producer toolkit for health plans with 2–150 employees

BlueCross BlueShield of Texas
Why We’re **Different** from the Rest

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**Strength of the Blue Brand**

The Blue Cross and Blue Shield Brands rank **first** in unaided brand recognition among health insurance carriers.

- Cigna: 11%
- United: 27%
- Aetna: 30%
- BCBS: 69%

Blue Cross and Blue Shield of Texas is a division of Health Care Service Corporation (HCSC), the largest customer-owned health insurer in the nation, and fourth largest overall, with solid financial ratings:

- **Standard & Poor’s**
  - AA- / Very Strong

- **A.M. Best**
  - A+ / Superior

- **Moody’s**
  - A1 / Good

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**ONE OF THE LARGEST MEMBERSHIPS**

Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation, has more than five million members – twice the market share of our closest competitor.

**MOST RECOGNIZED BRAND**

Ninety-seven percent of consumers nationwide recognize the Blue Cross and Blue Shield brand – making it the most recognized and trusted brand in the industry.

**TEXAS BORN AND BREED**

Local, accessible leadership … we know Texas and Texas health care issues.

**DOCTOR AND HOSPITAL NETWORKS**

More doctors and more hospitals!

- State’s largest PPO network – includes 79 percent of available physicians and 90 percent of hospitals covering all 254 counties in Texas
- Nation’s largest PPO networks – access to over 91 percent of physicians and over 95 percent of hospitals

**NETWORK DISCOUNTS**

Best health care value in Texas

**STATE-OF-THE-ART TECHNOLOGY**

Offers robust online functionality on our producer and member websites and helps us provide the superior customer service that wins the highest member loyalty

**WE ARE CUSTOMER-OWNED**

We invest in our policyholders, not shareholders – our accountability to our members is clear.

**FINANCIAL STRENGTH RATINGS**

- A.M. Best – A+ (Superior) (January 2014)
- Standard & Poor’s – AA- (Very Strong) (June 2014)
- Moody’s – A1 (Good) (July 2012)

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*Blue Cross and Blue Shield Association Brand Strength Measure Survey 2011

**Source:** Harris Interactive Survey, 2008

**Financial Services**

3rd among financial services brands

**Why We’re Different from the Rest**

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*Health Care Service Corporation (HCSC) is rated A+ (Superior) by A.M. Best Company, AA- (Very Strong) by Standard & Poor’s and A1 (Good) by Moody’s Investors Service. All A.M. Best ratings affirmed January 11, 2014. Standard & Poor’s rating affirmed June 2014.*
Producer Toolkit for health plans with 2–150 employees

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Why BCBSTX?

Introducing

This Producer Toolkit contains information and guidelines developed to support you in the sale and enrollment of Blue Cross and Blue Shield of Texas (BCBSTX) group products for health plans with 2–150 employees. On the following pages you will find product information, new business guidelines and useful tools that will help you in your sales endeavors. While all of the guidelines have not been specifically addressed, the toolkit provides a general overview of what BCBSTX has to offer both you and your clients. Please refer to our producer portal, Blue Access for ProducersSM, located at bcbstx.com/producer, for updates and additional information.

BCBSTX History

BCBSTX traces its origin to the non-profit Baylor Plan, the nation's first hospital pre-payment plan founded in 1929 by Dr. Justin Ford Kimball. Today, BCBSTX is the Texas-based division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company that operates the Blue Cross and Blue Shield plans in Illinois, Montana, New Mexico, Oklahoma, and Texas. HCSC is an independent licensee of the Blue Cross and Blue Shield Association.

Corporate Structure

Local offices throughout Texas serve unique markets, negotiate provider arrangements and recruit and manage network providers. Sales, service and network management personnel in local offices are supported by core functions that are centralized for training, consistency and efficiencies.

Full service units (FSUs), also located across the state, provide administrative services on an account-specific basis and serve as a single point of contact for member service issues.

BCBSTX Experience

With the Texas, Illinois, Montana, New Mexico and Oklahoma plans combined, HCSC serves more than 13 million members. BCBSTX individually provides or administers coverage for more than 5 million members — more than any other group health insurance company in the state.

In addition to national and local managed care products, BCBSTX serves Federal Employee Program members in Illinois, New Mexico, Oklahoma, and Texas. BCBSTX is also the administrator of the Texas Health Insurance Pool. Our expertise with the public sector includes insuring or administering benefits for hundreds of Texas counties, cities, school districts, colleges and universities.

Subsidiaries of HCSC

HCSC subsidiaries include:

• Dearborn National
• Dental Network of America (DNoA) — a dental benefits subsidiary formed in 1985
• Hallmark Services Corporation
• HCSC Insurance Service Company
• Medecision, Inc.
• TMG Health

Social Responsibility

At BCBSTX, our connection to Texas communities is a natural extension of our legacy of caring and commitment to our customers.

Our dedication to addressing the causes and effects of public health problems — through corporate contributions, community partnerships and, especially, employee volunteerism — not only distinguishes us amongst our competitors, but also demonstrates to our customers and other stakeholders that we embrace the opportunity to help fill the gap in health care access and delivery.
Why BCBSTX? BCBSTX PowerPoint Presentation

This concise presentation is designed for you to use when presenting BCBSTX to your prospects and clients. Note pages/speaking points are included for your reference.

Slide 1

BCBSTX has four key areas that differentiate them in the marketplace:

- Their mission to stand with members, in sickness and in health
- Network Value
- Unrivaled Service
- Health and Wellness

Each category differentiates them and is a market strength. However, combining these categories provides a value proposition that is unmatched by competitors.

Before diving into the discussion on network, service, health and wellness, let me take a moment to share the fabric of the company...who they are and what they are all about.

Almost everyone has heard the Blue Cross and Blue Shield name and most recognize the brand and logo. That’s a given. Beyond that, you may not be as familiar with their corporate structure, how they run their business, their culture and general philosophies.

There are some real differences that I’d like to point out which help set the stage for the rest of the presentation.

To download the presentation, log in to Blue Access for Producers. Select Marketing and Sales, then Producer Toolkit, then BCBSTX PowerPoint Presentation.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
You may or may not know that BCBSTX is operated by the largest customer-owned insurer in the nation. It operates Plans in five states (IL, MT, NM, OK and TX). With nearly 14 million members, it is the fourth largest health insurer in the nation.

It is non-investor-owned, meaning it is owned by policyholders, not shareholders. This allows them to focus on serving their customers, rather than driving profits for shareholders (as a for-profit company would). Their strategies are based on what’s best for their customers and how they can best align customer needs with running the business. Unlike competitors, they do not have outside pressures from third-party investors, nor do they feel the need to over-respond to quarterly fluctuations in the business. Just a note…they are not opposed to publicly traded companies…they just do not feel it is the best model for the health care marketplace.

They believe that health care decisions are best made where the services are delivered. That’s why their divisions remain locally focused and deeply involved in the communities they serve. While focusing on the individual communities, they also possess the financial strength of large, national companies, as demonstrated through the ratings they have received from various financial rating agencies including:

- Moody’s Investors Service = A1 Good
- Standard & Poor’s = AA- Very Strong
- A.M. Best Company = A+ Superior

Outstanding employees and a commitment to providing superior services and products to individual members and group customers have made them and their subsidiaries among the fastest-growing health and life insurance companies in the nation.
Why BCBSTX? BCBSTX PowerPoint Presentation

Slide 3

Blue Cross and Blue Shield of Texas

Texas Born and Bred

• The state’s first health insurer – with a legacy of meeting the health care delivery needs of Texas people and communities for 80 years
• 16 office locations all across the state
• More than 30% of the market share in Texas
• As a health care system, the Blue Cross and Blue Shield Brands are first in brand preference and in unaided recognition among health insurance carriers

Non-Investor Owned

The only statewide customer-owned health insurer, focused solely on policyholders – not shareholders.

