

**Amendment No. One
to the
EMPLOYEE BENEFIT PLAN
(herein referred to as the “Plan”)
MASTER BENEFIT PLAN DOCUMENT
describing
HEALTHSELECT OF TEXAS SM
MANAGED CARE PLAN (In-Area Benefits)
and
COMPREHENSIVE MEDICAL CARE PLAN (Out-of-Area Benefits)
(hereinafter referred to as “Plan” or “HealthSelect”)
for the
EMPLOYEES RETIREMENT SYSTEM OF TEXAS
(hereinafter referred to as “ERS”)

Account: 38000-B
Effective: September 1, 2004**

**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 exclusion 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 behavioral health benefits; and
6. Required coverage for reconstructive surgery following mastectomies.

However, HIPAA permits certain government group health plans the right of exemption from certain provisions of this federal law. For the plan year beginning September 1, 2004 through August 31, 2005, 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.

I. Exhibit A of the Master Benefit Plan Document describing the HealthSelect of Texas Managed Care Plan (In-Area Benefits) is amended as follows:

A. Article IV (Benefits Provided), Section G (Other Benefit Provisions), is modified by adding, Section 21:

21. Benefits for Durable Medical Equipment

Participants are eligible for coverage for Durable Medical Equipment (DME) as defined in Article I herein. Benefits provided will be allowed on the same terms and provisions as for treatment of any physical sickness generally, subject to the same Deductibles, Coinsurance amounts, limitations and exclusions, and other Plan provisions.

a. Network

To receive Network benefits, a Participant must receive therapeutic supplies and rehabilitation equipment required for therapeutic use at a BlueChoice Durable Medical Equipment Provider and the Participant must be directed to that Durable Medical Equipment Provider by his designated PCP or Specialist with a valid Referral. Benefits are payable at the amount specified in Item 6b, Level I of the Schedule.

b. Non-Network

To receive Non-Network benefits a Participant can either:

1. Receive therapeutic supplies and rehabilitation equipment required for therapeutic use at a Durable Medical Equipment Provider as defined in Article I herein who does not have a BlueChoice contract; or
2. Receive therapeutic supplies and rehabilitation equipment required for therapeutic use at a BlueChoice Durable Medical Equipment Provider without the direction of his designated PCP or Specialist with a valid Referral.

Non-Network benefits are payable at the amount specified in Item 6b, Level II of the Schedule. If the Participant chooses a Physician, Other Provider, Hospital, or Facility outside the BlueChoice or ParPlan Network, payment will be paid based on the Claims Administrator's Allowable Amount determination. The Participant is responsible for any charges over the Allowable Amount.

B. Article IV (Benefits Provided), Section G (Other Benefit Provisions), is modified by adding, Subsection 22:

22. Benefits for Diabetic Supplies

Participants are eligible for coverage for Diabetic Supplies as defined in Article I herein. Benefits provided will be allowed on the same terms and provisions as for

treatment of any physical sickness generally, subject to the same Deductibles, Coinsurance amounts, limitations and exclusions, and other Plan provisions.

Supplies excluded from coverage under the HealthSelect Managed Care Plan (In-Area Benefits) and the HealthSelect Comprehensive Plan (Out-of-Area Benefits) are supplies such as insulin, insulin analogs and syringes, which are eligible for coverage through the Prescription Drug Program as described in Exhibit C of the Master Benefit Plan Document.

To receive benefits, a Participant can receive Diabetic Supplies from a BlueChoice or ParPlan Durable Medical Equipment Supplier as defined in Article I herein or with any supplier such as a local pharmacy or mail-order supplier. Benefits will be determined at the Network benefit level for all Diabetic Supplies no matter where the Participant receives his supplies.

If the Participant chooses a Physician, Other Provider, Hospital, or Facility outside the BlueChoice or ParPlan Network, payment will be paid based on the Claims Administrator's Allowable Amount determination. The Participant is responsible for any charges over the Allowable Amount.

C. Article IX (General Provisions), Section D (Copies; Plan Information), is modified by deleting it in its entirety and substituting the following:

D. Copies; Plan Information: Any Employee or Retiree may obtain copies of this Master Benefit Plan Document and other Plan information by downloading the documents from the customized HealthSelect Web site at www.bcbstx.com/hs/onlinebenefits/index.htm. For Participants without Internet access, a copy of the Plan documents may be obtained by written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Such copies will be supplied within 30 days.

D. Schedule of Specifications is deleted in its entirety and is substituted with the following:

The Schedule of Specifications set out herein shall apply to the Master Benefit Plan Document for the Managed Care Plan (In-Area Benefits) portion of HealthSelect. The account number shall be 38000-B and the effective date of this Schedule of Specification is September 1, 2004.

