to the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaw to eliminate pain or dysfunction of the TMJ and all adjacent or related muscles and nerves. This exclusion shall not apply to any physical therapy which is necessary as a result of TMJ surgery, as described in the fourth bullet of the definition of Covered Oral Surgery.
- J. Contact lens exams, prescriptions or fittings of contact lenses or eyeglasses, and the cost of the contact lenses or eyeglasses.

- K. Treatment of myopia and other errors of refraction, orthoptics, visual training, or radial keratotomy, including related corrective vision procedures.
- L. Services or supplies for routine foot care, shoe orthotics, insoles, or shoe inserts of any type, except when prescribed for a diagnosis of, or related to, diabetes.
- M. Cosmetic, reconstructive, or plastic surgery, unless medically necessary due to accidental injury while covered under the Texas Employees Group Benefits Plan, congenital defect (up to age 19), neoplastic (cancer) surgery, or following a mastectomy. Coverage is provided for surgical breast reconstruction following a mastectomy to restore or achieve breast symmetry. Surgical reconstruction of the breast on which mastectomy surgery was performed and surgical reconstruction of the breast on which mastectomy surgery has not been performed are both covered.
- N. Marriage and family therapy/counseling; self-therapy; or therapy as a part of training.
- O. Travel services and accommodations, whether or not recommended or prescribed, except ambulance services.
- P. 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 before, in preparation for, or immediately after any of the above-referenced excluded procedures.
- R. Abortion, unless the participant's life would be endangered by continuing the pregnancy, or there is a diagnosed fetal anomaly, or unless the pregnancy is caused by a criminal act such as rape or incest.
- S. Home infusion therapy (HIT) treatment provided by an entity that is not a BCBSTX ParPlan provider 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.

- 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, even if recommended or prescribed by a physician or other provider.
- W. Environmental sensitivity, clinical ecology, or inpatient allergy testing or treatment. Chelation therapy, except for treatment of acute metal poisoning.
- X. Services or supplies that require preauthorization under HealthSelect, but were not preauthorized.
- Y. Dietary and nutritional services, except for an inpatient nutritional assessment program provided in and by a hospital and approved by BCBSTX, or diabetic management services that are provided by or directed by a physician approved by BCBSTX.
- Z. Prescription drugs or medicines which are covered under a separate prescription drug program with its own limitations and exclusions, as described in this book.
- AA. Any services or supplies for acupuncture.
- BB. Any services or supplies provided before the participant's effective date or after the expiration date of coverage except as provided through extension of benefits as described in Section Five, page 59.
- CC. Any occupational therapy services that do not consist of traditional physical therapy modalities.
- DD. The excess of any charge greater than the allowable amount as determined by BCBSTX.
- EE. Any services or supplies provided for, in preparation for, or in conjunction with autologous or allogenic bone marrow transplant with or without high dose chemotherapy, except for those nonexperimental transplants (as determined and preauthorized by BCBSTX) or as may be provided by BCBSTX through case management as described in Section Five, page 69.
- FF. Difference between the charge for a hospital private room and semiprivate room, except when coordinating secondary benefits with Medicare Part A.
- GG. Any services or supplies for which benefits are not provided under HealthSelect, unless provided through case management or ERS-approved pilot programs.
- HH. Services or supplies provided by a person or entity who is not a provider, as defined by HealthSelect.

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- 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.

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## Q & A Quick Reference

- 1. How many ID cards are issued to HealthSelect participants?**  
One Medical ID Card is issued for individual coverage and if you cover any dependents, a separate card is issued for each covered dependent. To receive additional Medical ID Cards, call BCBSTX Customer Service. If you need additional Prescription ID Cards, call Caremark Customer Service.
- 2. My EOB was sent to the wrong address. What should I do?**  
BCBSTX mails EOBs and subscriber reimbursement checks to the address shown in ERS OnLine. Contact your benefits coordinator if you are an active employee, or contact ERS if you are a retiree.
- 3. I have Medicare Part B for my primary coverage, and HealthSelect for my secondary coverage. Do I have to satisfy both the Medicare Part B deductible and HealthSelect deductible?**  
Yes. However, the amounts that are applied toward your Medicare deductible are also applied toward your HealthSelect deductible.
- 4. Does HealthSelect provide coverage for me and my covered dependents when we travel beyond Texas and outside the U.S.?**  
Yes, benefits are available for medically necessary eligible services. You may have to pay for these services in full when rendered and then file a claim with BCBSTX. See Section Five, pages 73-74 for information on BlueCard Worldwide. If you have Medicare and the services are performed in the U.S., most providers are required to file your claims with Medicare.
- 5. Does HealthSelect cover services that Medicare doesn't?**  
Yes. Some services that are not covered by Medicare are covered by HealthSelect - for example, hearing aids. For more specific information, refer to the Benefits Summary on pages 31-38 of this section, or contact BCBSTX Customer Service at (800) 252-8039.
- 6. Is HealthSelect a Medicare supplemental policy?**  
No, HealthSelect is not a Medicare supplement. It is a comprehensive medical plan which coordinates benefits with Medicare.
- 7. If I have Medicare Part A, am I still required to preauthorize with BCBSTX?**  
No, unless you are receiving private-duty nursing services, home infusion therapy, or your Medicare benefits have been exhausted. Please refer to pages 26-27 of this section for more details on BCBSTX preauthorization requirements.