BCBSTX serves customers’ interests.

BCBSTX understands the Texas market (employers, members, providers) better than anyone

• Serving Texas-based employees since 1929
• Largest health plan in Texas, covering 5 million members in Texas and more than 1 million more through BlueCard
• 16 offices with full leadership team, claims, customer service, provider relations, underwriting, offering a full range of medical and ancillary products
• Offered in all 254 Texas counties, serving customers across all market segments
• Focused on the needs of the local community

BCBSTX believes in being close to their customers and brokers. Their products include the Participating Provider Option (PPO), Health Maintenance Organization (HMO), Point of Service (POS) plan, High Deductible Health Plans that are compatible with Health Savings Accounts (HSAs) and Health Care Accounts (HCAs) as well as traditional indemnity and Medicare Supplemental plans.

A wide variety of health and life insurance products and related services are available through the Plans, affiliates and subsidiaries. Some employer-sponsored health plans include vision, dental, managed mental health and prescription drug coverage.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Why BCBSTX?

More Doctors! More Hospitals!

BlueChoice® – Largest PPO network in Texas
- Includes 90% of hospitals and 79% of available physicians covering all 254 counties in Texas

BlueCard® National PPO network
- Benefits portability in 50 states, District of Columbia and Puerto Rico
- Access to 91% of physicians and 96% of hospitals in the nation
- More than 1 million professionals and 5,699 hospitals in the PPO

BlueCard Worldwide®
- Enables members traveling or living temporarily abroad to access covered services in more than 200 countries

HMO Blue® Texas
- 254-county service area
- Access to more than 13,400 PCPs, 54,720 specialists, 406 hospitals

Blue Cross and Blue Shield means MORE doctors and MORE hospitals across the country and in the state of Texas.

The BlueChoice network is the largest network of its kind in the state of Texas. It offers access to 90 percent of the hospitals in Texas, 79 percent of the physicians, and is available in all 254 counties. The BCBSTX discounts are very competitive.

ADDITIONAL COVERAGE

BCBSTX organizes itself locally in order to best understand the Texas markets, but is connected with the largest national presence in the industry. They have national scope with local accountability.

Outside of Texas, BlueCard® is a national program that enables members of one Blue company to obtain health care services while traveling or living in another Blue company's service area.

Members receive national coverage available when traveling or living outside their home state in the U.S., international coverage while traveling outside the U.S.
BCBSTX offers superior competitive discounts. As you know, average discount comparisons are commonplace in the health insurance industry, and BCBSTX takes its responsibility to provide accurate discount information very seriously. That is why BCBSTX has taken the necessary steps to ensure the discount information you receive is complete, consistent, and reliable.

BCBSTX and other Blue Cross and Blue Shield Plans submit actual claims data to a third-party actuarial firm to validate the data according to industry standards each time. They adhere to the strict criteria developed by Milliman USA when submitting claims data twice a year. The criteria include providing in-network benefits paid (not just contracted providers) and prohibit excluding network providers with low discounts. Other carriers may provide discount information based on contracted providers or even exclude providers with no or very low discounts, raising questions about the credibility of those discounts.

The dates across which the data was gathered impact the credibility of the discount data as well. It can take close to two years from the day a claim is filed, based on the dates selected, available for comparison in an analysis. The need for consistency among carriers is paramount if reliable results are to be achieved.
Several factors, in addition to the average discount, are involved in determining an employer’s actual costs. The fact that carriers do not adhere to the same methodology makes it even more difficult to produce accurate comparisons. Variations can include:

- Is the discount data calculated based on historical claims data or is it arrived at using projections?
- In the case of rural areas, are discounts from metropolitan areas substituted for the discounts in rural area, where a network may not even exist?
- For those carriers who rent networks in certain areas, are extraneous fees being paid in order to “buy” bigger discounts?
- Is the mix of providers between carriers the cause for misleading discount information? Not all specialties offer similar discounts. A broader network may include modest discounts on a provider type not even represented in another network. Because the provider types would be out of network, they would be excluded as data for comparison even though they impact the client’s bottom line.
- Are catastrophic claims such as burns and transplants included in the discount calculation?
- Are claims from specialty providers, such as children’s hospitals excluded from the carrier’s discount calculation? This can significantly impact the reported overall discount and it can significantly impact the employer’s bottom line.
Carriers with statewide networks, such as Blue Cross and Blue Shield of Texas, may report more modest discounts in a rural area than in metropolitan areas, bringing the average discount of a larger carrier down. When employers make discount comparisons, they should consider whether the geographic areas under review are the same for both carriers, and whether credit is given for rural areas where one carrier has a modest discount and the competitor may have no discount or very little network at all.

By looking at the numbers in this scenario, you can see that greater in-network access makes a big difference in overall claims savings. Looking simply at projected average discounts does not give a complete picture. Which carrier would you choose in this scenario?

Professionals in the health care industry will likely always request and use the average discount as a quick and easy way to compare various carriers. However, you should keep in mind some of the complexities that can impact how an average discount is derived. More importantly, we suggest that comparisons of average discounts be included as part of a larger conversation that incorporates network size, network location, variety of specialties available and appropriate utilization that also impact employers' costs.
Slide 6 (CONTINUED)

BCBSTX makes significant contracting improvements within its networks on an ongoing basis, and those improvements are not reflected in claims data for some time; therefore, benchmark data does not provide a current representation of BCBSTX networks today. BCBSTX is unique in the industry because they contract with 73 percent of their network inpatient facilities through DRG arrangements (diagnosis-related group). **DRGs ensure cost predictability when members go into the hospital, which translates to significant savings for employers and BCBSTX:**

- Caps costs to the expected length-of-stay and intensity of the diagnosis
- Reduces burden on payer to control actions of the hospital; motivates hospitals to control costs and deliver quality care
- Same reimbursement methodology as Medicare
- Limited carve outs
- Fixed Fee – No Charge Master creep – increases in charge masters by facilities reduces the percent of charge discount yields. Charge master cap language is standard in most BCBSTX contracts – it is rare that competition has this language in place

BCBSTX contracts with a majority of their outpatient facilities for surgical services through groupers, subject to a maximum. This allows them to cap the cost of outpatient procedures to a cost that is no more than would have been paid under the inpatient setting. Other carriers typically have no capping mechanism. **And with generally 29 percent of outpatient services hitting the DRG cap, you can see how often BCBSTX has the opportunity to save.** BCBSTX also has a unique stop-loss advantage. In the 40 percent of their network hospitals that have stop-loss provisions in their contract, BCBSTX achieves significant savings through per-day caps. Most carriers just pay the percentage of billed charges, but BCBSTX pays the percentage of billed charges or the per-day cap, whichever is less.
In rare situations where network access is not possible or preferred, BCBSTX members are still protected.

BCBS contracts with hundreds of physicians and thousands of hospitals in the United States who agree to accept BCBS allowable amounts for covered services and will not balance bill members. They'll even file claims. BCBS has offered this cost-saving alternative for many years now, and other carriers are still trying to catch up.
In addition to standard provider search results, BCBSTX members and non-members can compare Texas PPO network doctors and hospitals on certain aspects of the performance with the BlueCompare tool:

- Provides helpful information about the doctors and hospitals in the PPO network, BlueChoice.
- Uses claims and member data to help compare doctors’ performance on certain clinical guidelines called evidence-based measures.
- Uses data that hospitals report to help compare general acute-care hospitals’ performance and affordability.

A ribbon is used to show how physicians performed in comparison to their peers on certain evidence-based measures. For example, an internist, family practitioner or cardiologist practicing evidence-based medicine would be monitoring the LDL cholesterol in every patient in his or her practice who is known to have coronary artery disease. Physicians in these specialties who are not consistently monitoring their patients’ cholesterol are not likely to receive a ribbon that indicates strong evidence-based medicine performance.