Schedule of Specifications		
	Level I Network Benefits	Level II Non-Network Benefits
Deductibles		
1. Deductible each Participant each Calendar Year (applies to all Covered Services and Supplies)	N/A	\$500
2. Family Deductible each Calendar Year (three family members)	N/A	\$1,500
3. Deductible each Hospital Admission (waived if Hospital Admission is preauthorized)	N/A	\$200
Inpatient Hospital Expense		
4. Benefit percentage of allowable amount Inpatient Copayment amount (not to exceed \$500 per admission)	80% \$100 per day	60% \$100 per day
Other Medical Expense		
5. Copayment amounts:		
a. Each PCP office visit	\$20	N/A
b. Each Specialist office visit	\$30	N/A
c. Outpatient Day-Surgery	\$100	\$100
d. Each emergency room visit (waived if admitted)	\$100	N/A
6. Benefit Percentage of allowable amount:		
a. For office visits (after Copayment amount)	100%	60%
b. For all other expenses	80%	60%
7. Transplants (Organ and Tissue)	80%	60%
8. Infertility Services (see Article V, Q for excluded services)	80%	60%
Extended Care Services		
9. a. Benefit percentage of allowable amount	80%	60%
b. Skilled Nursing Care in a Skilled Nursing Facility: (1) Maximum days each Calendar Year (2) Maximum benefit each Calendar Year	60* N/A	60* \$4,200*
c. Home Health Care: (1) Maximum visits each Calendar Year (2) Maximum benefit each Calendar Year	N/A N/A	100* \$3,500*
d. Hospice Care: (1) Maximum lifetime benefit	\$18,000*	\$18,000*
e. Private-Duty Nursing: (1) Maximum benefit each Calendar Year (2) Maximum lifetime benefit	N/A N/A	\$7,000* \$35,000*

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**

Schedule of Specifications

	Level I Network Benefits	Level II Non-Network Benefits
Other Benefit Provisions *		
10. Maternity Care Benefits (all participants are eligible for Maternity Care Benefits and benefits for treatment for Complications of Pregnancy)		
a. Benefit percentage for routine Maternity Care (doctor charges only; hospital charges subject to inpatient coinsurance and inpatient copayment).	100%	60%
b. Copayment amount for routine Maternity Care with PCP (initial visit only)	\$20	Only applies to Level I, Network Benefits
c. Copayment amount for routine Maternity Care with Specialist (initial visit only)	\$30	Only applies to Level I, Network Benefits
d. Benefit percentage for Complications of Pregnancy	80%	60%
e. Copayment amount for Complications of Pregnancy with PCP (each office visit)	\$20	Only applies to Level I, Network Benefits
f. Copayment amount for Complications of Pregnancy with Specialist (each office visit)	\$30	Only applies to Level I, Network Benefits
11. Serious Mental Illness Benefits Benefits for Covered Services and Supplies are determined on same basis as for treatment of sickness	-----	-----
12. Behavioral Health Care Benefits (Not Serious Mental Illness)		
a. Inpatient Hospital Expense:		
(1) Maximum number of days each Calendar Year	30*	30*
(2) Inpatient Copayment amount (not to exceed \$500 per admission)	\$100 per day	\$100 per day
(3) Benefit percentage:		
(a) First 15 days	80%	60%
(b) Next 15 days	60%	50%
b. Psychiatric Intermediate Care Facility:		
(1) Maximum number of visits each Calendar Year	60*	60*
(2) Intermediate Copayment amount (not to exceed \$500 per admission)	\$50 per day	\$50 per day
(3) Benefit percentage:		
(a) First 30 days	80%	60%
(b) Next 30 days	60%	50%

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**

Schedule of Specifications

	Level I Network Benefits	Level II Non-Network Benefits
c. Other Medical Expense:		
(1) Maximum Inpatient Physician visits each Calendar Year	30*	30*
(a) Benefit percentage:		
First 15 days	80%	60%
Next 15 days	60%	50%
(2) Maximum Outpatient Physician visits each Calendar Year	30*	30*
(a) Maximum allowable charge each visit	N/A	\$60
(b) Benefit percentage	80%	60%
13. Substance Abuse Treatment Benefits Benefits for Covered Services and Supplies are determined on same basis as for treatment of sickness	-----	-----
14. Mammography Screening Benefits Benefits for Other Medical Expense are determined as specified in items 5 and 6, above	-----	-----
15. Hearing Aid Benefits		
a. Benefit percentage for Other Medical Expense	100%	100%
b. Maximum benefit per ear for any consecutive three year period	\$500*	\$500*
16. Coinsurance Stop-Loss Amount Maximum each Participant each Calendar Year	\$1,000	\$3,000
17. Inpatient Copayment Maximum Maximum each Participant each Calendar Year for network, non-network, and out-of-area benefits	\$1,500	\$1,500
18. Maximum Lifetime Benefits Maximum lifetime benefit for each Participant	No Limit	\$1,000,000

