



BlueCross BlueShield
of Texas

HealthSelectSM (Coverage for Employees and Dependents of the State of Texas and Some Institutions for Higher Education): Overview

HealthSelect Definition

HealthSelect is the self-insured health plan for employees and dependents of the state of Texas and some institutions of higher education. BCBSTX administers this plan, commonly referred to as “Group 38000.” HealthSelect In-Area coverage is very similar to BlueChoice Plus coverage. HealthSelect Out-of-Area coverage works like a traditional indemnity plan.

Effective March 1, 2006 an additional group number was added to HealthSelect: 38001. This new group number is used for dependents whose coverage type differs from the subscriber’s. For example, subscribers who reside in Texas, but have dependents residing outside of Texas.

In-area or Out-of-area Coverage?

Participants covered under HealthSelect will have either in-area or out-of-area coverage, depending upon where they reside.

In-Area coverage refers to subscribers and dependents that reside in those areas of the state where the BlueChoice Network is developed and operational. Subscribers and covered dependents realize lower out-of-pocket costs when a PCP is chosen to direct their care. When treatment is provided by either the PCP or a specialty care physician/professional provider to whom the PCP has referred, the patient receives the highest level of benefits available (in-network benefits). When treatment is not directed by the PCP, the patient will experience greater out-of-pocket expenses (out-of-network benefits).

Out-of-Area coverage applies to subscribers and dependents that reside in counties where the BlueChoice Network is not fully operational. Out-of-area coverage generally means that the benefits resemble indemnity coverage with a calendar year deductible and 70 percent coverage of eligible care and services. Retirees who are over the age of 65 also have out-of-area coverage.

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HealthSelectSM (Coverage for Employees and Dependents of the State of Texas and Some Institutions for Higher Education): Overview, Continued

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HealthSelect ID Cards

Introduction

The HealthSelect ID card will indicate your patient's type of coverage. Individuals presenting an ID card with a copayment amount and PCP information have in-area coverage. Patients presenting ID cards without this information have out-of-area coverage.

Following are examples of the in-area and out-of-area ID cards:

Health Select ID Cards

Point of Service

BlueCross BlueShield HEALTH SELECT

New Alpha Prefix

Subscriber Name: **John Q. Sample, Jr.**
 Identification Number: **HXE123456789**
 Group Number: 038000
 Network: PSTQA

PCP: **Dr. Smith & Associates**
 1-800-333-6789 01/01/08

Dependent Name: **Mary Sample**

PCP \$20
 Specialist \$30
 Emergency Copay \$100

RxBIN: 004336 RxGroup: RX1292
 RxPCN: ADV

Traditional

BlueCross BlueShield HEALTH SELECT

New Alpha Prefix

Subscriber Name: **John Q. Sample, Jr.**
 Identification Number: **HXE123456789**
 Group Number: 038000
 Coverage Date: 09/01/08

Dependent Name: **Mary Sample**

Deductible \$200

RxBIN: 004336 RxGroup: RX1292
 RxPCN: ADV

www.bcbstx.com/hs

BlueCross BlueShield of Texas

Members Call 1-800-252-8039
 Providers Call 1-800-451-0287
 Preauth Medical 1-800-344-2354
 Preauth MHCD 1-800-528-7284
 Condition Mgmt. 1-800-462-3275
 Special Beginnings 1-800-462-3275
 24/7 Nurseline 1-888-334-9473
 Pharmacy* 1-888-886-8490

Network coverage is available through HealthSelect providers with a PCP referral. Nonnetwork services will be covered at a lower level. Some services must be preauthorized, including mental health (MH) and chemical dependency (CD). Refer to your online benefits for additional information. File claims with your local Blue Cross and/or Blue Shield Plan.

BlueCross BlueShield of Texas, an independent licensee of the Blue Cross BlueShield Association, provides claims processing only and assumes no financial risk for claims.

* Pharmacy Benefits Manager
 * Not a BCBSTX product.

Caremark

New Pharmacy Benefit Manager
 (Effective 09/01/2008)

www.bcbstx.com/hs

BlueCross BlueShield of Texas

Members Call 1-800-252-8039
 Providers Call 1-800-451-0287
 Preauth Medical 1-800-344-2354
 Preauth MHCD 1-800-528-7284
 Condition Mgmt. 1-800-462-3275
 Special Beginnings 1-800-462-3275
 24/7 Nurseline 1-888-334-9473
 Pharmacy* 1-888-886-8490

Some services must be preauthorized, including mental health (MH) and chemical dependency (CD). Refer to your online benefits for additional information.