Color-coded ribbons are also used to show how hospitals perform in comparison to other hospitals. A simple affordability scale shows which hospitals are historically more or less affordable when providing inpatient care.

- BlueCompare provides ONLY performance ratings for doctors.
- BlueCompare provides performance AND affordability ratings for general acute care hospitals.
Coordination among Blues Plans makes it very easy to provide seamless claims and customer services, no matter where employees are located.

Blue Cross and Blue Shield of Texas controls the entire process:

- Consolidated functionality of eligibility and membership, medical care management, customer service, claims and implementation process
- Electronic connectivity among all nationwide and worldwide networks
- Consistent ID cards, claims adjudication and benefits design

All members have the same ID card, the same benefits, and the same team of Customer Advocates to assist them whenever necessary.

Here’s how electronic connectivity simplifies claims:
1. A member visits a Blue Cross and Blue Shield provider in their local area.
2. The provider submits the claim to the Local Blue Plan.
3. The Local Plan prices the claim and submits it electronically to the Lead Blue Plan.
4. The Lead Plan determines eligibility and coverage and adjudicates the claim.
BCBSTX Customer Advocates are unique in the industry today because they:

- Are trained to focus on what’s important to the caller, rather than what might be important to the “transaction”
- Are not evaluated based on call volume, but call QUALITY
- Are willing to step outside the typical call parameters to assist members

BCBSTX invests heavily in training Customer Advocates so they can provide answers to the “unasked” questions.

- For example: The member asks about pregnancy benefits or mentions in the conversation they are expecting a baby. The Customer Advocate would then inform the member of their maternity program for healthy pregnancies.

Advocates ensure that members fully understand the benefits and services available to them.
Blue Cross and Blue Shield of Texas scores higher than competitors on first-call resolution because they make members’ satisfaction a high priority, and they’ve invested the resources in technology and personnel to ensure members get the attention they deserve.

**BCBSTX offers customer Service Choices for members:**

**PERSONAL TOUCH:**

Personalized telephonic customer support with experienced BCBS Customer Advocate.

**SELF SERVICE:**

Robust suite of online tools and information, via Blue Access® Online.

Customer Advocates can also assist members in using the online tools and resources available to them.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Here’s a quick snapshot of some of the health and wellness tools and resources available to help members manage their health and benefits. Start on the website at bcbstx.com, to see the [read tools on left].

To help employees understand such things as whether high performance networks are right for them, or if they should select an HSA or HCA product offered by their employer, it is critical that information on provider access, treatment costs and health risks be made publicly available so they can make better health care decisions. When you combine the Provider Finder with the member liability estimator, the Well onTarget member portal and Health Assessment tools available through Blue Access with the online benefit plans and provider and pharmacy search tools, as well as social media channels where members and non-members alike can follow BCBSTX on Twitter and Facebook, or view wellness videos on YouTube, members get a full spectrum of detailed health benefits and cost information that can help them make the right health care decisions for themselves and their families.

Once members log on they have access to all the tools you see here [read items on right]. Some functionality is available on a mobile phone. Or connect with BCBSTX on Facebook, Twitter and YouTube. Members can save time using self-service support tools, to do the following and more:

- Check the status of a claim; view and print Explanation of Benefits (EOBs)
- Request new ID cards; print temporary ID cards
- Confirm who is covered under the plan
- Check plan coverage details and Rx benefit information
- Secure access – employees can log in to their accounts and perform protected transactions 24 Hours a day, 7 days a week* [“Claim Statements/EOBs are not available from 3 - 6 a.m.”]

+The Dental Wellness Center is available for members who have dental coverage through BCBS
+MyPrime.com is available for members who have Rx coverage through BCBS

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Blue Access Mobile is a Public Site – No log-in required

Shop for Insurance: Shop for plans and get a quote before applying

Find a Doctor or Hospital: Locate in-network providers by name/specialty, find nearest urgent care center by city or ZIP

Blue Access for Members Log-in: Allows members to log into secure mobile site or register directly from mobile phone

Contact Us: Phone and mail contact information

Blue Access for Members, Secure Site – Log-in Required

ID Card: Instant digital membership card Coverage effective date, ID number, member ID

Coverage: Benefits and eligibility – deductibles, coinsurance, copays, covered dependents, out-of-pocket maximums

Claims: Claim status by patient, date or status

Health and Wellness

• Diabetes Care
• Maternity Care (Enrollees in Special Beginnings®)
• Texting
BCBSTX also offers simple, easy-to-use online tools for employers to maintain their account online through Blue Access for Employers. Navigate with ease and keep an eye on health care spend and handle health care benefits administration. Blue Access offers employers features such as:

- Online and real-time self-service capabilities
- Reduced administration and coordination
- Form Finder
- FAQs and Help Center
- Quicker turnaround for what they need
- Increased satisfaction

**Employees can:**

- Add a new member
- Cancel a member
- Reinstatement of a member
- Request ID card
- Change employee information
- View pending activities
- Transfers
  - Category Transfer (section to section changes)
  - Maintain Product (change PPO to HMO, etc.)
- Online Bill Payment
BCBSTX can look beyond conditions and costs alone to identify risk and tailor their approach to meet employees where they are on their individual health journey — whether it’s keeping the healthiest employees well, reducing the risk of illness for more at-risk members, or helping them navigate the maze of health care options when dealing with an illness or chronic conditions.

All of their innovations and programs, from care and utilization management to personal health coaching and decision support have a single aim: to connect employees to better health. BCC offers a variety of integrated services and levels of intervention to engage members. Whether members initiate contact, trigger a communication when identified at risk or accept outreach, there are multiple ways and opportunities to take advantage of BCC that meet diverse health needs and lifestyles. Blue Care Advisors provide telephonic outreach and coaching to individuals identified through: medical/lab/pharmacy/dental/vision claims data, Health Assessments, Utilization Management triggers, Employer referrals, Physician referrals, Self-referrals, cross-referrals between Condition Management, Case Management, Lifestyle Management and the Special Beginnings Programs.*

Wellness offerings – Web-based, self-service health and wellness resources, cost comparison tools, Provider Finder, treatment decision support tool for bariatric surgery – all with a focus on member education and consumerism.

Lifestyle Management – enhanced to include Metabolic Syndrome and Leading Indicators for MetS, Diabetes and Heart Disease. Lifestyle management assists members on their journey to manage weight, quit smoking or change their behaviors; offers personal coaching, online support, tools and resources.
Utilization Management – Care/UM nurses may provide guidance, assistance, education and oversight on hospital admissions and post-discharge follow-up care using industry and national standard of care guidelines, as well as referrals to CM and DM where appropriate.

Care Coordination and Early Intervention – Market-leading program provides support for navigating health care needs, with intense Coordination of Care and Early Intervention. Focus on leading indicators to prevent avoidable admissions, readmissions and ER visits. This new program does not focus on utilization of services or authorization of inpatient days or any service.

Condition Management – Members with certain health conditions or who are at risk for medical complications — experiencing gaps in care that could be addressed through intervention and counseling — are targeted for condition management programs. BCBS identifies members with certain chronic conditions who may be experiencing gaps in care that could be addressed through intervention and counseling.

BCBSTX targets the top conditions that represent roughly 30 percent* of claims costs and morbidity for members: asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD) and diabetes. Targeted conditions also include Cardiac Condition Clusters and Low Back Pain. In addition, BCBSTX manages co-morbid conditions. The program assists members with adopting healthier behaviors, setting goals and learning to manage their medical conditions more effectively.