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**

Schedule of Specifications

	Level I Network Benefits	Level II Non-Network Benefits
19. Prescription Drug Program		
Plan Year Prescription Drug Deductible	\$50 per person, per Plan Year	
Participating pharmacies (non-maintenance, up to a 30-day supply)	\$10 for Tier 1 drugs; \$25 for Tier 2 drugs; \$40 for Tier 3 drugs**	
Participating pharmacies (maintenance, up to a 30-day supply)	\$15 for Tier 1 drugs; \$35 for Tier 2 drugs; \$55 for Tier 3 drugs**	
Non-Participating pharmacies (up to a 30-day supply)	60% of the lesser of: The amount Participant pays for the prescription, minus the copayment OR the average wholesale price of the drug, plus the dispensing fee, minus the copayment. **	
Mail Order pharmacy (up to a 90-day supply)	\$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, participants will also be responsible for the difference in the cost between the generic and the brand name drug.**

II. Exhibit B of the Master Benefit Plan Document describing the HealthSelect of Texas Comprehensive Medical Care Plan (Out-Of-Area Benefits) is amended as follows:

A. Article IV (Benefits Provided), Section G (Other Benefit Provisions), is modified by adding, Section 22:

22. Benefits for Durable Medical Equipment

Participants are eligible for coverage for Durable Medical Equipment (DME) as defined in Article I herein. Benefits provided will be allowed on the same terms and provisions as for treatment of any physical sickness generally, subject to the same Deductibles, Coinsurance amounts, limitations and exclusions, and other Plan provisions.

Benefits for therapeutic supplies and rehabilitation equipment required for therapeutic use are determined at the amounts specified in Item 2 of the Schedule in excess of the Deductible and Copayment amounts. Any remaining unpaid Other Medical Expenses in excess of the Deductible and Copayments, if applicable, will be applied to the Coinsurance amount as specified in Item 16 of the Schedule.

B. Article IV (Benefits Provided), Section G (Other Benefit Provisions), is modified by adding, Subsection 23:

23. Benefits for Diabetic Supplies

Participants are eligible for coverage for Diabetic Supplies as defined in Article I herein. Benefits provided will be allowed on the same terms and provisions as for treatment of any physical sickness generally, subject to the same Deductibles, Coinsurance amounts, limitations and exclusions, and other Plan provisions.

Supplies excluded from coverage under the HealthSelect Managed Care Plan (In-Area Benefits) and the HealthSelect Comprehensive Plan (Out-of-Area Benefits) are supplies such as insulin, insulin analogs and syringes, which are eligible for coverage through the Prescription Drug Program as described in Exhibit C of the Master Benefit Plan Document.

Benefits are determined at the amounts specified in Item 2 of the Schedule in excess of the Deductible and Copayment amounts. Any remaining unpaid Other Medical Expenses in excess of the Deductible and Copayments, if applicable, will be applied to the Coinsurance amount as specified in Item 16 of the Schedule.

C. Article IX (General Provisions), Section D (Copies; Plan Information), is modified by deleting it in its entirety and substituting the following:

D. Copies; Plan Information: Any Employee or Retiree may obtain copies of this Master Benefit Plan Document and other Plan information by downloading the documents from the customized HealthSelect Web site at

www.bcbstx.com/hs/onlinebenefits/index.htm. For Participants without Internet access, a copy of the Plan documents may be obtained by written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Such copies will be supplied within 30 days.

D. Schedule of Specifications is deleted in its entirety and is substituted with the following:

The Schedule of Specifications set out herein shall apply to the Master Benefit Plan Document for the Comprehensive Medical Care Plan (Out-of-Area Benefits) portion of the HealthSelect of Texas Program. The account number shall be 38000-B and the effective date of this Schedule of Specifications is September 1, 2004.

