

**Amendment No. Four
to the
EMPLOYEE BENEFIT PLAN
(herein referred to as the “Plan”)
MASTER BENEFIT PLAN DOCUMENT
describing
HEALTHSELECTSM OF TEXAS
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

**Implementing Amendments effective:
January 1, 2008; April 1, 2008; May 1, 2008**

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, 2007 through August 31, 2008, 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 Managed Care Plan (In-Area Benefits) is amended as follows:

A. Article I (Definitions), Definition DD (Provider) is modified by deleting it in its entirety and substituting the following:

DD. Provider means a Facility, Hospital, Physician (as defined in Article I of this Plan) or Other Provider that is licensed to provide services and supplies within the scope of their license. Other Providers shall include only the following, unless otherwise provided herein:

1. Doctor of Chiropractic;
2. Doctor of Dentistry;
3. Doctor of Optometry;
4. Doctor of Podiatry;
5. Doctor in Psychology (certified as a health service provider);
6. Licensed Audiologist;
7. Licensed Dietitian;
8. Licensed Hearing Aid Fitter and Dispenser;
9. Licensed Marriage and Family Therapist;
10. Licensed Master Social Worker-Advanced Clinical Practitioner;
11. Licensed Professional Counselor;
12. Licensed Speech-Language Pathologist;
13. Spiritual Care Provider (for example, Christian Science Practitioner);
14. Therapeutic Optometrist;

15. Licensed Chemical Dependency Counselor;
16. Licensed Psychological Associate;
17. Physicians' Assistant (must be approved by the Claims Administrator);
18. Advanced Practice Nurse (must be approved by the Claims Administrator);
19. Nurse First Assistant;
20. Licensed Surgical Assistant;
21. Licensed Physical Therapist;
22. Licenses Occupational Therapist; and
23. Retail Health Clinic.

In states where there is a licensure requirement, Other Providers must be licensed by the appropriate state administrative agency. Other Providers must also meet state licensing requirements comparable to those applicable in the state of Texas in order to receive benefits under the Plan, regardless of whether services are provided in the state of Texas.

Benefits are only available for services provided by providers included in this definition or as referenced in the definition of Other Medical Expense.

B. Article I (Definitions), is modified by adding definition EB (Retail Health Clinic Provider) :

EB. Retail Health Clinic Provider means 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.

C. Article IV (Benefits Provided), Section G (Other Benefit Provisions), Subsection 12. (Benefits for Organ and Tissue Transplant) is modified by deleting it in its entirety and substituting the following:

12. Benefits for Organ and Tissue Transplant (Effective January 1, 2008)

- a. Covered services and supplies related to organ or tissue transplants include, but are not limited to:
 - (1) X-rays, laboratory, chemotherapy, radiation therapy, prescription drugs, and complications arising from such transplant.
 - (2) Evaluation of organs and tissues including but not limited to the determination of tissue matches; removal of organs or tissues from deceased donors; and transportation and storage of donated organs or tissues.

- b. Benefits for covered services and supplies provided to a Participant (donor and/or recipient) by a Hospital Physician, or Other Provider related to an organ or tissue transplant will be determined based on whether:
 - (1) Donated human organs or tissue are used;
 - (2) FDA approved artificial devices are used and when determined to be Medically Necessary by the Claims Administrator and not Experimental and Investigational in nature;
 - (3) The recipient is a Participant under the Plan;
 - (4) The transplant procedure was preauthorized;
 - (5) The participant meets all the criteria established by Claims Administrator in its written medical policy guidelines;
 - (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

- c. Transplant benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is for the following organ(s) or tissues:
 - (1) Kidney;
 - (2) Cornea;
 - (3) Liver;
 - (4) Heart;
 - (5) Heart-lung;
 - (6) Lung;
 - (7) Pancreatic-kidney;

- (8) Bone marrow; and
- (9) Other organ transplants that are determined to be non-Experimental and/or non-Investigational according to the current Claims Administrator's medical policy guidelines.

d. No benefits are available for the following services or supplies:

- (1) Transplant procedures (including transplantation of non-human organs) or the services performed in preparation for, or in conjunction with such procedure, which Claims Administrator considers to be Experimental and/or Investigational in nature;
- (2) Living and/or Travel expenses of the live donor or recipient;
- (3) Donor search and acceptability testing of potential living donors;
- (4) Expenses related to maintenance of life for purposes of organ or tissue donations;
- (5) Purchase of the organ or tissue; or
- (6) Organs or tissue (xenograft) obtained from another species.