Case Management – UM and DM referrals, IPM, high-cost claimants and complex catastrophic cases, among others. BCBSTX has been providing personal attention, resources and support to members with complex or special health care needs for more than 30 years. The case management programs are a collaborative process that engages the member, provider, case manager and Blue Care Advisor to establish individual goals, utilizing available resources and promoting cost-effective outcomes, to improve the member’s quality of life and slow the progression of the condition. There is a focus on access to needed resources, maximizing in-network utilization or referrals to Blue Distinction Centers of Excellence where appropriate.

*Co-management between programs is supported within BCC if the member is amenable.
The Blue Care Advisor (BCA) is the foundation of the BCBSTX program and is usually a registered nurse. (Licensed professional counselors or social workers are assigned to the Lifestyle Management Programs.) The BCA works with both community resources and other third parties, including pharmacy programs, the Employer’s Employee Assistance and/or Occupational Health Programs, Behavioral Health vendors and Lifestyle Management Programs. BCBSTX accepts files from vendors to support BCC member identification and outreach.

Blue Care Advisors are registered nurses that reach out to members identified as at-risk or high-risk to engage them in the programs, provide health counseling specific to their health conditions and help them improve their health. BCAs provide health information resources and help members understand and comply with treatment plans.

Members are contacted by a Blue Care Advisor to assess their health needs and readiness to change. If the member wants to participate in the program, the BCA works with the member and their physician to educate and facilitate and monitor compliance with treatment protocols. The Advisor continues to reach out to the member regarding his or her health condition and treatment outcomes, and discusses education, preventive screenings and wellness strategies/goals.

Blue Care Advisors also conduct wellness interventions with participants. Based on the most frequent potential treatment opportunities identified, Blue Care Advisors primarily helped members with:

- Taking medications properly
- Getting recommended preventive health screenings
- Understanding how to manage their conditions
- Preventing unnecessary ER/hospital visits
Slide 16 (CONTINUED)

Clockwise from top right:

**Identify:** Medical, Pharmacy and Lab Claims, Predictive Model, Vision and Radiology, self-referral, physician referral, health fairs, authorizations, customer service and the client’s third-party vendor partners

**Outreach/Engage:** Telephonic Outbound Calling, Mailing for Unable to Reach, Lost to Follow-up Outreach, Seasonal Mailers, Web-based Secure Messaging, Campaign Manager

**Coach:** Reinforce Physician’s Treatment Plan, Promote Medication Compliance, Self-management Techniques, Trigger and Symptom Management, Biometric Screenings, Condition-specific Education

**Collaborate with MD:** Communicate member engagement, treatment plan validation/consultation, alerts for untoward events, biometric results

**Close Gaps in Care:** Preventive care, condition-specific screenings, emergency action plan, condition-specific knowledge, medication compliance, durable medical equipment

**Graduate:** Mastery of self-management techniques, chronic condition controlled, optimize health status, satisfaction with the program, direct access to BCA
Virtual care management, condition specific online assessments, interactive health tutorials

Effective management of this population also means meeting members where they are. Which, increasingly, is online. Through our new virtual care management program, BCBSTX is innovating to improve service delivery for individuals living with a chronic condition, making it easier for them to access the information and support they need.

Through Blue Access for Members or referred by their Blue Care Advisor, members can complete online assessments, access video tutorials, view educational materials, click to chat. Anyone can access the sites through their BAM account.
The BCBSTX Well onTarget member portal features many tools to help people become healthier:

**Member Dashboard**
The innovative design of this page makes it simple for individuals to access their goal information, self-directed program information, Coach (BCC Enhanced only), status of program steps, food and exercise diary, and RSS feeds of current health news which is pertinent to the active goals of the participant.

**Health Assessment**
A health assessment is available through the member dashboard page. Your Personal Wellness Report that is generated from the health assessment can be accessed at any time through the portal.

**Self-Directed Courses**
Courses are intended to provide key clinical and behavioral information that is pertinent to the individual’s wellness opportunities, the tools to understand why individuals are motivated to change and tips on sustaining a high level of motivation, and most critical to the behavior change process – the appropriate tools and resources that teach the individual how to change and how to maintain those healthy behaviors over time. Courses available include Nutrition, Physical Activity, Stress, Weight Management and Tobacco.

**Trackers and Tools**
Goal Trackers give participants a way to track and supply information related to the goals they have chosen.
Why BCBSTX?

Social Networking
Ability to upload portal activity to Facebook or twitter Ability to upload portal activity to Facebook or Twitter.

Text Messaging
Members can set up mobile reminders such as to get their blood pressure checked or get 8 hours of sleep a night.

Food and Exercise Diary
The diary allows participants to log food choices and physical activity and match it to their overall calorie budget. This tool is a great way for participants to gain a realistic view of their current lifestyle choices.

Life Points
Members will earn points for completing Life Points-eligible activities and can redeem them for merchandise as well as supplement point balances with a personal credit card.

Dedicated Coach Page
(only available in BCC Enhanced)
The Coach’s Bio and Blog is available on the portal, so that the participant can learn more about his or her Dedicated Health Coach. The ability to “Rate My Coach” gives participants the opportunity to give feedback on their experiences with their coach and the health and wellness program.

Fitness Program
(value-add with no Life Points, built in starting at standard with Life Points)
$25 down, $25 a month and gives the member unlimited access to all gyms in the network. Members can earn Life Points for enrollment and utilization.
For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Taking the lead and following through – that’s why Blue Cross and Blue Shield of Texas is the most trusted name in health care insurance. BCBSTX offers its members more than 80 years of invaluable experience by an insurer focused on their health and well-being.
Nearly one in three Americans has health coverage with a Blue Cross and Blue Shield plan. For more than 80 years, Blue Cross and Blue Shield of Texas has provided innovative and affordable solutions to help employers manage their companies’ health plans.

An array of product options lets you create the health care benefit plan that’s right for your client.

**Choices**

Our focus on developing innovative solutions to meet the health care needs of our customers and members has earned Blue Cross and Blue Shield of Texas (BCBSTX) an enviable reputation. Flexible product combinations give employers more benefit design options at an affordable cost, without compromising the range of benefits and services that employers want. An array of wellness programs, online tools and other resources help guide and empower employees to make responsible health care decisions.

Choose from among the standard product categories noted in the table below to create a benefit plan portfolio that best suits the employer’s needs.

Groups can choose up to six plans, but it has to be across multiple networks (with at most, two plans per network). For example, a group could choose one plan on three networks, two plans designs on two networks, or two plan designs on two networks plus one additional plan design.

### BestChoice® PPO

Choose from a wide range of benefit designs that offer options for coinsurance, deductible and out-of-pocket maximums, as well as office visit and three-tier and four-tier drug card copayments. Participating Provider Organization (PPO) members are not required to select primary care physicians (PCPs). They have the freedom to choose a doctor whenever they need care, including specialists, from one of the largest PPO networks in Texas. When employees use contracting network doctors and hospitals, there are no claim forms to complete, and because providers agree to accept BCBSTX’s negotiated rates, there is no balance billing.

### Blue Advantage HMO

HMO options offer flexible plan designs and a wide range of benefits. Each covered family member can choose his or her own PCP and a medical group/Independent Practice Association (IPA). Female members may self refer to an obstetrician/gynecologist who is in the same medical group/IPA as the member’s PCP. Other advantages include predictable copayments, no claim forms or other paperwork, and no deductibles to meet. Blue Advantage HMO offers a broad network of PCPs and hospitals.
Health Benefits Overview

**MEDICAL CARE**
The range of benefits includes coverage for:

- Well-child care
- Adult care
- Physician office visits
- Inpatient hospital services
- Outpatient surgery and diagnostic tests
- Outpatient hospital services
- Maternity care
- Behavioral Health – mental health and substance abuse – inpatient and outpatient treatment
- Rehabilitative therapy such as physical, speech and occupational therapy

**PREVENTIVE CARE**
All plan options include 100 percent coverage for certain preventive care services with no copayment, deductible or coinsurance when using network providers including:

- Well-baby care (after newborn’s initial examination and discharge from the hospital)
- Childhood health screenings
- Routine annual physical exams
- Immunizations
- Mammography screenings
- Osteoporosis screenings
- Tests for detection of colorectal cancer
- Prostate cancer screenings
- Certain tests for detection of human papillomavirus and cervical cancer

HMO members also receive reminders about scheduling flu shots, mammograms and Pap tests.