File claims with your local Blue Cross and/or Blue Shield Plan.

BlueCross BlueShield of Texas, an independent licensee of the Blue Cross BlueShield Association, provides claims processing only and assumes no financial risk for claims.

* Pharmacy Benefits Manager
 * Not a BCBSTX product.

Caremark

New Pharmacy Benefit Manager
 (Effective 09/01/2008)

HealthSelect Customer Service

Capabilities

BCBSTX provides a Customer Service Department dedicated to serving State of Texas subscribers and the health care physician/professional providers who treat them. The Customer Service representatives are available to assist you with inquiries about:

- Benefits and eligibility
 - Claims
 - BlueChoice Network physician/professional providers
 - Complaint procedures
-

Blue Care[®] Connection

Blue Care[®] Connection is the disease management and wellness program available to HealthSelect members. The program simplifies the coordination of members' health care benefits, educates and empowers them to make informed choices, and supports wellness by aiding their understanding of preventive care guidelines, personal risk assessments, and preventive screenings. These services are part of their benefits and are provided to HealthSelect members at no additional cost. Key components of Blue Care Connection include:

- **Wellness Programs** - targeted participant mailings regarding key preventive screenings and disease specific immunizations
- **24/7 NurseLine** - caring, experienced nurses available 24 hours, seven days a week—even on holidays. Toll-free, (888) 334-9473
- **Personal Health Manager** - online resources including health and medication information, Health Risk Assessment, and Ask a Nurse
- **Care Management** – operates through the pre-certification process
- **Case Management** - provides continuity of care for more complex treatment
- **Disease Management** - programs designed for members with specific conditions such as asthma, diabetes, CHF, or CAD
- **Special Beginnings[®]** - integrates high-risk pregnancy identification and the case management program. Toll-free, (800) 462-3275

For more information on the Blue Care Connection programs, go to www.bcbstx.com/hs/blucareconnection.htm on the HealthSelect Web site or call (800) 462-3275.

Telephone Numbers

You may reach the HealthSelect Customer Service Department by calling the number listed below and choosing the option for HealthSelect/Group 38000 & 38001 Customer Service.

Toll-free 1-800-451-0287

HealthSelect Referrals and Precertification

<p>Referral Certification</p>	<p>Referral certification procedures for HealthSelect are the same as outlined for BlueChoice POS. Please see the referral section of this guide. (Sections C & D) It is extremely important that these procedures are followed when referring in-area patients for specialty care. Failure to do so may result in non-network benefits and a higher out-of-pocket expense for the subscriber.</p>
<p>Self-referral</p>	<p>Effective September 1, 1998, female HealthSelect patients do not need a referral to access any BlueChoice OB/GYN for their gynecological and maternity care. HealthSelect patients also have direct access to any BlueChoice optometrist or ophthalmologist for an annual refractive vision exam.</p>
<p>Precertification and Behavioral Health Procedures</p>	<p>Administrative procedures for HealthSelect subscribers, such as referrals, precertification and certification of behavioral health care services, are handled in the same manner as described in those sections of this guide. (Sections C, D, & E) For behavioral health information see the Behavioral Health section of this guide. (Section J)</p>
<p>Benefit Charts and Exclusions List</p>	<p>Charts outlining the different HealthSelect benefit levels can be found on the following pages of this section. A list of the most common contract exclusions for HealthSelect is also provided. Please refer to this information for more detailed explanations of benefits for the HealthSelect subscriber.</p>

HealthSelect In-Area Benefits Summary Effective September 1, 2006

General Provisions	Network	Non-Network
		<i>Calendar year deductible applies to charges except as noted.</i>
Calendar year deductible	None	\$500 individual
Calendar year out-of-pocket coinsurance maximum (does not include copayments)	\$1,000 per person (includes network and non-network coinsurance)	\$3,000 per person (does not include network coinsurance)
Calendar year inpatient copayment maximum (does not include office visit or outpatient day surgery copayments)	\$1,500 per person (includes both network and non-network inpatient copayments)	\$1,500 per person (includes both network and non-network inpatient copayments)
Precertification penalty deductible	None	\$200 per hospital admission (if not precertification)
Responsibility for precertification	Provider	Participant
Lifetime Maximum benefit	None	\$1,000,000
Doctor and Lab Services		
PCP office visits (includes immunizations, injections, diagnostic x-rays, and lab tests)	\$20 copayment per visit	Plan pays 60%, you pay 40%
Specialist office visits (includes immunizations, injections, diagnostic x-rays, and lab tests)	\$30 copayment per visit	Plan pays 60%, you pay 40%
Retail Health Clinic	\$20 copayment per visit or you pay 20% with no office visit	Plan pays 60%, you pay 40%
Physicals	\$20 copayment with designated PCP or \$30 copayment with a Specialist (one per calendar year for adults, periodic for children; women are allowed one routine well-woman office visit to an OB/GYN each calendar year)	Plan pays 60%, you pay 40% (one per calendar year for adults and children – women are also allowed one well-woman office visit to an OB/GYN each calendar year)
Diagnostic x-rays, mammography, routine immunizations, and lab tests (except when performed during an office visit)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%