D. Article IV (Benefits Provided), Section G (Other Benefit Provisions), Subsection 16 (Benefits for Ambulance Services) is modified by deleting it in its entirety and substituting the following:

16. Benefits for Ambulance Services (Effective April 1, 2008)

Ambulance services must be: (a) prescribed by a physician; (b) Medically Necessary; or (c) approved by the Claims Administrator. Benefits provided will be allowed on the same terms and same Copayments, Deductibles, Coinsurance, limitations and exclusions, as other Plan provisions.

If a Participant receives services from a non-contracting (Non-BlueChoice and Non-ParPlan) ambulance provider, benefits are paid at the allowed amount up to the Out-of-Pocket Maximum specified in Item 16, Level I of the Schedule of Specifications.

After the Out-of-Pocket Coinsurance Maximum is met, benefits are payable at 100% of allowed charges.

E. Article IV (Benefits Provided), Section G (Other Benefit Provisions), Subsection 20 (Treatment of Medical Emergency by Non-Contracting Provider) is modified by deleting it in its entirety and substituting the following:

20. Treatment of Medical Emergency by Non-Contracting Provider (Effective April 1, 2008)

Benefits provided will be allowed on the same terms and same Copayments, Deductibles, Coinsurance, limitations and exclusions, as other Plan provisions.

If a Participant is treated by a non-contracting (Non-BlueChoice and Non-ParPlan) Provider during the first 48 hours of a medical emergency, benefits will be reimbursed at the Network level based on the billed amount. This will prevent the patient from paying differences between the billed and Allowable Amount.

F. Article IV (Benefits Provided), Section G (Other Benefit Provisions), Subsection 24 (Benefits for Retail Health Clinics) is modified by adding the following:

24. Benefits for Retail Health Clinics

Benefits are available for treatment at a Retail Health Clinic 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 Copayments, Deductibles, Coinsurance, limitations and exclusions, as other Plan provisions.

a. *Network Benefits*

To receive Network benefits, a Participant must have services rendered at a BlueChoice Retail Health Clinic as defined in Article I herein. No PCP Referral is required.

Benefits will be determined at the Copayment specified in Item 5e, Level I or the Coinsurance amount specified in Item 6b, Level I of the Schedule of eligible Other Medical Expense.

No deductible will be applied to Network Benefits. Any remaining unpaid Other Medical Expense will be applied to the Level I Coinsurance amount specified in item 16 of the Schedule.

b. *Non-Network Benefits*

If a Participant receives services at a Non-BlueChoice Retail Health Clinic, Non-Network Benefits will apply and will be determined at the amount specified in Item 6b, Level II of the Schedule of eligible Other Medical Expense in excess of the Calendar Year Deductible.

Any remaining unpaid Other Medical Expense in excess of the Deductible will be applied to the Level II Coinsurance amount as specified in Item 16 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.

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

- T. Transplant procedures (including transplantation of non-human organs) or the services performed in preparation for, or in conjunction with such procedure, which the Claims Administrator considers to be Experimental and/or Investigational in nature; living and/or travel expenses of the live donor or recipient; donor search and acceptability testing of potential living donors; expenses related to maintenance of life for purposes of organ or tissue donations; purchase of organ or tissue; or organs or tissue (xenograft) obtained from another species.

H. 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 January 1, 2008.

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
e. Each Retail Health Clinic office visit (eff May 1, 2008)	\$20	N/A
6. Benefit Percentage of allowable amount:		
a. For office visits (after Copayment amount for Level I)	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%

¹ Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a BlueChoice Network Provider or ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a Non-Network and non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit A, Article IV, Section L, Subsection 1 (a-f).