**NATIONAL AND INTERNATIONAL COVERAGE (NON-HMO MEMBERS)**
Members have nationwide access to contracting providers linked through the BlueCard program when they or their covered dependents live, work or travel anywhere in the country. Network doctors and hospitals can be found at bcbstx.com or by calling 800-810-BLUE (800-810-2583).

When members use providers that contract in the BlueCard program, they receive the highest level of benefits. They do not have to file claims, and they take advantage of the savings the local Plan has negotiated with area providers.

Members traveling outside the United States have access to providers that participate in the BlueCard Worldwide program in more than 200 countries. If care is received from a non-contracting provider, members will have to pay the doctor or hospital for care at the time of service and then submit a claim form for reimbursement.

**OUT-OF-AREA COVERAGE (HMO MEMBERS)**
HMO members have access to health care benefits when traveling or temporarily living out of state.

- **The Away From Home Care® (AFHC) Guest Membership** program covers HMO members who are living out of the participating service area for at least 90 consecutive days. Employees can become guest members at an affiliated Blue Cross and Blue Shield HMO in another state. Guest membership is a particularly valuable benefit for covered students who are living out of state while attending school or for members on extended travel out of state. Members can sign up by calling Member Services using the phone number on the back of their ID cards.

- **The BlueCard** program covers HMO members traveling outside of Texas who need medical attention for a condition that is not an emergency. Members can find contracting providers by calling 800-810-BLUE (800-810-2583) or visiting bcbstx.com.

**EMERGENCY CARE**
If employees, as prudent laypersons with an average knowledge of health and medicine, need to go to the emergency room of any hospital, their care is covered subject to the plan’s deductible and any applicable copayments or coinsurance. HMO members should notify the primary care physician as soon as possible, especially if the member is admitted to the hospital. Any follow-up care for HMO members must be coordinated by the PCP. If the emergency results in a non-HMO member being admitted to a hospital, he or she may be required to notify BCBSTX for preauthorization.
Health Benefits Overview  CONTINUED

PRESCRIPTION BENEFITS
Our prescription drug program is not only cost-efficient; it is also convenient for employers. Through seamless coordination with our Pharmacy Benefit Manager (PBM), BCBSTX provides consolidated billing, reporting and account management for employers who also select us for their health plan, reducing administration associated with multiple carriers.

All prescription drug offerings (except certain PPO plans) include three-tier copay plans with at least a $15 spread between generic, preferred and non-preferred copays. Four-tier copay plans are now available with an additional $8 copay tier.

MEDICAL PROGRAM INTEGRATION
Because our relationship with our PBM allows us to retain responsibility for local pharmacy network management and clinical pharmacy initiatives, we have fully integrated our prescription drug and medical programs to help identify opportunities for improving members’ health and lowering employers’ costs. For example, the prescription drug program is coordinated with our condition management programs to help participating members with chronic conditions, such as asthma, be compliant with related medications, and to identify medications that might be considered for coverage.

CONVENIENCE OF CHOICE
The Prescription Drug Program offers members comprehensive network access and a three-tier or four-tier copayment system for drug selection. There are more than 62,000 contracting retail pharmacies across the country.

To access their prescription drug benefits, employees simply show their member ID cards at a contracting pharmacy convenient to them. The BCBSTX preferred drug list is a regularly updated list of preferred drugs selected by a committee, comprising current and former practicing physicians and pharmacists, who evaluate all U.S. Food and Drug Administration-approved drugs based on efficacy, safety, uniqueness and cost-effectiveness. The preferred drug list is designed so members have the lowest copayment amount for generic drugs and higher copayment amounts for preferred brand and non-preferred brand drugs. This system encourages members to select drugs that are less costly but equally effective, to help reduce overall prescription drug costs. The generic, preferred brand and non-preferred brand drug lists are reviewed and updated regularly to include new drugs in the market. The preferred drug list structure provides coverage for nearly all drugs, even those that are not on the preferred list.

MAIL SERVICE PROGRAM
Members can receive up to a 90-day supply of maintenance medication through the mail service programs.

DRUG UTILIZATION REVIEW
Our drug utilization review program helps control costs by addressing inappropriate usage, such as early refills, incorrect dosage, average days’ supply, drug interactions, duplicate or concurrent therapy, under-utilization, and high utilization/fraud. We profile BCBSTX contracted physicians to generate comparative peer analyses, using standard benchmarks such as drug list compliance, generic drug utilization, and average number of prescriptions per member.

ONLINE TOOLS
Members and employers may access our website at bcbstx.com to review a current listing of preferred and non-preferred drugs, search for a network pharmacy, research drugs and their uses, place mail order refill requests, and more.

CUSTOMER SERVICE
Members, physicians and pharmacists may call pharmacy-dedicated customer service representatives toll free 24 hours a day, seven days a week. A registered pharmacist is available to answer physician and member questions.
Health Benefits Overview  CONTINUED
BLUE CARE CONNECTION®

Blue Care Connection (BCC) provides personalized attention, support, online resources and health advocacy, helping members find the right resources, optimize their health care benefits and manage their medical conditions. Programs include:

• 24/7 Nurseline – Around the clock, toll-free access to registered nurses for health information.

• Lifestyle Management Programs – Provide tools and information which may help members lose weight, quit smoking or reduce their risk for developing heart disease, stroke or diabetes.

• Utilization Management – Can help members and their doctors obtain information about benefits, navigate the health care system and help maximize benefits for covered services.

• CCEI™ Care Coordination and Early Intervention – Uses advanced analytics and leading indicators of chronic disease to identify members who have an increased risk for avoidable hospital admissions, re-admissions and emergency room (ER) visits. Those members will receive interventions designed to improve health outcomes.

• Condition Management – Blue Care® Advisors (registered nurses and other health care professionals) work with members and their doctors to provide education, coaching and monitoring if you are at risk for or already have a chronic condition.

• Special Beginnings® – Maternity program offering expectant mothers ongoing support and education from prenatal to postpartum care, including convenient online and mobile tools and educational materials.

• Case Management – Case managers help members navigate complex medical situations and access the services they need.

• Behavioral Health – Licensed behavioral health professionals help members access services and offer support with co-existing medical conditions and disorders such as anxiety, depression, etc

WELL ONTARGET®1:
A NEW WAY TO EXPERIENCE WELLNESS

Well onTarget offers personalized tools and resources to help all members—no matter where they may be on the path to health and wellness. Services include:

• Liveon Member Wellness Portal - This engaging portal links members to a suite of innovative programs and tools.
  - onmytime Self-directed Courses – Online courses about nutrition, fitness, weight management, tobacco cessation and stress.
  - Health and Wellness Content - Health library teaches and empowers through evidence-based, user-friendly articles.
  - Tools and Trackers - Interactive tools help make wellness fun. Includes food and workout diaries, health calculators and medical and lifestyle trackers.

• onmyway™ Health Assessment (HA) - The HA features adaptable questions so members can learn more about their health. After taking the HA, members receive a personal wellness report. The confidential record offers tips for healthy living.

• Life Points Program – Members earn points by taking part in wellness activities. Points can be redeemed in the new online shopping mall.