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HealthSelect In-Area Benefits Summary

Effective September 1, 2006, Continued

Doctor and Lab Services	Network	Non-Network
Immunizations for children 0-6 years old (except when performed during an office visit)	Plan pays 100%	Plan pays 100%
Allergy injections and antigens (when no office visit is billed)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Office surgery and diagnostic procedures	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Inpatient doctor visits	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Outpatient surgery and anesthesia (physician charges)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Routine eye exam (one per calendar year per participant)	\$30 Specialist copayment	Plan pays 60%, you pay 40%
Maternity care (doctor charges only; see Hospital Services for inpatient charges)	If care is with designated PCP, \$20 for the first office visit, then Plan pays 100% for maternity care. If care is with Specialist, \$30 for the first office visit, then Plan pays 100% for maternity care	Plan pays 60%, you pay 40%
Hospital Services		
Inpatient hospital (semi-private room and board or intensive care unit)	After a \$100 copayment per day (\$500 max per stay), Plan pays 80%, you pay 20%	After a \$100 copayment per day (\$500 max per stay), Plan pays 60%, you pay 40%
Other inpatient charges, including surgery and anesthesia	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Outpatient facilities, including treatment room and/or preadmission testing	After a \$100 copayment, Plan pays 80%, you pay 20%	After a \$100 copayment, Plan pays 60%, you pay 40%
Emergency care	After a \$100 copayment (waived if you are admitted — hospital stay of at least 24 hours; however, inpatient hospital copayment will apply), Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%

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HealthSelect In-Area Benefits Summary

Effective September 1, 2006, Continued

Extended Care Services	Network	Non-Network
*Skilled nursing care in a skilled nursing facility (does not include custodial care)	Plan pays 80%, you pay 20% (60 day maximum per calendar year)	Plan pays 60%, you pay 40% (60 days/\$4,200 maximum per calendar year)
*Hospice care (\$18,000 lifetime maximum)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
*Home health care	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% (100 visits up to \$3,500 calendar year maximum)
*Private duty nursing	Plan pays 80%, you pay 20% (even after out-of-pocket coinsurance is met)	Plan pays 60%, you pay 40% (even after out-of-pocket coinsurance maximum is met); \$7,000 calendar year maximum, \$35,000 lifetime maximum
Other Medical Services		
Hearing aids (repairs not covered)	Plan pays 100% (up to \$500 per year every three years)	Plan pays 100% (no deductible – up to \$500 per year every three years)
Hearing aid batteries	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for the use in your hearing aid (not subject to the \$500/three-year limitation)	
Diabetes supplies, other than insulin and syringes	Plan pays 80%, you pay 20%	Plan pays 80%, you pay 20%
Durable medical equipment (includes medically necessary purchase and/or rental)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Prosthetic appliances (\$10,000 maximum per occurrence)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Physical, occupational, speech therapy, and chiropractic care	Plan pays 80%, you pay 20% if no office visit, with office visit \$30 copayment plus 20%	Plan pays 60%, you pay 40%
Ambulance services	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%

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HealthSelect In-Area Benefits Summary

Effective September 1, 2006, Continued

Other Medical Services	Network	Non-Network
*Home infusion therapy (HIT)	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% if you use a BCBSTX contracting provider; Plan pays 0% and you pay 100% if you use a noncontracting provider
Behavioral Health (Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)		
Outpatient visits (maximum 30 visits per calendar year), including speech therapy for certain speech disorders	Plan pays 80%, you pay 20% (even after out-of-pocket coinsurance is met)	Plan pays 60%, you pay 40% (even after out-of-pocket coinsurance maximum is met); maximum allowable amount \$60 per visit
*Inpatient visits (maximum 30 days per calendar year) Inpatient copayments apply toward calendar year inpatient copayment maximum of \$1,500 per person.	After \$100 copayment per day (\$500 max per stay), Plan pays 80% for the first 15 days, you pay 20%. The next 15 days, Plan pays 60%, you pay 40%	After \$100 copayment per day (\$500 max per stay), Plan pays 60% for the first 15 days, you pay 40%. The next 15 days, Plan pays 50%, you pay 50%
**Intermediate care facility (maximum 60 days per calendar year) Intermediate copayments apply toward the calendar year inpatient copayment maximum of \$1,500 per person.	After \$50 copayment per day (\$500 max per stay), Plan pays 80% for the first 30 days, you pay 20%. The next 30 days, Plan pays 60%, you pay 40%	After \$50 copayment per day (\$500 max per stay), Plan pays 60% for the first 30 days, you pay 40%. The next 30 days, Plan pays 50%, you pay 50%