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8. **Aren't my claims automatically transferred from Medicare to BCBSTX?**  
Yes, if you have supplied BCBSTX with your Medicare HIC number, effective date, and type of coverage (Part A and/or Part B). If your Medicare claims are not being transferred, please contact BCBSTX Customer Service to ensure they have your Medicare information.
  9. **I retired before September 1, 1992 and I don't have Medicare Part B coverage. Why do my EOBs from BCBSTX state they need an EOB from Medicare to process my claim?**  
BCBSTX may not have accurate information regarding your Medicare coverage. Please call BCBSTX Customer Service and provide them with your Medicare Part A number and effective date.
  10. **I retired after September 1, 1992. Why does HealthSelect recommend that I purchase Medicare Part B?**  
HealthSelect recommends that employees who retired and became 65 on or after September 1, 1992, purchase Medicare Part B. (If it is not purchased, HealthSelect does not pay for those services which could have been paid by Medicare Part B.) Unlike many public sector employers and private companies, retirees have health insurance made available to them by the state of Texas, and the state of Texas continues to pay 100% of the contribution for coverage. If Medicare were not paying primary benefits, the cost of HealthSelect coverage would increase, requiring either increased funding from the Texas Legislature, payment of a share by retirees, or a decrease in the benefits offered to retirees.

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

11. **I see that I could be responsible for inpatient or outpatient day-surgery copayments, but will I be required to pay the full copayment if Medicare is my primary insurance?**  
If Medicare is your primary insurance, these copayments will be coordinated when claims are sent to BCBSTX for secondary processing. In most cases, the entire copayment amount is paid by HealthSelect and you will not be responsible for any of these copayments. However, there may be situations when you may have an out-of-pocket expense for these copayments. See Section Five, pages 64-68 for more details regarding coordination with Medicare.

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## Section Four

### Guide for Prescription Drug Benefits

#### About the Prescription Drug Program

When you enroll in HealthSelect, whether you are in-area or out-of-area, you are automatically enrolled in the Prescription Drug Program (PDP). The PDP for HealthSelect participants is administered by 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](http://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](http://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, HealthSelect 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

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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 limitation 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 ERS 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); and
- The valid National Drug Code (NDC) for each ingredient.

The claim form is available through the website at [www.caremark.com/ers](http://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

HealthSelect 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. You will need your receipt to file a paper claim. The amount of the reimbursement will be 60% of the remaining balance of the lesser of: 1) the usual and customary price of the drug minus your deductible (if not met) and your copayment; **OR** 2) the ERS contract price of the drug minus your deductible (if not met) and your copayment.

Please note that if a brand name medication that has a generic equivalent available is dispensed, in addition to paying the generic copayment, you are also responsible for the difference in the cost between the generic and preferred or non-preferred brand name 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 to avoid additional non-participating pharmacy costs.

## **Steps to submitting a claim for 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](http://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](http://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<sup>R</sup> 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.**

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## Steps to refilling a mail service prescription

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.

1. Reorder online using the Caremark website at **[www.caremark.com/ers](http://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**

2. 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**

3. 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 Spending Account – Health Care**.

## Services available through the Caremark website

You may access these services through the website at **[www.caremark.com/ers](http://www.caremark.com/ers)**, following the instructions provided to register, HealthSelect 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

	<b>Tier 1:</b> Primarily Generic drugs	<b>Tier 2:</b> Mostly preferred brand name drugs	<b>Tier 3:</b> 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 HealthSelect.