• Fitness Program³ – This flexible membership program provides unlimited access to a nationwide network of more than 8,000 fitness centers. Other program perks are:
  - No long-term contract required. Membership is month to month. Monthly fees are $25 per month per member, with a one-time enrollment fee of $25.
  - Automatic withdrawal of monthly fee.
  - Online tools for locating gyms and tracking visits.

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1 Registered mark of Health Care Service Corporation, a Mutual Legal Reserve Company
2 onmyway is registered mark of Onlife Health.
3 Healthways, Inc. is an independent contractor which administers the Prime Network of fitness centers. The Prime Network is made up of independently-owned and managed fitness centers.
Health Benefits Overview CONTINUED

BLUE365®: A DISCOUNT PROGRAM FOR MEMBERS

Blue365 is just one more advantage of being a BCBSTX member. Blue365 offers members and covered dependents access to savings on a number of health care and wellness products and services. To learn more, visit the Blue365 website at blue365deals.com/BCBSTX. Services and products include:

Davis VisionSM' TruVision®
877-393-8844, 877-882-2020
Members can save on eyeglasses, as well as contact lenses, laser vision correction services, examinations and accessories. For a list of Davis Vision providers visit bcbtx.com, click Find a Doctor then select Find a Vision Provider. The Davis Vision network consists of major national and regional retail locations as well as independent ophthalmologists and optometrists. Members and eligible dependents can receive discounts on laser vision correction services through the TLC/TruVision network.

Jenny Craig®
877-JENNY70 (877-536-6970)
Jenny Craig can help members reach their weight loss goals by getting one-on-one support given by a trained weight loss expert who will provide a tailored program based on the essential components of successful weight management: food, body, mind. Members can experience the Jenny difference with discounts to the Jenny As You Go monthly program or the Jenny All Access yearly membership program.

Life Time® Fitness
Life Time Fitness offers members a total health fitness experience no matter the fitness level, interests, schedule or budgets. For new members, Life Time Fitness offers a $0 enrollment fee when you sign up online.2

Procter & Gamble (P&G) Dental Products
877-333-0121
Members get savings on dental packages containing the latest in Oral B® power toothbrushes and Crest® products. The dental packages from P&G can help members improve the health of their teeth and gums. Packages may contain items such as an electric toothbrush, mouth rinse, floss and more.

TruHearing®
800-687-4617
Members save on digital hearing aids through TruHearing. They can get a hearing test at no extra charge when performed to fit a hearing aid. Members get a choice of hearing aid styles at a number of price levels and enough batteries to last a year when you buy a hearing aid. They also enjoy a 45-day, money-back guarantee and a three-year warranty.

The following Blue Care Connection features do not apply to HMO members:

- Utilization and Case Management Program
- Behavioral Health Program

The relationship between these vendors and Blue Cross and Blue Shield of Texas (BCBSTX) is that of independent contractors.

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1 Blue365 is a discount program only for BCBSTX members. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program’s services or products. You may want to talk to your doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

2 Proof of Blue Cross and Blue Shield of Texas coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at blue365deals.com/BCBSTX. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members’ prices, dues and fees may change at any time. Offer expires September 1, 2014. Other rules may apply. Always check with the Life Time Fitness club in your area for the most up-to-date offer.

- All trademarks and service marks are property of their respective owners.
Online tools to help your accounts and their employees get the most from their health care benefit plan

FOR EMPLOYERS
Find helpful information and easy-to-use online services at Blue Access for Employers, our secure site at bcbstx.com*. Check employee eligibility as well as access and update membership information, such as enrolling new members, adding dependents, changing names and addresses, and canceling/reinstating employees. Employers can also view premium bills, weekly invoice details and monthly settlements, review standard customer reports and download forms.

FOR EMPLOYEES
Through Blue Access for Members℠ (BAM), members can check the status of a claim, view the Explanation of Benefits (EOB) and receive email notification when a health or dental claim is finalized. (HMO members do not receive EOBs.) Members can use BAM to confirm who is covered under their plan. The Cost Estimator helps members obtain cost information for common health care services based on demographic and geographic data.

* This service may not be available to all groups.

DENTAL, LIFE AND DISABILITY OPTIONS
BlueCare Dental Freedom℠ covers dental benefits at the same level whether services are provided by a contracting or non-contracting dentist. Existing indemnity dental plans can easily be replaced by our plan with minimal disruption to employees. Members may be subject to balance billing when services are provided by non-contracting providers.

LIFE AND DISABILITY PLANS
A full range of life and disability products is available through Dearborn National.**

Term Life Coverage
• Group Term Life with an Accelerated Death Benefit
• Accidental Death and Dismemberment (AD&D)
• Dependent Life

Disability Coverage
• Short-term Disability
• Long-term Disability

Voluntary Coverage
• Portable Voluntary Life/Voluntary AD&D
• Voluntary Short- and Long-term Disability

**Life, disability and network dental insurance are marketed under the Dearborn National® brand and underwritten by Dearborn National Life Insurance Company®. Dearborn National Life Insurance Company does not provide Blue Cross and Blue Shield of Texas products or services and is a separate company. Dearborn National Life is solely responsible for the life, disability and network dental coverage provided.

Refer to the Dearborn National Products and BlueCare Dental Products sections of this guide for more details on dental, life and disability products.

Refer to the Online Tools and Resources section of this guide for more details about online tools.

Summaries of Benefit Coverage for all available small group plans are available in the Products and Forms section under eSales Tools of Blue Access for Producers. A sample highlight sheet is included at the end of this section.
On-Exchange Products

Plans are listed by metallic level and in order by plan ID.

### BLUE ADVANTAGE HMO

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### Off-Exchange Products

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<td></td>
</tr>
<tr>
<td>S606ADT</td>
<td>$6,000</td>
<td>$6,000</td>
<td>100%</td>
<td>$30</td>
<td>$50</td>
<td>$500</td>
<td>$0/$10/$50/$100/$150</td>
</tr>
<tr>
<td>S607ADT</td>
<td>$3,000</td>
<td>$6,350</td>
<td>80%</td>
<td>$35</td>
<td>$55</td>
<td>$500</td>
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</tr>
<tr>
<td>S608ADT</td>
<td>$3,000</td>
<td>$6,000</td>
<td>70%</td>
<td>$40</td>
<td>$60</td>
<td>$500</td>
<td>$20/$40/$60</td>
</tr>
<tr>
<td>S610ADT</td>
<td>$2,000</td>
<td>$6,350</td>
<td>70%</td>
<td>$40</td>
<td>$60</td>
<td>$500</td>
<td>$0/$10/$50/$100/$150</td>
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<tr>
<td>S611ADT</td>
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<td>$6,000</td>
<td>80%</td>
<td>NA</td>
<td>NA</td>
<td>$500</td>
<td>$0/$10/$50/$100/$150</td>
</tr>
<tr>
<td><strong>BRONZE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B634ADT</td>
<td>$6,000</td>
<td>$6,000</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>100%</td>
</tr>
<tr>
<td>B636ADT</td>
<td>$5,000</td>
<td>$6,250</td>
<td>80%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>90%/90%/80%/70%/60%</td>
</tr>
</tbody>
</table>

For the most current agent/producer information and materials, log in to our secured portal at [bcbstx.com/producer](http://bcbstx.com/producer).
**Off-Exchange Products**

Plans are listed by metallic level and in order by plan ID.

