

**Amendment No. Three  
to the  
EMPLOYEE BENEFIT PLAN  
(herein referred to as the “Plan”)  
MASTER BENEFIT PLAN DOCUMENT  
describing  
HEALTHSELECT OF TEXAS<sup>SM</sup>  
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, 2007**

**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 of Texas Managed Care Plan (In-Area Benefits) is amended as follows:**
- A. Article I (Definitions), Section AA (Deductible), is modified by deleting it in its entirety and substituting the following:**
- AA. Deductible** means the dollar amount of Covered Services and Supplies that must be incurred by a Participant before benefits under the Plan will be available. Only the Allowable Amount of Covered Services and Supplies will be applied to the Deductible.
- B. Article I (Definitions), Section AU (Family Deductible), is modified by deleting it in its entirety and substituting the following:**
- AU. Family Deductible** means a Deductible amount that is satisfied when three individuals in the same family that are covered under one Subscriber Identification Number each meet their Calendar Year Deductible. When that Family Deductible amount is reached, no further individual Deductibles will have to be satisfied for that Calendar Year. Only the Allowable Amount of Covered Services and Supplies will be applied to the Deductible.
- C. Article V (Limitations and Exclusions), Exclusion P, is modified by deleting it in its entirety and substituting the following:**
- 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 by the Claims Administrator.
- D. Article V (Limitations and Exclusions), Exclusion AM, is modified by deleting it in its entirety and substituting the following:**
- AM.** 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.

**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 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, 2007.

<b>Schedule of Specifications</b>		
	<b>Level I Network Benefits</b>	<b>Level II Non-Network Benefits</b>
<b>Deductibles</b>		
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
<b>Inpatient Hospital Expense</b>		
4. Benefit percentage of allowable amount Inpatient Copayment amount (not to exceed \$500 per admission)	80% \$100 per day	60% \$100 per day
<b>Other Medical Expense</b>		
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%
<b>Extended Care Services</b>		
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
<b>Other Benefit Provisions *</b>		
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 (a) Benefit percentage: First 15 days Next 15 days	30*  80% 60%	30*  60% 50%
(2) Maximum Outpatient Physician visits each Calendar Year (a) Maximum allowable charge each visit (b) Benefit percentage	30*  N/A 80%	30*  \$60 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 b. Maximum benefit per ear for any consecutive three year period	100% \$500*	100% \$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 Comprehensive Medical Care Plan (Out-of-Area Benefits) is amended as follows:**

**A. Article I (Definitions), Section Z (Deductible), is modified by deleting it in its entirety and substituting the following:**

**Z. Deductible** means the dollar amount of Covered Services and Supplies that must be incurred by a Participant before benefits under the Plan will be available. Only the Allowable Amount of Covered Services and Supplies will be applied to the Deductible.

**B. Article I (Definitions), Section AT (Family Deductible), is modified by deleting it in its entirety and substituting the following:**

**AT. Family Deductible** means a Deductible amount that is satisfied when three individuals in the same family that are covered under one Subscriber Identification Number each meet their Calendar Year Deductible. When that Family Deductible amount is reached, no further individual Deductibles will have to be satisfied for that Calendar Year. Only the Allowable Amount of Covered Services and Supplies will be applied to the Deductible.

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

**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 by the Claims Administrator.

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

**AM.** 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.

**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, 2007.

<b>Schedule of Specifications</b>	
	<b>Out-of-Area Benefits</b>
<b>In-Patient Hospital Expense Benefits</b>	
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
<b>Other Medical Expense Benefits</b>	
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%
<b>Other Benefit Provisions</b>	
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**

<b>Schedule of Specifications</b>	
	<b>Out-of-Area Benefits</b>
<b>15. Prescription Drug Program</b>	
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.**

<b>Schedule of Specifications</b>	
	<b>Out-of-Area Benefits</b>
<b>Coinsurance Stop-Loss (Out-of-Pocket Coinsurance Maximum)</b>	
16. Coinsurance amount per Participant, per Calendar Year***	\$1,000
<b>Inpatient Copayment Stop-Loss</b>	
17. Inpatient Copayment Maximum per Participant, per Calendar Year for network, non-network, and out-of-area benefits	\$1,500
<b>Maximum Lifetime Benefits</b>	
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).**

**For: Employees Retirement System of Texas**

By: Signature On File \_\_\_\_\_  
Ann S. Fuelberg, Executive Director

**For: Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company**

By: Signature On File \_\_\_\_\_  
Jackie Hamilton, Senior Vice President