⁴ 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

	Level I Network Benefits	Level II Non-Network Benefits
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 ¹ N/A	60 ¹ \$4,200 ²
c. Home Health Care: (1) Maximum visits each Calendar Year (2) Maximum benefit each Calendar Year	N/A N/A	100 ¹ \$3,500 ²
d. Hospice Care: (1) Maximum lifetime benefit	\$18,000 ¹	\$18,000 ¹
e. Private-Duty Nursing: (1) Maximum benefit each Calendar Year (2) Maximum lifetime benefit	N/A N/A	\$7,000 ² \$35,000 ¹
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

¹ Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a BlueChoice Network Provider or ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a Non-Network and non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit A, Article IV, Section L, Subsection 1 (a-f).

⁴ 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

	Level I Network Benefits	Level II Non-Network Benefits
Other Benefit Provisions		
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 ¹	30 ¹
(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 ¹	60 ¹
(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%
c. Other Medical Expense:		
(1) Maximum Inpatient Physician visits each Calendar Year	30 ¹	30 ¹
(a) Benefit percentage:		
First 15 days	80%	60%
Next 15 days	60%	50%
(2) Maximum Outpatient Physician visits each Calendar Year	30 ¹	30 ¹
(a) Maximum allowable charge each visit	N/A	\$60
(b) Benefit percentage	80%	60%

¹ Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a BlueChoice Network Provider or ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a Non-Network and non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit A, Article IV, Section L, Subsection 1 (a-f).

⁴ 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

	Level I Network Benefits	Level II Non-Network Benefits
Other Benefit Provisions		
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 b. Maximum benefit per ear for any consecutive three year period	100% \$500 ²	100% \$500 ²
16. Coinsurance Stop-Loss Amount Maximum each Participant each Calendar Year	\$1,000 ³	\$3,000 ³
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

¹ Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a BlueChoice Network Provider or ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a Non-Network and non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit A, Article IV, Section L, Subsection 1 (a-f).

⁴ 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		
	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 ⁴	
Participating pharmacies (maintenance, up to a 30-day supply)	\$15 for Tier 1 drugs; \$35 for Tier 2 drugs; \$55 for Tier 3 drugs ⁴	
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. ⁴	
Mail Order pharmacy (up to a 90-day supply)	\$30 for Tier 1 drugs; \$75 for Tier 2 drugs; \$120 for Tier 3 drugs ⁴	

¹ Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a BlueChoice Network Provider or ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a Non-Network and non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit A, Article IV, Section L, Subsection 1 (a-f).

⁴ 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 Comprehensive Medical Care Plan (Out-of-Area Benefits) is amended as follows:

A. Article I (Definitions), Definition CT (Provider) is modified by deleting it in its entirety and substituting the following:

CT. Provider means a Facility, Hospital, Physician (as defined in Article I of this Plan) or Other Provider that is licensed to provide services and supplies within the scope of their license. Other Providers shall include only the following, unless otherwise provided herein:

1. Doctor of Chiropractic;
2. Doctor of Dentistry;
3. Doctor of Optometry;
4. Doctor of Podiatry;
5. Doctor in Psychology (certified as a health service provider);
6. Licensed Audiologist;
7. Licensed Dietitian;
8. Licensed Hearing Aid Fitter and Dispenser;
9. Licensed Marriage and Family Therapist;
10. Licensed Master Social Worker-Advanced Clinical Practitioner;
11. Licensed Professional Counselor;
12. Licensed Speech-Language Pathologist;
13. Spiritual Care Provider (for example, Christian Science Practitioner);
14. Therapeutic Optometrist;
15. Licensed Chemical Dependency Counselor;
16. Licensed Psychological Associate;

17. Physicians' Assistant (must be approved by the Claims Administrator);
18. Advanced Practice Nurse (must be approved by the Claims Administrator);
19. Nurse First Assistant;
20. Licensed Surgical Assistant;
21. Licensed Physical Therapist;
22. Licenses Occupational Therapist; and
23. Retail Health Clinic.