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

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# What is Not Covered

## Exclusions

### Your HealthSelect Prescription Drug Program does not cover expenses for:

- A. Drugs that do not require a prescription;
- B. Drugs that are not prescribed in writing or verbally by a provider;
- C. Durable medical equipment or devices;
- D. Administration or injection of any drugs;
- E. Vitamins, except those that require a prescription by law and have no non-prescription equivalent;
- F. Drugs dispensed in a provider's office; while a patient is in a hospital, skilled nursing facility, or other institution; or any take-home drugs;
- G. Drugs provided by laws of the federal or local government, including Workers' Compensation;
- H. Services or supplies for which a pharmacy does not normally charge;
- I. Drugs for which a pharmacy's usual and customary charge to the public is less than or equal to the copayment;
- J. Contraceptive devices or materials (birth control pills are covered);
- K. Prescription mouthwash preparations or topical oral solutions or preparations;
- L. Investigational or experimental drugs;
- M. Refills over the number prescribed, or over the 30-day or 90-day limit under HealthSelect;
- N. Fluids, solutions, medications, or nutrients used intravenously, including intravenous or infusion therapy drugs (injectable insulin is covered);
- O. Drugs used primarily for cosmetic purposes, including but not limited to: Retin-A, Renova, Solage, 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 HealthSelect 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 HealthSelect is the secondary plan or when required for other government programs in which case ERS will coordinate benefits; and/or
- W. Homeopathic products and herbal remedies.

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## 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 HealthSelect 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 lower 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 Five, pages 72-73 for more details on how to file a claim to BCBSTX.

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**Section Five**  
**Important Plan Provisions**  
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## Section Five

### Important Plan Provisions

#### About this section

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

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

#### Eligibility

##### Eligible retirees and dependents

Eligibility for HealthSelect under the Texas Employees 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 ERS.

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

##### When you retire

When you retire, and are age 65 or older, you will automatically be covered by HealthSelect's traditional benefits unless you select other coverage, such as a Health Maintenance Organization (HMO). However, you should complete an enrollment form within 30 days after your retirement. Contact ERS to facilitate your enrollment as a retiree. You may, at this time, also add your eligible dependents without having to provide evidence of insurability.

If you have any covered dependents who are under age 65, please contact BCBSTX Customer Service at (800) 252-8039 to request In-Area coverage for those dependents. Once in-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 in-area benefits information and a different group number. Your group number will continue to be 038000 and your in-area dependent will now have coverage under group number 038001.

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For more information regarding In-Area coverage, please refer to the HealthSelect Under 65 Benefits Book, Section Three, Guide to In-Area Benefits.

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

Retirees who return to active employment at a state agency or certain higher education institutions 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. After the 30-day period, evidence of insurability may be required. 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 a return-to-work retiree (full-time or part-time), age 65 or older, have not elected coverage as an active employee, and are currently enrolled in HealthSelect and Medicare, you have out-of-area coverage. HealthSelect will be your primary coverage and Medicare will be secondary. If your spouse is age 65 or older, he or she will have out-of-area coverage. If your spouse is under age 65, he or she will also have out-of-area coverage unless you select in-area coverage for your dependent. Refer to page 17 for more information on selecting in-area coverage for under age 65 dependents.

If you are a return-to-work retiree (full-time or part-time), age 65 or older and have elected coverage as an active employee, your HealthSelect coverage will change to in-area. HealthSelect will be your primary coverage and Medicare will be secondary. To receive network benefits, you must select a primary care physician, get referrals to specialists, and pay in-area copayments, even if you have already paid all or part of your HealthSelect and Medicare deductibles as an out-of-area participant.

When you terminate employment, you will return to retiree benefits status and your HealthSelect coverage will be out-of-area. Medicare will be your primary coverage and HealthSelect will be secondary.

## **Changing Your HealthSelect Coverage**

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

Contact ERS for information on how and when you may:

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

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## Evidence of insurability (EOI)

EOI will usually be required of any 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 an annual 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 75 of this section for information on how to appeal a denied application.

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

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

**To check status on your application you can call FDL at (800) 451-0271, option 1. FDL reviews EOI applications on behalf of BCBSTX.**

Participants who are approved for coverage through Evidence of Insurability 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 claims and may be cause for expulsion from the Texas Employees Group Benefits Program (GBP) or other sanctions.

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## When Coverage Ends

### When retiree coverage ends

Your HealthSelect coverage as a retiree will end when:

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

### Surviving dependents

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

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

### 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 an entity other than BCBSTX chosen by ERS.

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## 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 certain higher education institutions 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.