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HealthSelect In-Area Benefits Summary Effective September 1, 2006, Continued

Prescription Drugs – Administered by Caremark effective September 1, 2008	
Prescription Drug Deductible	\$50 per person, per plan year (September 1 – August 31)
At participating pharmacies	<p>Up to a 30-day supply for nonmaintenance drugs. Copayments: \$10 for generic drugs, \$25 for preferred brand name drugs, \$40 for nonpreferred brand name drugs ***</p> <p>Up to a 30-day supply for maintenance drugs. Copayments: \$15 for generic drugs, \$35 for preferred brand name drugs, \$55 for nonpreferred brand name drugs***</p>
At nonparticipating pharmacies	Up to a 30-day supply. 60% of the lesser of: the amount you pay for the prescription, minus your copayment OR the average wholesale price of the drug, plus the dispensing fee, minus your copayment ***
Mail order pharmacy	90-day supply. Copayments: \$30 for generic drugs, \$75 for preferred brand name drugs, \$120 for nonpreferred brand name drugs ***

*Precertification required

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

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

The percentages paid by the Plan or by the Participant represent either the percentages of the negotiated price with providers or the allowable amount as determined by BCBSTX, not the billed charges.

HealthSelect Out-of-Area Benefits Summary Effective September 1, 2006

The following charts explain benefits when Medicare is the patient's primary plan and services are covered by Medicare, if the patient is a grandfathered retiree, if the patient is a dependent under 65 without Medicare coverage, and when services are not covered by Medicare. All benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers and, if you are eligible for Medicare, using providers who accept Medicare assignment will protect the patient from liability for amounts over the allowable amount.

General Provisions	Retirees with Medicare Primary, (Part A and B) when services are covered by Medicare	Grandfathered Retirees, dependents under age 65 who do not have Medicare and when services are not covered by Medicare
	<i>Calendar year deductible applies to charges except as noted</i>	<i>Calendar year deductible applies to charges except as noted</i>
Calendar year deductible	\$200 individual/\$600 family maximum (\$100 Medicare deductible counts toward this amount)	\$200 individual/\$600 family maximum
Calendar year out-of-pocket coinsurance maximum (does not include copayments)	\$1,000 per person	\$1,000 per person
Calendar year inpatient copayment maximum	\$1,500 per person	\$1,500 per person
Precertification penalty deductible	\$200 per hospital admission (if not precertified)	\$200 per hospital admission (if not precertified)
Responsibility for precertification	Participant	Participant
Lifetime maximum benefit	None	None
Doctor and Lab Services		
Doctor office visits	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Annual physicals (one per calendar year for adults and children)	Plan pays 70%, you pay 30%	Plan pays 70%, you pay 30%
Women are also allowed one well-woman office visit to an OB/GYN each calendar year	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%

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HealthSelect Out-of-Area Benefits Summary

Effective September 1, 2006, Continued

General Provisions	Retirees with Medicare Primary, (Part A and B) when services are covered by Medicare	Grandfathered Retirees, dependents under age 65 who do not have Medicare and when services are not covered by Medicare
Diagnostic x-rays, mammography, injections, routine immunizations, pap smears, and lab tests	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Specific immunizations for children 0-6 years old (except when performed during an office visit)	Plan pays 100%	Plan pays 100%
Allergy injections and antigens	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Office surgery and diagnostic procedures	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Inpatient doctor visits	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Outpatient surgery and anesthesia	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Routine eye exam (one per calendar year per participant)	Plan pays 70%, you pay 30%	Plan pays 70%, you pay 30%
Maternity care	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%

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HealthSelect Out-of-Area Benefits Summary

