

**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
(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, 2006

**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 from September 1, 2006 through August 31, 2007, the Employees Retirement System of Texas (ERS) has elected to exempt HealthSelect of Texas (HealthSelect) from HIPAA provisions 2 and 3 above. Therefore, employees and retirees who do not enroll themselves and their dependents in HealthSelect during their initial period of eligibility may be subject to evidence of insurability requirements if they wish to enroll at a later date.

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 I (Definitions), Section W (Covered Oral Surgery) is modified by deleting it in its entirety and substituting the following:

W. Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and nonodontogenic cysts;
2. Incision and drainage of cellulitis;
3. Surgical procedures involving accessory sinuses, salivary glands and ducts;
4. Reduction of a dislocation of, excisions of, and injection of the temporomandibular joint, excluding all oral appliances and devices used to diagnose and/or treat temporomandibular pain disorders or dysfunction of the joint and related structures, such as the jaws, jaw muscles and nerves (does not include any type of correction of the occlusion of the teeth to eliminate temporomandibular joint pain or dysfunction or related appliances);
5. 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
6. Orthognathic surgery.

B. Article I (Definitions), Section DD (Provider) is modified by adding the following new Subsections 21 and 22:

21. Licensed Physical Therapist; and
22. Licensed Occupational Therapist.

C. Article I (Definitions), Section DG (Referral) is modified by deleting it in its entirety and substituting the following:

DG. Referral means authorization for In-Area Participants to receive Network Benefits for Covered Services and Supplies rendered by a Specialty Care Provider when medical care is required by a Provider other than the Participant's PCP. A referral from the Participant's PCP must be obtained and authorized through the Claims Administrator before the Participant receives specialty care services from a Provider other than his PCP except for those services rendered by Specialty Care Providers described herein that do not require a referral. An informal Referral or recommendation from a Physician or Other Provider that has not been approved by the Claims Administrator, even if it is in writing will not be sufficient in order to receive Network benefits. A Referral does not guarantee payment.

D. Article IV (Benefits Provided), Section G (Other Benefit Provision), Subsection 11 (Routine Eye Exams) is modified by adding the following:

Benefits for Routine Eye Exams

One Routine Eye exam per Participant per Calendar Year. Network benefits are available without a referral from a Primary Care Physician when a routine eye exam is provided by a BlueChoice Optometrist or Ophthalmologist. A routine exam includes: (a) external examination of the eye and its structure; (b) determination of refractive status; and (c) glaucoma screening test. It does not include a contact lens exam.

If additional care or follow up visits are required, for Network benefits to apply, the Participant must be referred by his Primary Care Physician. If a referral is not obtained, Non-Network benefits will apply.

E. Article V (Limitations and Exclusions), Exclusion AC is modified by deleting it in its entirety and substituting the following:

AC. Any occupational therapy services which do not consist of traditional physical therapy modalities as defined by the Claims Administrator.

F. Article IX (General Provisions), Section B (Claim Denial and Appeal), Subsection 2b (Review by an Independent Review Organization (IRO)) is modified by deleting it in its entirety and substituting the following:

- b.** In a circumstance involving a life-threatening condition, the Participant is entitled to an immediate review by an IRO and is not required to first comply with the normal process described in Subsection 1 above.

G. Schedule of Specifications is modified by deleting it in its entirety and substituting 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, 2006.

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	60*	60*
(2) Maximum benefit each Calendar Year	N/A	\$4,200*
c. Home Health Care:		
(1) Maximum visits each Calendar Year	N/A	100*
(2) Maximum benefit each Calendar Year	N/A	\$3,500*
d. Hospice Care:		
(1) Maximum lifetime benefit	\$18,000*	\$18,000*
e. Private-Duty Nursing:		
(1) Maximum benefit each Calendar Year	N/A	\$7,000*
(2) Maximum lifetime benefit	N/A	\$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**

*****The coinsurance maximum is based only on eligible charges and does not include amounts as described in Article IV, Section L, Subsection 1(a-f).**

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. Deductible will be subtracted if not met.**	
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 Managed Care Plan (Out-of-Area Benefits) is amended as follows:

A. Article I (Definitions), Section V (Covered Oral Surgery) is modified by deleting it in its entirety and substituting the following:

V. Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and nonodontogenic cysts;
2. Incision and drainage of cellulitis;
3. Surgical procedures involving accessory sinuses, salivary glands and ducts;
4. Reduction of a dislocation of, excisions of, and injection of the temporomandibular joint, excluding all oral appliances and devices used to diagnose and/or treat temporomandibular pain disorders or dysfunction of the joint and related structures, such as the jaws, jaw muscles and nerves (does not include any type of correction of the occlusion of the teeth to eliminate temporomandibular joint pain or dysfunction or related appliances);
5. 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
6. Orthognathic surgery.

B. Article I (Definitions), Section CT (Provider) is modified by adding the following new Subsections 21 and 22:

21. Licensed Physical Therapist; and
22. Licensed Occupational Therapist.

C. Article V (Limitations and Exclusions), Exclusion AC is modified by deleting it in its entirety and substituting the following:

AC. Any occupational therapy services which do not consist of traditional physical therapy modalities as defined by the Claims Administrator.

D. Article IX (General Provisions), Section B (Claim Denial and Appeal), Subsection 2b (Review by an Independent Review Organization (IRO)) is modified by deleting it in its entirety and substituting the following:

b. In a circumstance involving a life-threatening condition, the Participant is entitled to an immediate review by an IRO and is not required to first comply with the normal process described in Subsection 1 above.

E. Schedule of Specifications is modified by deleting it in its entirety and substituting 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 HealthSelect. The account number shall be 38000-B and the effective date of this Schedule of Specifications is September 1, 2006.

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. Deductible will be subtracted if not met.**
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**

*****The coinsurance maximum is based only on eligible charges and does not include amounts as described in Article IV, Section N, Subsection 1(a-g).**