<table>
<thead>
<tr>
<th>PLAN ID</th>
<th>DEDUCTIBLE (IN/OUT) (INDIVIDUAL)</th>
<th>OOPX (IN/OUT) (INDIVIDUAL INC. DED)</th>
<th>COINS (IN/OUT)</th>
<th>PCP COPAY</th>
<th>SPC COPAY</th>
<th>ER PER OCCURRENCE COPAY</th>
<th>DRUG PLAN</th>
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<tbody>
<tr>
<td><strong>PLATINUM</strong></td>
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<tr>
<td>P600CHC</td>
<td>$250/$500</td>
<td>$1,250/$2,500</td>
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<td>$25</td>
<td>$45</td>
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<td>P601CHC</td>
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<td>$1,250/$2,500</td>
<td>100%/80%</td>
<td>$25</td>
<td>$45</td>
<td>$300</td>
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</tr>
<tr>
<td>P603CHC</td>
<td>$0/$500</td>
<td>$1,250/$2,500</td>
<td>100%/80%</td>
<td>$25</td>
<td>$45</td>
<td>$300</td>
<td>$0/$10/$35/$75/$150</td>
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<tr>
<td><strong>GOLD</strong></td>
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<td></td>
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<td>$50</td>
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<td>NA</td>
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<td>100%</td>
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<td>G620CHC</td>
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<td>$3,900/$7,800</td>
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<td>G621CHC</td>
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<td>100%/80%</td>
<td>$30</td>
<td>$50</td>
<td>$400</td>
<td>$10/$40/$60</td>
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<td>G622CHC</td>
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<td>$3,500/$7,000</td>
<td>80%/60%</td>
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<td>$15</td>
<td>$40</td>
<td>$300</td>
<td>$0/$10/$35/$75/$150</td>
</tr>
<tr>
<td>G624CHC</td>
<td>$1,000/$2,000</td>
<td>$3,000/$6,000</td>
<td>80%/60%</td>
<td>$30</td>
<td>$50</td>
<td>$400</td>
<td>$0/$10/$50/$100/$150</td>
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<tr>
<td><strong>SILVER</strong></td>
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<td>S606CHC</td>
<td>$6,000/$12,000</td>
<td>$6,000/$12,000</td>
<td>100%/80%</td>
<td>$30</td>
<td>$50</td>
<td>$500</td>
<td>$0/$10/$50/$100/$150</td>
</tr>
<tr>
<td>S607CHC</td>
<td>$3,000/$6,000</td>
<td>$6,350/$12,700</td>
<td>80%/60%</td>
<td>$35</td>
<td>$55</td>
<td>$500</td>
<td>$0/$10/$50/$100/$150</td>
</tr>
<tr>
<td>S608CHC</td>
<td>$3,000/$6,000</td>
<td>$6,000/$12,000</td>
<td>70%/50%</td>
<td>$40</td>
<td>$60</td>
<td>$500</td>
<td>$20/$40/$60</td>
</tr>
<tr>
<td>S609CHC*</td>
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<td>$5,000/$10,000</td>
<td>100%/80%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>100%</td>
</tr>
<tr>
<td>S610CHC</td>
<td>$2,000/$4,000</td>
<td>$6,350/$12,700</td>
<td>70%/50%</td>
<td>$40</td>
<td>$60</td>
<td>$500</td>
<td>$0/$10/$50/$100/$150</td>
</tr>
<tr>
<td>S611CHC</td>
<td>$2,000/$4,000</td>
<td>$6,000/$12,000</td>
<td>80%/60%</td>
<td>NA</td>
<td>NA</td>
<td>$500</td>
<td>$0/$10/$50/$100/$150</td>
</tr>
<tr>
<td><strong>BRONZE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B633CHC</td>
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<td>$6,250/$12,500</td>
<td>80%/60%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>80%</td>
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<tr>
<td>B634CHC</td>
<td>$6,000/$12,000</td>
<td>$6,000/$12,000</td>
<td>100%/80%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Denotes HSA Plan
Our Network

We have been building strong contractual and professional relationships with providers for more than 80 years.

We have built one of the largest networks of contracting providers in Texas, including more than 42,000 physicians and specialists in our HMO Blue Texas network and more than 62,000 in the BlueChoice PPO network. The PPO network is so extensive that employers who move from another health carrier experience very little, if any, network disruption.

We have also built a unique negotiating position with the provider community, resulting in consistently deeper discounts.

In addition, we have agreements with many non-network providers who also accept our allowable amounts, file claims as needed and agree not to balance bill our members. Altogether, more than 81 percent of Texas physicians and 96 percent of Texas hospitals have contractual arrangements with BCBSTX – a significant advantage over other health plans and a tremendous benefit for members.

While we aggressively negotiate rates with providers, we are just as aggressive about responding to their needs. Our programs are designed to let doctors do their job – provide care. Our systems are designed to help them with their business needs, enabling such efficiencies as electronic claims filing and quick reimbursement.

NETWORK HIGHLIGHTS

<table>
<thead>
<tr>
<th></th>
<th>PPO/CDHP</th>
<th>PAR</th>
<th>HMO Blue® Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATEWIDE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Name</td>
<td>BlueChoice®</td>
<td>ParPlan</td>
<td>HMO Blue® Texas</td>
</tr>
<tr>
<td>Service Area</td>
<td>Statewide**</td>
<td>Statewide</td>
<td>Statewide</td>
</tr>
<tr>
<td>PCPs</td>
<td>11,522</td>
<td>62,010</td>
<td>7,951</td>
</tr>
<tr>
<td>Specialists</td>
<td>52,225</td>
<td>43,135</td>
<td></td>
</tr>
<tr>
<td>Hospitals*</td>
<td>616</td>
<td>535</td>
<td>548</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>4,100</td>
<td>Not applicable</td>
<td>3,700</td>
</tr>
<tr>
<td>Percent of All</td>
<td>81%</td>
<td>81%</td>
<td>65%</td>
</tr>
<tr>
<td>Available Physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of All</td>
<td>96%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Available Hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NATIONWIDE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Access</td>
<td>50 States</td>
<td>49 States</td>
<td>Guest memberships are available in 32 states and the District of Columbia***</td>
</tr>
<tr>
<td>(also D.C. and Puerto Rico)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>More than 720,000</td>
<td>More than 740,000</td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>More than 6,300</td>
<td>More than 6,600</td>
<td></td>
</tr>
<tr>
<td>Pharmacies</td>
<td>62,000</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

September, 2013

* Hospital and provider numbers do not include behavioral health facilities/providers.
** Statewide represents all 254 Texas counties.
*** Away from Home Care® is not available in the following states: Alabama, Alaska, Idaho, Iowa, Kansas, Maryland, Mississippi, Montana, Nebraska, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia and Wyoming.
Reasons to Choose Blue Cross and Blue Shield of Texas

Our success in the health insurance industry is the result of proven, integrated management of several key elements, which differentiates our service from the competition.

**Account Management** – Our account staff will work closely with your clients to anticipate needs, offer strategic consultation and quickly resolve issues.

**Network Management** – Our strategy helps make the dollars your clients spend on employee health care benefits go further. Our strong relationships mean we can negotiate provider discounts for your clients and their employees.

**Medical Care Management** – The Blue Care Connection program includes education to help members take more responsibility for their health. The program also helps strengthen the doctor-patient relationship to improve health outcomes. Through online tools and other resources, we engage members by helping them be more proactive in their health care decisions.

**Claims and Customer Advocacy** – Coordination through the national BlueCard program provides the same seamless claims administration for national accounts with multiple locations as it does for local accounts. Members can obtain convenient, self-service information through our secure website or personal service from customer advocates in our full service units.

For more information about our products, contact your Blue Cross and Blue Shield of Texas representative.
# 2014 Sample Summary of Benefits and Coverage

Summary of Benefits and Coverage sheets (SBCs) for small group plans are available in the Products and Forms section of Blue Access for Producers.