**NOTE:** 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 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.

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## 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 pre-existing 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 coverage.**

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## **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 health plan 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 of Texas coverage (group coverage plus conversion contract) 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 Medical 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.

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## Coordination of Benefits (COB)

### What is coordination of benefits?

You and your family could be covered by more than one group medical plan, including Medicare. The combination of benefits under HealthSelect, Medicare, and any other group insurance plan will never equal more than 100% of the billed charge. HealthSelect does not coordinate with individual policies- only with other group policies. This means that in coordinating benefits, HealthSelect does not consider benefits you receive through any individual medical policy you may have.

**TIP: If you have a dependent that is under the age 65 who wishes to continue with in-area benefits, you can contact BCBSTX to make arrangements for the dependent to continue with in-area benefits.**

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

### How does COB work?

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

## COB with Medicare

If you are a retiree who is eligible for Medicare, your HealthSelect benefits will be coordinated with Medicare. If your spouse is eligible for Medicare, his or her HealthSelect benefits will be coordinated with Medicare in the same manner as yours. Please note, if your spouse has group health insurance through active employment, that carrier would be primary for both of you if you are carried as a dependent under your spouse's employee coverage. Medicare would be secondary for you and HealthSelect would be tertiary. If your spouse has group health insurance through retirement, Medicare would be primary for your spouse, the other carrier secondary, and HealthSelect tertiary.

The following chart shows which coverage is primary and which is secondary when Medicare and HealthSelect are involved.

### Primary vs. Secondary Coverage for Retirees:

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

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

Medicare Part A has a deductible for each "benefit period." A new benefit period begins when you have been out of a hospital (as an inpatient) or skilled nursing facility for at least 60 consecutive days. Your benefit plan with HealthSelect pays that deductible amount and the "blood deductible" (a charge excluded by Medicare, for the first three pints of blood for transfusions). When claims are coordinated between Medicare and HealthSelect you will rarely be responsible for any inpatient copayment amounts. Between Medicare and HealthSelect, your patient share will usually be zero as long as the services are covered by both Medicare and HealthSelect and you have not exhausted your Medicare benefits. Additionally, in the event the Medicare Reserve Days are used and no more Medicare benefits are available during a particular hospital stay, HealthSelect would become your primary insurance for the services that Part A usually pays. **In the absence of Medicare benefits or if your Medicare benefit amount has been exhausted, preauthorization is required, or a penalty will be applied and you will be responsible for any deductible, coinsurance and inpatient copayments.**

Medicare Part B, which applies to outpatient services, has a calendar year deductible. Your HealthSelect plan has a deductible for outpatient services as well. Please note that the amounts applied toward your Medicare deductible are also applied toward your HealthSelect deductible. When the HealthSelect deductible has been met, the plan coordinates with Medicare and pays secondary benefits. In most cases, that means paying 20% of Medicare's eligible charges after Medicare has paid 80%. There may be exceptions to this percentage if the provider of services does not accept Medicare assignment, or if it is a service that Medicare does not cover, but HealthSelect does cover.

HealthSelect has an outpatient day-surgery copayment of \$100. This copayment will be coordinated between Medicare and HealthSelect if it is a covered benefit under both plans. Between the two plans, you will rarely be responsible for any of this copayment amount. In situations where Medicare does not cover a service, you will be responsible for this copayment as well as any deductible and coinsurance amounts.

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

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

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## **If services are not covered by Medicare**

If you receive treatment for services that are not covered by Medicare, but are eligible services under HealthSelect, you will still have coverage. HealthSelect will act as your primary plan and pay accordingly if you have met your calendar year deductible with HealthSelect. This means that if you have satisfied your HealthSelect deductible, HealthSelect will pay 70% of the allowable amount and you will be responsible for 30%, up to your coinsurance maximum plus any amounts over the allowable. For more detailed information regarding coinsurance and coinsurance maximums, refer to the Benefits Summary found in Section Three, beginning on page 31.