Effective September 1, 2006, Continued

Hospital Services	Retirees with Medicare Primary (Part A & B) when services are covered by Medicare	Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare
Inpatient hospital (semi-private room and board or intensive care unit)	Medicare pays 80%, Health Select will coordinate by paying the inpatient deductible, private room difference, and first three pints of blood, and you may be responsible for a copayment amount	Grandfathered Retirees only – Medicare pays 80%, Health Select will coordinate by paying the inpatient deductible, private room difference, and first three pints of blood, and you may be responsible for a copayment amount All others – Plan pays 70%, you pay a \$100 copayment per day (\$500 maximum per stay) plus pay 30% (no deductible)
Other inpatient charges, including surgery and anesthesia	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Outpatient facilities, including treatment room and preadmission testing	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay \$100 copayment plus 30%
Emergency care	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays \$70, you pay 30%
Extended Care Services		
*Skilled nursing care in a skilled nursing facility (does not include custodial care)	Medicare pays primary, HealthSelect will coordinate paying secondary up to a maximum of 60 days or \$6,000 per calendar year	Plan pays 100% up to a maximum of 60 days or \$6,000 per calendar year (no deductible)
*Hospice care	Medicare pays primary, HealthSelect will coordinate paying secondary up to \$18,000 lifetime maximum	Plan pays 70%, you pay 30%; \$18,000 lifetime maximum (no deductible)

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HealthSelect Out-of-Area Benefits Summary

Effective September 1, 2006, Continued

Extended Care Services, <i>Continued</i>	Retirees with Medicare Primary (Part A & B) when services are covered by Medicare	Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare
*Home health care	Medicare pays primary, HealthSelect will coordinate paying secondary up to a maximum of 100 visits or \$5,000 per calendar year	Plan pays 100% up to a maximum of 100 visits or \$5,000 per calendar year (no deductible)
***Private duty nursing	Medicare pays primary, HealthSelect will coordinate paying secondary up to a maximum of \$8,000 per calendar year and \$40,000 lifetime maximum	Plan pays 70%, you pay 30% (even after out-of-pocket coinsurance maximum is met); \$8,000 calendar year maximum; \$40,000 lifetime maximum
Other Medical Services		
Hearing aids (repairs not covered)	Plan pays up to \$500 per year every three years (no deductible)	Plan pays up to \$500 per year every three years (no deductible)
Hearing aid batteries	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for use in your hearing aid (not subject to the \$500/three- year limitation)	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming that the batteries were purchased for use in your hearing aid (not subject to the \$500/three year limitation)

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HealthSelect Out-of-Area Benefits Summary

Effective September 1, 2006, Continued

Other Medical Services, Continued	Retirees with Medicare Primary (Part A & B) when services are covered by Medicare	Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare
Diabetes supplies, other than insulin and syringes	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Durable medical equipment (includes medically necessary purchase and/or rental)	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Prosthetic appliances (\$10,000 maximum per occurrence)	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Physical occupational, speech therapy, and chiropractic care	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
Ambulance services	Medicare pays 80%, HealthSelect will coordinate paying secondary	Plan pays 70%, you pay 30%
*Home infusion therapy (HIT)	Medicare pays 80%, HealthSelect will coordinate paying secondary. You must use a BCBSTX contracting provider to receive any coverage from HealthSelect.	Plan pays 70%, you pay 30% if you use a BCBSTX contracting provider to receive any coverage from HealthSelect. Plan pays 0% and you pay 100% if you use a noncontracting provider
Behavioral Health (Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)		
Outpatient visits (maximum 30 visits per calendar year), including speech therapy for certain speech disorders	Medicare pays 80%, HealthSelect will coordinate paying secondary; maximum allowable amount \$60 per visit	Plan pays 70%, you pay 30% (even after coinsurance maximum is met); maximum allowable amount \$60 per visit

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HealthSelect Out-of-Area Benefits Summary Effective September 1, 2006, Continued

Behavioral Health, Continued (Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)	Retirees with Medicare Primary (Part A & B) when services are covered by Medicare	Grandfathered Retirees, dependents under age 65 who do not have Medicare, and when services are not covered by Medicare
*Inpatient visits (maximum 30 days per calendar year) Inpatient copayments apply toward the calendar year inpatient copayment maximum	Medicare pays 80%, HealthSelect will coordinate paying secondary and you may be responsible for a copayment amount	After you pay a \$100 copayment per day (\$500 maximum per stay), Plan pays 70% for the first 15 days and you pay 30%; the next 15 days the Plan pays 50% and you pay 50%
** Intermediate care facility (maximum 60 days calendar year) Intermediate care copayments apply toward the calendar year inpatient copayment maximum	Medicare pays 80%, HealthSelect will coordinate paying secondary and you may be responsible for a copayment amount	After you pay a \$50 copayment per day (\$500 maximum per stay), Plan pays 70% for the first 30 days and you pay 30%; the next 30 days the Plan pays 50%, you pay 50%
Prescription Drugs – Administered by Caremark effective September 1, 2008		
Prescription Drug Deductible	\$50 per person, per plan year (September 1 – August 31)	
At participating pharmacies	<p>Up to a 30-day supply for nonmaintenance drugs. Copayments: \$10 for generic drugs, \$25 for preferred brand name drugs, \$40 for nonpreferred brand name drugs***</p> <p>Up to a 30-day supply for maintenance drugs. Copayments: \$15 for generic drugs, \$35 for preferred brand name drugs, \$55 for nonpreferred brand name drugs</p>	
At nonparticipating pharmacies	Up to a 30-day supply. 60% of the lesser of: the amount you pay for the prescription, minus your copayment OR the average wholesale price of the drug, plus the dispensing fee, minus your copayment ****	