In states where there is a licensure requirement, Other Providers must be licensed by the appropriate state administrative agency. Other Providers must also meet state licensing requirements comparable to those applicable in the state of Texas in order to receive benefits under the Plan, regardless of whether services are provided in the state of Texas.

Benefits are only available for services provided by providers included in this definition or as referenced in the definition of Other Medical Expense.

B. Article I (Definitions), is modified by adding definition DO (Retail Health Clinic Provider) :

DO. Retail Health Clinic Provider means 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.

C. Article IV (Benefits Provided), Section E (Other Benefit Provisions), Subsection 17 (Benefits for Ambulance Services) is modified by deleting it in its entirety and substituting the following:

17. Benefits for Ambulance Services (Effective April 1, 2008)

Ambulance services must be: (a) prescribed by a physician; (b) Medically Necessary; or (c) approved by the Claims Administrator. Benefits provided will be allowed on the same terms and same Copayments, Deductibles, Coinsurance, limitations and exclusions, as other Plan provisions.

Benefits are paid at the allowed amount up to the out-of-pocket coinsurance maximum. After the out-of-pocket coinsurance maximum is met, benefits are payable at 100% of the allowed amount for eligible charges.

If the Participant receives services from a non-contracting (non-ParPlan) ambulance provider, benefits will be paid at the allowed amount.

D. Article IV (Benefits Provided), Section E (Other Benefit Provisions), Subsection 13. (Benefits for Organ and Tissue Transplant) is modified by deleting it in its entirety and substituting the following:

13. Benefits for Organ and Tissue Transplant (Effective January 1, 2008)

- a. Covered services and supplies related to an organ or tissue transplants include, but are not limited to:
 - (1) X-rays, laboratory, chemotherapy, radiation therapy, prescription drugs, and complications arising from such transplant.
 - (2) Evaluation of organs and tissues including but not limited to the determination of tissue matches; removal of organs or tissues from deceased donors; and transportation and storage of donated organs or tissues.
- b. Benefits for covered services and supplies provided to a Participant (donor and/or recipient) by a Hospital Physician, or Other Provider related to an organ or tissue transplant will be determined based on whether:
 - (1) Donated human organs or tissue are used;
 - (2) FDA approved artificial devices are used and when determined to be Medically Necessary by the Claims Administrator and not Experimental and Investigational in nature;

- (3) The recipient is a Participant under the Plan;
 - (4) The transplant procedure was preauthorized;
 - (5) The participant meets all the criteria established by BCBSTX in its written medical policy guidelines;
 - (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.
- c. Transplant benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is for the following organ(s) or tissues:
- (1) Kidney;
 - (2) Cornea;
 - (3) Liver;
 - (4) Heart;
 - (5) Heart-lung;
 - (6) Lung;
 - (7) Pancreatic-kidney;
 - (8) Bone marrow; and
 - (9) Other organ transplants that are determined to be non-Experimental and/or non-Investigational according to the current Claims Administrator's medical policy guidelines.
- d. No benefits are available for the following services or supplies:
- (1) 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;
 - (2) Living and/or Travel expenses of the live donor or recipient;
 - (3) Donor search and acceptability testing of potential living donors;
 - (4) Expenses related to maintenance of life for purposes of organ or tissue donations;
 - (5) Purchase of the organ or tissue; or
 - (6) Organs or tissue (xenograft) obtained from another species.

E. Article IV (Benefits Provided), Section E (Other Benefit Provisions), Subsection 24 (Benefits for Retail Health Clinics) is modified by adding the following:

24. Benefits for Retail Health Clinics

Benefits are available for treatment at a Retail Health Clinic 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, Copayments, Coinsurance, limitations and exclusions, and other Plan provisions.

Benefits for services and supplies received at a Retail Health Clinic will be determined at the amounts specified in Item 2d of the Schedule in excess of the Deductible amounts.

Any remaining unpaid Other Medical Expense in excess of the Deductible and Copayment, if applicable, will be applied to the Coinsurance amount as specified in Item 16 of the Schedule.