## **If you do not sign up for Medicare**

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

## **If you are not eligible for Medicare Part A**

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

## Retirees with Medicare Part A & B

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

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

Service	Medicare Pays	HealthSelect Pays	Your Patient Responsibility
<b>Inpatient hospital</b>	All covered charges, except inpatient and blood deductibles and private room difference	Inpatient deductible, blood deductible, and private room difference	Personal items and copayment amounts if applicable
<b>Outpatient hospital (day-surgery)</b>	80% of allowed charges after Part B deductible met	20% of allowed charges after \$200 HealthSelect deductible met	Both deductibles (met concurrently)*; copayment amounts if applicable, and then usually \$0
<b>Physician’s services</b>	80% of allowed charges after Part B deductible met	20% of allowed charges after \$200 HealthSelect deductible met	Both deductibles (met concurrently)*; then usually \$0
<b>Routine or yearly Physical exams</b>	\$0	70% if HealthSelect deductible has been met	Up to \$200 if HealthSelect deductible has not been met, otherwise 30%
<b>Laboratory charges</b>	Most paid at 100%, if covered	If paid at 100% by Medicare, no payment. If not covered, paid at 70%	\$0, if covered by both plans; 30% if only covered by HealthSelect
<b>Radiology</b>	80% of allowed charges after Part B deductible met	20% of allowed charges after \$200 HealthSelect deductible met	Both deductibles (met concurrently)*; then usually \$0
<b>Skilled nursing facility (skilled care only)</b>	100% for first 20 days, then 80% for next 80 days (for total of 100 days)	20% beginning on 21 <sup>st</sup> day, for a maximum of 60 days or \$6,000 each calendar year	\$0 for first 80 days, then 20% for last 20 days (of 100 days covered by Medicare)

<b>Service</b>	<b>Medicare Pays</b>	<b>HealthSelect Pays</b>	<b>Your Patient Responsibility</b>
<b>Durable medical equipment</b>	80% of allowed charges after Part B deductible met	20% of allowed charges after \$200 HealthSelect deductible met	Both deductibles (met concurrently)* then usually \$0
<b>Home health care (skilled care only)</b>	100%	\$0	\$0
<b>Hospice</b>	Usually 100%	Usually \$0	\$0
<b>Home infusion therapy</b>	\$0	70% if HealthSelect deductible has been met (must be preauthorized)	Up to \$200 if HealthSelect deductible has not been met, otherwise 30%

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

## **Payments By Another Party**

When another party is or may be responsible for payment of your medical bills because of a sickness or injury to you (expenses related to an auto accident, for example), HealthSelect will still pay your benefits. However, HealthSelect is subrogated to all rights of recovery that you may have to the extent of benefits provided. 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.

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## Case Management

### What is case management?

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

### How does it work?

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

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

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

## Blue Care Connection<sup>®</sup>

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, and 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.

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## 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 group.

## 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 night's 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 11-12.

## 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; and
- Immunization schedules that help remind parents to make doctor's appointments for their babies.

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## 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 their charge and the BCBSTX allowable amount;
- Not bill you for any bundled charges;
- Not bill you for services determined by BCBSTX to be not medically necessary; and
- Not bill you for services that are experimental, investigational, or based upon unproven treatment methodologies.

## ParPlan Provider advantages

If you turned age 65 and retired before September 1, 1992, and you are not covered by Medicare Part B, you might want to use a ParPlan provider in order to reduce your out-of-pocket costs. If you see a ParPlan provider, you pay 30% of the allowable amount (after your deductible); HealthSelect pays 70% and the provider accepts the two amounts as payment in full. You will not be billed any additional amounts. (You may be billed for services that are not covered.)

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

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

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

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

## ParPlan and Non-ParPlan: An example

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

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

### ParPlan and Non-ParPlan: A typical example.

<u>Item</u>	<u>Par-Plan</u>	<u>Non-ParPlan</u>
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 Claims

### Filing claims if you have Medicare

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

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

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

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

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

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

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## Steps to filing claims without Medicare

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

**Step 1** You may get a claim form by calling BCBSTX Customer Service at (800) 252-8039. You may also download a claim form from the HealthSelect website at [www.bcbstx.com/hs/forms.htm](http://www.bcbstx.com/hs/forms.htm).

**Step 2** Fill out your part of the claim form completely.

**Step 3** Attach your original itemized bills that show the services performed, 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 pages 73-74 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 mailed to you along with an EOB. (BCBSTX must pay ParPlan providers and facilities directly.)

## Claims for services received outside of Texas

### BlueCard Worldwide<sup>®</sup>

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 (2583), OR
- Visit [www.bluecares.com/healthtravel/finder.html](http://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 are 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<sup>®</sup> Access Number.)
- Step 3:** Go to the nearest participating provider or hospital in your location and present your ID card.
- Step 4:** If necessary, call Blue Cross and/or Blue Shield for preauthorization of inpatient admissions. Refer to your 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 U.S. 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 U.S. 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  
P.O. Box 72017  
Richmond, VA 23255-2017

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

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## **Claims filing deadline**

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

## **How to Appeal a Denied Claim or a Denied EOI Application**

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

In general, if your claim is denied, you have the right to appeal regardless of who filed the claim. However, you may not appeal a denied claim for which you or your family are not financially responsible. You may write to 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 may need additional information to review the claim. 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.