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HealthSelect Out-of-Area Benefits Summary Effective September 1, 2006, Continued

Prescription Drugs, <i>Continued</i>	
Mail order pharmacy	Up to a 90-day supply. Copayments: \$30 for generic drugs, \$75 for preferred brand name drugs, \$120 for nonpreferred brand name drugs****

*Precertification required unless you have Medicare Part A benefits

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

***Precertification required.

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

The percentages paid by the Plan or by the Participant represent either the percentages of the negotiated price with providers or the allowable amount as determined by BCBSTX, not the billed charges.

HealthSelect Out-of-Area Benefits Summary (Under 65) Effective September 1, 2006

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability for amounts over the allowable amount. These benefits apply to Participants who reside outside the state. These benefits do not apply to Participants who have “*opted*” for *in-area benefits based on their work county*.

General Provisions	Benefits
Calendar year deductible	\$200 individual/\$600 family maximum
Calendar year out-of-pocket coinsurance maximum (does not include copayments)	\$1,000 per person
Calendar year inpatient copayment maximum (includes any inpatient copayments paid while covered as an in-area participant during the same calendar year)	\$1,500 per person
Precertification penalty deductible	\$200 per hospital admission (if not precertified)
Responsibility for precertification	Participant
Lifetime maximum benefit	None
Doctor and Lab Services	
Doctor office visits	Plan pays 70%, you pay 30%
Annual physicals (one per calendar year for adults and children; women are also allowed one well-woman office visit to an OB/Gyn each calendar year)	Plan pays 70%, you pay 30%
Diagnostic x-rays, mammography, injections, routine immunizations, pap smears, and lab tests	Plan pays 70%, you pay 30%
Specific immunizations for children 0 – 6 years old (except when performed during an office visit)	Plan pays 100%

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HealthSelect Out-of-Area Benefits Summary (Under 65) Effective September 1, 2006, Continued

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability for amounts over the allowable amount. These benefits apply to Participants who reside outside the state. These benefits do not apply to Participants who have “*opted*” for in-area benefits based on their work county.

Doctor and Lab Services	Benefits
Allergy injections and antigens	Plan pays 70%, you pay 30%
Office surgery and diagnostic procedures	Plan pays 70%, you pay 30%
Inpatient doctor visits	Plan pays 70%, you pay 30%
Outpatient surgery and anesthesia (physician charges)	Plan pays 70%, you pay 30%
Routine eye exam (one per calendar year per participant)	Plan pays 70%, you pay 30%
Maternity care	Plan pays 70%, you pay 30%
Hospital Services	
Inpatient hospital (semi-private room and board or intensive care unit)	After a \$100 copayment per day (\$500 max per stay), Plan pays 70%, you pay 30% (no deductible)
Other inpatient charges, including surgery and anesthesia	Plan pays 70%, you pay 30%
Outpatient facilities, including treatment room and/or preadmission testing	After a \$100 copayment per day, Plan pays 70%, you pay 30%
Emergency care	Plan pays 70%, you pay 30%
Extended Care Services	
*Skilled nursing care in a skilled nursing facility (does not include custodial care)	Plan pays 100%; 60 days up to \$6,000 calendar year maximum (no deductible)
*Hospice care	Plan pays 70%, you pay 30%; \$18,000 lifetime maximum (no deductible)
*Home health care	Plan pays 100%; 100 visits up to \$5,000 calendar year maximum (no deductible)
**Private duty nursing	Plan pays 70%, you pay 30% (even after out-of-pocket coinsurance maximum is met); \$8,000 calendar year maximum; \$40,000 lifetime maximum

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HealthSelect Out-of-Area Benefits Summary (Under 65) Effective September 1, 2006, Continued

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability for amounts over the allowable amount. These benefits apply to Participants who reside outside the state. These benefits do not apply to Participants who have “*opted*” for *in-area benefits based on their work county*.