Schedule of Specifications	
	Out-of-Area Benefits
In-Patient Hospital Expense Benefits	
1. Benefit percentage of allowable amount	70%
a. Preadmission testing Services	70%
b. Preauthorization penalty Deductible each Hospital Admission (waived if admission is preauthorized)	\$200
c. Inpatient Copayment amount (not to exceed \$500 per admission)	\$100 per day
Other Medical Expense Benefits	
2. Benefit percentage of allowable amount	70%
a. Deductible each Participant each Calendar Year	\$200
b. Family Deductible each Calendar Year (three family members)	\$600
c. Outpatient Day-Surgery copayment	\$100
3. Infertility Services (See Article V, Q for excluded services)	70%
Other Benefit Provisions	
4. Maternity Care Benefits	
a. All Participants are eligible for Maternity Care benefits and benefits for treatment of Complications of Pregnancy	70%
b. Benefits for Covered Services and Supplies are considered on the same basis as for treatment of any sickness	-----
5. Serious Mental Illness Benefits Benefits for Covered Services and Supplies are considered on the same basis as for treatment of any sickness	-----
6. Behavioral Health Care Benefits	
a. Inpatient Hospital Expense:	
(1) Maximum number of days each Calendar Year	30*
(2) Inpatient Copayment amount (not to exceed \$500 per admission)	\$100 per day
(3) Benefit percentage:	
(a) First 15 days	70%
(b) Next 15 days	50%
b. Psychiatric Intermediate Care Facility:	
(1) Maximum number of days each Calendar Year	60*
(2) Inpatient Copayment amount (not to exceed \$500 per admission)	\$50 per day
(3) Benefit percentage:	
(a) First 30 days	70%
(b) Next 30 days	50%

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**

Schedule of Specifications

Other Benefit Provisions	Out-of-Area Benefits
c. Other Medical Expense: (1) Maximum Inpatient Physician or Other Provider visits each Calendar Year (a) Benefit percentage first 15 visits (b) Benefit percentage next 15 visits	30* 70% 50%
(2) Maximum Outpatient Physician or Other Provider visits each Calendar Year (a) Benefit percentage (b) Maximum allowed for Covered Services and Supplies not to exceed \$60 per visit	30* 70%
7. Substance Abuse Treatment Benefits Benefits for Covered Services and Supplies are determined on same basis as for treatment of sickness	-----
8. Private-Duty Nursing: a. Benefit percentage for Other Medical Expense b. Maximum benefit each Calendar year c. Maximum lifetime benefit d. Preauthorization required	70% \$8,000* \$40,000*
9. Mammography Screening Benefits Benefit percentage for Other Medical Expense	70%
10. Hearing Aid Benefits a. Benefit percentage b. Maximum benefit per ear for any consecutive three-year period	100% \$500*
11. Skilled Nursing Care in a Skilled Nursing Facility a. Benefit percentage b. Maximum number of days each Calendar Year, Or maximum benefit each Calendar Year (whichever occurs first) c. Deductible waived d. Preauthorization required	100% 60* \$6,000*
12. Home Health Care Benefits a. Benefit percentage b. Maximum number of visits each Calendar Year, Or maximum benefit each Calendar Year (whichever occurs first) c. Deductible waived d. Preauthorization required	100% 100* \$5,000*
13. Hospice Care Benefits a. Benefit percentage b. Maximum lifetime benefit c. Deductible waived d. Preauthorization required	70% \$18,000*
14. Home Infusion Therapy Benefits a. Benefit percentage for Other Medical Expense b. Preauthorization required	70%

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**

Schedule of Specifications

	Out-of-Area Benefits
15. Prescription Drug Program	
Plan year Prescription Drug Deductible	\$50 per person, per Plan Year
Participating pharmacies (non-maintenance, up to a 30-day supply)	\$10 for Tier 1 drugs; \$25 for Tier 2 drugs; \$40 for Tier 3 drugs **
Participating pharmacies (maintenance, up to a 30-day supply)	\$15 for Tier 1 drugs; \$35 for Tier 2 drugs; \$55 for Tier 3 drugs **
Non-Participating pharmacies (up to a 30-day supply)	60% of the lesser of: The amount Participant pays for the prescription, minus the copayment OR the average wholesale price of the drug, plus the dispensing fee, minus the copayment. **
Mail Order pharmacy (up to a 90-day supply)	\$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, participants will also be responsible for the difference in the cost between the generic and the brand name drug.**

Schedule of Specifications

	Out-of-Area Benefits
Coinsurance Stop-Loss (Out-of-Pocket Coinsurance Maximum)	
16. Coinsurance amount per Participant, per Calendar Year	\$1,000
Inpatient Copayment Stop-Loss	
17. Inpatient Copayment Maximum per Participant, per calendar year for network, non-network, and out-of-area benefits	\$1,500
Maximum Lifetime Benefits	
18. Maximum lifetime benefit for each Participant	No limit

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**