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

- U. Transplant procedures (including transplantation of non-human organs) or the services performed in preparation for, or in conjunction with such procedure, which the Claims Administrator considers to be Experimental and/or Investigational in nature; living and/or travel expenses of the live donor or recipient; donor search and acceptability testing of potential living donors; expenses related to maintenance of life for purposes of organ or tissue donations; purchase of organ or tissue; or organs or tissue (xenograft) obtained from another species.

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 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 January 1, 2008.

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
d. Each Retail Health Clinic visit (eff May 1, 2008)	70%
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	-----

¹ Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ 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.

⁴ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit B, Article IV, Section N, Subsection 1 (a-g).

Schedule of Specifications

Other Benefit Provisions	Out-of-Area Benefits
<p>6. Behavioral Health Care Benefits</p> <p>a. Inpatient Hospital Expense:</p> <p>(1) Maximum number of days each Calendar Year</p> <p>(2) Inpatient Copayment amount (not to exceed \$500 per admission)</p> <p>(3) Benefit percentage:</p> <p>(a) First 15 days</p> <p>(b) Next 15 days</p>	<p>30¹</p> <p>\$100 per day</p> <p>70%</p> <p>50%</p>
<p>b. Psychiatric Intermediate Care Facility:</p> <p>(1) Maximum number of days each Calendar Year</p> <p>(2) Inpatient Copayment amount (not to exceed \$500 per admission)</p> <p>(3) Benefit percentage:</p> <p>(a) First 30 days</p> <p>(b) Next 30 days</p>	<p>60¹</p> <p>\$50 per day</p> <p>70%</p> <p>50%</p>
<p>c. Other Medical Expense:</p> <p>(1) Maximum Inpatient Physician or Other Provider visits each Calendar Year</p> <p>(a) Benefit percentage first 15 visits</p> <p>(b) Benefit percentage next 15 visits</p>	<p>30¹</p> <p>70%</p> <p>50%</p>
<p>(2) Maximum Outpatient Physician or Other Provider visits each Calendar Year</p> <p>(a) Benefit percentage</p> <p>(b) Maximum allowed for Covered Services and Supplies not to exceed \$60 per visit²</p>	<p>30¹</p> <p>70%</p>

¹ Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ 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.

⁴ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit B, Article IV, Section N, Subsection 1 (a-g).

Schedule of Specifications

Other Benefit Provisions	Out-of-Area Benefits
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 ² \$40,000 ¹
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 ²
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 ¹ \$6,000 ²
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 ¹ \$5,000 ²
13. Hospice Care Benefits a. Benefit percentage b. Maximum lifetime benefit c. Deductible waived d. Preauthorization required	70% \$18,000 ¹
14. Home Infusion Therapy Benefits a. Benefit percentage for Other Medical Expense b. Preauthorization required	70%

¹ Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ 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.

⁴ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit B, Article IV, Section N, Subsection 1 (a-g).

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 ³
Participating pharmacies (maintenance, up to a 30-day supply)	\$15 for Tier 1 drugs; \$35 for Tier 2 drugs; \$55 for Tier 3 drugs ³
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. ³
Mail Order pharmacy (up to a 90-day supply)	\$30 for Tier 1 drugs; \$75 for Tier 2 drugs; \$120 for Tier 3 drugs.

¹Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits

² Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³ 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.

⁴ The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit B, Article IV, Section N, Subsection 1 (a-g).

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 ⁴
Inpatient Copayment Stop-Loss	
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

²Includes all Network, Non-Network Benefits and Out-of-Area Benefits. Benefits are paid on the Claims Administrators Allowable Amount. The Participant may be billed and responsible for amounts over the benefit maximum. If the Participant uses a ParPlan Provider he or she will only be responsible for amounts above the benefit maximum up to the Allowable Amount. If the Participant is using a non-ParPlan Provider, he or she will be responsible for amounts above the benefit maximum up to the billed amount.

³If 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.

⁴The Out-of-Pocket Coinsurance Maximum is based on the Allowable Amount for Covered Services and Supplies and does not include items described in Exhibit B, Article IV, Section N, Subsection 1 (a-g).