Other Medical Services	Benefits
Hearing aids (repairs not covered)	Plan pays up to \$500 per ear every three years (no deductible)
Hearing aid batteries	Plan pays 100% (up to a maximum of \$1 per battery); you must submit a signed statement and the receipt with each hearing aid battery claim, confirming the batteries were purchased for use in your hearing aid (not subject to the \$500/three-year limitation)
Diabetes supplies, other than insulin and syringes	Plan pays 70%, you pay 30%
Durable medical equipment (includes medically necessary purchase and/or rental)	Plan pays 70%, you pay 30%
Prosthetic appliances (\$10,000 maximum per occurrence)	Plan pays 70%, you pay 30%
Physical, occupational, speech therapy, and chiropractic care	Plan pays 70%, you pay 30%
Ambulance services	Plan pays 70%, you pay 30%
*Home infusion therapy (HIT)	Plan pays 70%, you pay 30% if you use a BCBSTX contracting provider, Plan pays 0% and you pay 100% if you use a noncontracting provider
Behavioral Health	Benefits
(Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)	
Outpatient visits (maximum 30 visits per calendar year), including speech therapy for certain speech disorders	Plan pays 70%, you pay 30% (even after coinsurance maximum is met); maximum allowable amount \$60 per visit

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HealthSelect Out-of-Area Benefits Summary (Under 65) Effective September 1, 2006, Continued

Benefits are paid based on the BCBSTX allowable amount. Using ParPlan providers will protect you from liability for amounts over the allowable amount. These benefits apply to Participants who reside outside the state. These benefits do not apply to Participants who have “*opted*” for in-area benefits based on their work county.

Behavioral Health, <i>Continued</i>	Benefits
(Does not include serious mental illness or substance abuse treatment, which are covered like any other injury or illness)	
*Inpatient treatment (maximum 30 days per calendar year) Inpatient copayments apply toward calendar year inpatient copayment maximum of \$1,500 per person.	After \$100 copayment per day (\$500 max per stay), Plan pays 70% for the first 15 days, you pay 30%. The next 15 days, Plan pays 50%, you pay 50%
**Intermediate care facility (maximum 60 days per calendar year) Intermediate copayments apply toward the calendar year inpatient copayment maximum of \$1,500 per person.	After \$50 copayment per day (\$500 max per stay), Plan pays 70% for the first 30 days, you pay 30%. The next 30 days, Plan pays 50%, you pay 50%
Prescription Drugs – Administered by Caremark effective September 1, 2008	
Prescription Plan Year Drug Deductible	\$50 per person, per plan year (September 1 – August 31)
At participating pharmacies	Up to a 30-day supply for nonmaintenance drugs. Copayments: \$10 for generic drugs, \$25 for preferred brand name drugs, \$40 for nonpreferred brand name drugs *** Up to a 30-day supply for maintenance drugs. Copayments: \$15 for generic drugs, \$35 for preferred brand name drugs, \$55 for nonpreferred brand name drugs***
At nonparticipating pharmacies	Up to a 30-day supply. 60% of the lesser of the amount you pay for the prescription, minus your copayment OR the average wholesale price of the drug, plus the dispensing fee, minus your copayment***
Mail order pharmacy	90-day supply. Copayments: \$30 for generic drugs, \$75 for preferred brand name drugs, \$120 for nonpreferred brand name drugs***

*Precertification required.

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

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

HealthSelect Exclusions

Introduction

The following list of HealthSelect exclusions is current as of September 1, 2006. This list is subject to change.