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

If your EOI application is denied, you will receive notification from Fort Dearborn Life Insurance Company (FDL), the entity that reviews EOI applications 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

## **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 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, ERS Customer Service Division 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 Six

## Glossary of Important Terms

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## Section Six

### Glossary of Important Terms

This section of your book provides definitions of important HealthSelect terms. 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 governmental program benefits.

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

#### B

**Behavioral Health Care** – The treatment for 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. Behavioral health 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 benefit 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 included in that charge and therefore not eligible for separate benefits. The process was developed in conjunction with physician specialists from across the country. When you use a ParPlan provider, they must “write-off” charges that bundle with other services. If the provider is 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); and
- Sublingual provocative testing (putting drops of allergenic extracts in the mouth), or any other method **not** recognized as safe and effective by the American Academy of Allergists and Immunologists.

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

**Complications of Pregnancy** - Medical conditions that 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 a medical service and prescription drugs at the time they are provided.

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

**Cosmetic, Reconstructive, or Plastic Surgery** - Surgery that:

- Improves physical appearance, but does not correct or restore a bodily function;
- Is performed for psychological reasons; or
- Restores form, but does not correct or restore a bodily function.

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

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

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

**Covered Services and Supplies** - The allowable amount for services or supplies that are specifically covered under HealthSelect. Covered services and supplies are described in Section Three, pages 31-38 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 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.

**Dental Care Services (although no benefits are available for dental services, the following definition is included for clarification purposes)** - The professionally recognized dental services, supplies, or appliances which are provided to a participant by a Physician or Provider, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree), and shall also include a provider who is a Doctor of Medicine or a Doctor of Osteopathy. **Dental Care Services include, but are not limited to:**

- Cleaning;
- Filling of teeth;
- Crowns (capping);
- Root canals;
- Restoration;
- Replacement or repositioning of teeth; or
- Alteration of the alveolar or periodontium process of the maxilla and the mandible.

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

**Diabetes Equipment** is specifically defined as:

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

\* Covered as Durable Medical Equipment.

**Diabetes Supplies** are specifically defined as:

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

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

\* Covered as Durable Medical Equipment.

\*\* Covered under the Prescription Drug Program.

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

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

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

- Setting, regulating, or managing a diet; and
- 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:

- Placing the participant's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ;
- Serious disfigurement; or
- 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 (EOI)** - 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** - Three individuals in the family must each meet a calendar year deductible under one subscriber ID number in order to reach the family deductible.

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**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 innovated 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 as a provider of home infusion therapy.

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

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

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

The term hospital as used in this book also includes:

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

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

## 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.

**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 Section Three, page 40, Exclusion Q, 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 private room, 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** - Routine medical care and services provided to a pregnant woman including pre- and post-natal care and delivery (including delivery by C-section).

**Medically Necessary (Medical Necessity)** – Medical 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

**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 to 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 Section Three, pages 31-38 of this book.

**Out-of-Pocket Coinsurance Maximum** - The amount that a participant must pay in a calendar year (excluding copayments or deductibles) 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 the following:

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

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

**Participating (Network) Pharmacy** – An independent pharmacy or chain of pharmacies that have contracted with Caremark to provide pharmacy services to HealthSelect 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 of the current year through August 31st of the following year.

**Preauthorization** - Advance approval that is required from BCBSTX. Preauthorization is not a guarantee of payment, but 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 is required to receive any 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 (P&T) Committee as acceptable based on efficiency, safety, and cost.

**Preferred Drug List** – A list of prescription drugs, biologicals, and devices approved by the Pharmacy and Therapeutics (P&T) Committee for inclusion in the pharmacy benefit program. The Preferred Drug list is subject to change.

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

**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 their license. Benefits are available for services provided by providers included in this definition only as referenced in the definition of Other Medical Expenses. Providers also include:

- Licensed Audiologist;
- Licensed Master Social Worker-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 First Nurse Assistant;

- Licensed Surgical Assistant;
- Physician's Assistant (PA)\*;
- Advanced Nurse Practitioner (ANP)\*; and
- Retail Health Clinic.

\*PAs and ANPs must be supervised by an M.D. or D.O.

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

## R

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

**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.

**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 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.

**Subscriber Identification Number (Subscriber ID)** - The unique identifying 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:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral;
- Accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
- 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.

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**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.

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