HealthSelect Exclusions List

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

**HealthSelect
Exclusions
List, *Continued***

- I. Any services or supplies provided for the nonsurgical and/or nondiagnostic treatment of or related services to the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaw to eliminate pain or dysfunction of the TMJ and all adjacent or related muscles and nerves. This exclusion shall not apply to any physical therapy that is necessary as a result of TMJ surgery, as described in the fourth bullet of the definition of Covered Oral Surgery (see glossary of terms).
 - J. Contact lens exams, prescriptions or fittings of contact lenses or eyeglasses, and the cost of the contact lenses or eyeglasses.
 - K. Treatment of myopia and other errors of refraction, orthoptics, visual training, or radial keratotomy, including related corrective vision procedures.
 - L. Services or supplies for routine foot care, shoe orthotics, insoles, or shoe inserts of any type, except when prescribed for a diagnosis of or related to diabetes.
 - M. Cosmetic, reconstructive, or plastic surgery, unless medically necessary due to accidental injury while covered under the Texas Employees Uniform Group Insurance Program, congenital defect (up to age 19), neoplastic (cancer) surgery, or following a mastectomy. Coverage is provided for surgical breast reconstruction following a mastectomy to restore or achieve breast symmetry. Surgical reconstruction of the breast on which mastectomy surgery was performed and surgical reconstruction of the breast on which mastectomy surgery has not been performed are both covered.
 - N. Marriage and family therapy/counseling, self-therapy, or therapy as a part of training.
 - O. Travel services and accommodations, whether or not recommended or prescribed, except ambulance services.
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HealthSelect Exclusions, Continued

**HealthSelect
Exclusions
List, Continued**

- P. Weight reduction programs, services, supplies, surgeries, including but not limited to Gastric Bypass or Vertical Banding, or gym subscriberships, even if the participant has medical conditions that might be helped by weight loss, or even if prescribed by a physician.
 - Q. Sterilization reversal, transsexual surgery, gender reassignment, artificial insemination and related services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed two weeks before in preparation for or immediately after any of the above-referenced excluded procedures.
 - R. Abortion, unless the participant's life would be endangered by continuing the pregnancy, or there is a diagnosed fetal anomaly, or unless the pregnancy is caused by a criminal act such as rape or incest.
 - S. Home infusion therapy treatment provided by an entity that does not contract with BCBSTX as a provider of Home Infusion Therapy.
 - T. Transplant procedures (including transplantation of nonhuman organs) or the services performed in preparation for, or in conjunction with such procedure, which BCBSTX considers to be Experimental and/or Investigational in nature, living and travel expenses of the live donor or recipient, organ donor search and acceptability testing of potential living donors, expenses related to maintenance of life for purpose of organ donation, purchase of organ or tissue, and donor expenses where donor is not a participant under the Texas Employees Uniform Group Insurance Program.
 - U. Medical social services, bereavement counseling (except as part of a precertified hospice treatment plan), or vocational counseling.
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HealthSelect Exclusions, Continued

**HealthSelect
Exclusions
List, *Continued***

- V. Items for patient convenience or comfort as determined by BCBSTX such as, but not limited to, motorized lifts, over-the-counter splints or braces, air conditioners or purifiers, humidifiers, dehumidifiers, physical fitness and/or whirlpool bath equipment, personal hygiene protection, allergen-free pillows, home air fluidized beds, mattresses, blood pressure cuffs, etc., even if recommended or prescribed by a physician or other provider.
 - W. Environmental sensitivity, clinical ecology, or inpatient allergy testing or treatment. Chelation therapy except for treatment of acute metal poisoning.
 - X. Services or supplies that require precertification under HealthSelect, but were not precertified.
 - Y. Dietary and nutritional services, except for an inpatient nutritional assessment program provided in and by a hospital and approved by BCBSTX, or diabetic management services that are provided by or directed by a physician approved by BCBSTX.
 - Z. Prescription drugs or medicines which are covered under a separate prescription drug program with its own limitations and exclusions, as described in the benefit booklet.
 - AA. Any services or supplies for acupuncture.
 - BB. Any services or supplies provided before the participant's effective date or after the expiration date of coverage except as provided through extension of benefits.
 - CC. Any occupational therapy services that do not consist of traditional physical therapy modalities.
 - DD. The excess of any charge greater than the allowable amount as determined by BCBSTX.
 - EE. Any services or supplies provided for, in preparation for, or in conjunction with autologous or allogenic bone marrow transplant with or without high dose chemotherapy, except for those nonexperimental transplants (as determined and precertified by BCBSTX) or as may be provided by BCBSTX through case management.
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HealthSelect Exclusions, Continued

**HealthSelect
Exclusions
List, Continued**

- FF. Difference between the charge for a hospital private room and semiprivate room, except when coordinating secondary benefits with Medicare Part A.
 - GG. Any services or supplies for which benefits are not provided under HealthSelect, unless provided through Case Management or ERS-approved pilot programs.
 - HH. Services or supplies provided by a person or entity who is not a provider, as defined by HealthSelect.
 - II. Physical examinations conducted solely for school admission, insurance, employment, or licensure examination purposes.
 - JJ. Telemedicine services provided by telephone or fax machine.
 - KK. Services, supplies, and related expenses that the BCBSTX Claims Administrator determines to be Experimental and/or Investigational.
 - LL. Services and supplies provided by an immediate family member.
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