## Blue Cross and Blue Shield of Texas: Blue Choice Platinum PPO 013

**Coverage Period:** 01/01/2014-12/31/2014

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Service You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay/visit</td>
<td>$50 copay/visit</td>
<td>20% coinsurance, one copay for primary care visit</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$25 copay/visit</td>
<td>$45 copay/visit</td>
<td>20% coinsurance, one copay for other practitioner office visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>No Charge</td>
<td>20% coinsurance, one copay for preventive care/screening/immunization</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>No Charge</td>
<td>20% coinsurance, one copay for diagnostic test (x-ray, blood work)</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT / PET scans, MRI)</td>
<td>No Charge</td>
<td>No Charge</td>
<td>20% coinsurance, CT for heart disease screening maximum charge of $200 for EDI every 5 years.</td>
</tr>
</tbody>
</table>

**Summary of Benefits and Coverage:**
Blue Cross and Blue Shield of Texas: Blue Choice Platinum PPO 013

**Coverage Period:** 01/01/2014-12/31/2014

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com/coverage/index.html, or by calling 1-800-521-2227 or 1-800-810-2583.

For more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com/coverage/index.html, or by calling 1-800-521-2227 or 1-800-810-2583. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com/coverage/index.html, or by calling 1-800-521-2227 or 1-800-810-2583.
# Summary of Benefits and Coverage:

**What this Plan Covers & What it Costs**

**Blue Cross and Blue Shield of Texas: Blue Choice Platinum PPO 013**

**Coverage Period:** 01/01/2014-12/31/2014

**Coverage for:** Individual/Family  
**Plan Type:** PPO

## Common Medical Event

<table>
<thead>
<tr>
<th>Service You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition&lt;br&gt;More information about prescription drugs coverage is available at <a href="http://www.bcbstx.com/member/rx_drugs.html">www.bcbstx.com/member/rx_drugs.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Generic Drugs</td>
<td>No Charge</td>
<td>No Charge</td>
<td>One Copay per 30-Day Supply, up to a 90-Day Supply. Standard Formulary applies. Certain women's preventive services will be covered with no cost to the member. For a full list of these services, please contact Customer Service. 20% Out-of-Network Penalty.</td>
</tr>
<tr>
<td>Non-Preferred Generic Drugs</td>
<td>$10 retail/$20 mail copay/ prescription</td>
<td>$10 retail/$20 mail copay/ prescription</td>
<td>---none---</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$35 retail/$70 mail copay/ prescription</td>
<td>$35 retail/$70 mail copay/ prescription</td>
<td>---none---</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>$75 retail/$150 mail copay/ prescription</td>
<td>$75 retail/$150 mail copay/ prescription</td>
<td>---none---</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$150 copay/ prescription</td>
<td>$150 copay/ prescription</td>
<td>Standard Formulary applies. Certain women's preventive services will be covered with no cost to the member. For a full list of these services, please contact Customer Service. 20% Out-of-Network Penalty.</td>
</tr>
</tbody>
</table>

| If you have outpatient surgery<br>Facility fee (e.g., ambulatory surgery center) | No Charge                                   | 20% coinsurance                                 | ---none--- |
| Physician/surgeon fee                     | No Charge                                   | 20% coinsurance                                 | ---none--- |

| If you need immediate medical attention<br>Emergency room service | $500 copay/visit                            | $500 copay/visit                                | Copay amount waived if admitted. If admitted, Inpatient Hospital services deductible will apply. |
| Emergency medical transportation         | No Charge                                   | No Charge                                       | ---none--- |
| Urgent care                              | No Charge                                   | No Charge                                       | Copay may apply. |
| Facility fee (e.g., hospital room)       | No Charge                                   | 20% coinsurance                                 | $250 penalty for failure to Preauthorize. |
| Physician/surgeon fee                     | No Charge                                   | 20% coinsurance                                 | ---none--- |

| If you have a hospital stay<br>Facility fee (e.g., hospital room) | No Charge                                   | 20% coinsurance                                 | ---none--- |
| Physician/surgeon fee                     | No Charge                                   | 20% coinsurance                                 | ---none--- |

Questions: Call 1-800-521-2227 or visit us at [http://www.bcbstx.com/coverage/index.html](http://www.bcbstx.com/coverage/index.html). If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ehbs/pdf/SBCUUniformGlossary.pdf](http://www.dol.gov/ehbs/pdf/SBCUUniformGlossary.pdf) or call 1-855-756-4448 to request a copy.
Blue Cross and Blue Shield of Texas: Blue Choice Platinum PPO 013

Coverage Period: 01/01/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What is Cost

**Coverage for: Individual/Family Plan Type: PPO**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Service You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>sidewalks</td>
<td>Eye exam</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Up to $30 out-of-network. One visit per calendar year. Ages 18 and under only.</td>
</tr>
<tr>
<td>sidewalks</td>
<td>Glasses</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Up to $1.50 In-Network. $15 frame/ lens Out-of-Network. One pair per calendar year. Ages 18 and under only.</td>
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<tr>
<td>sidewalks</td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

- Acupuncture
- Bariatric surgery
- Dental Care (Adults)
- Long-term care
- Private-duty nursing (only covered for extended care expenses)
- Routine foot care (only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Chiropractic care
- Cosmetic surgery (only covered for correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases When Medically Necessary)
- Female internal treatment (diagnosis covered but treatment and livivro not covered)
- Most coverage provided outside the United States. See www.bcbstx.com.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adults)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance at (855) 839-2427 or visit www.tdi.texas.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage meets the minimum value standard for the benefits it provides.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
- Tagalog (Tagalog): Kaya hahangan na ang tulong sa Tagalog tumbang sa 1-800-521-2227.
- Chinese (Chinese): 如果需要中文的帮助,请拨打这个号码 1-800-521-2227.
- Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
- Navajo (Dine): Dinek'ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-521-2227.

-To see examples of how this plan might cover costs for a sample medical situation, see the next page-

Questions: Call 1-800-521-2227 or visit us at http://www.bcbstx.com/coverage/index.html.
Blue Cross and Blue Shield of Texas: Blue Choice Platinum PPO 013

Coverage Period: 03/01/2014-12/31/2014

Coverage for: Individual/Family  | Plan Type: PPO

### About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don’t use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Amount owed to providers</th>
<th>Plan pays</th>
<th>Patient pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
<td>$2,220</td>
<td>$480</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
<td>$600</td>
<td>$300</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
<td>$900</td>
<td>$0</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
<td>$400</td>
<td>$100</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
<td>$200</td>
<td>$0</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
<td>$200</td>
<td>$0</td>
</tr>
<tr>
<td>Vaccines, other preventive care</td>
<td>$40</td>
<td>$40</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
<td><strong>$6,620</strong></td>
<td><strong>$920</strong></td>
</tr>
</tbody>
</table>

### Patient pays:

- Deductibles: $150
- Co-pays: $20
- Coinsurance: $0
- Limits or exclusions: $150
- **Total**: $320

### Managing type 2 diabetes (mildly uncontrolled condition)

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Amount owed to providers</th>
<th>Plan pays</th>
<th>Patient pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,500</td>
<td>$2,000</td>
<td>$500</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
<td>$1,300</td>
<td>$0</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
<td>$700</td>
<td>$0</td>
</tr>
<tr>
<td>Education</td>
<td>$500</td>
<td>$500</td>
<td>$0</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
<td>$100</td>
<td>$0</td>
</tr>
<tr>
<td>Vaccines, other preventive care</td>
<td>$100</td>
<td>$100</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
<td><strong>$5,400</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

### Patient pays:

- Deductibles: $0
- Co-pays: $50
- Coinsurance: $0
- Limits or exclusions: $0
- **Total**: $200

### Questions:

**What are some of the assumptions behind the Coverage Examples?**

- Costs don’t include **premiums**.
- Sample care costs based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any number covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

**What does a Coverage Example show?**

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-pays**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

**Does the Coverage Example predict my own care needs?**

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

**Does the Coverage Example predict my future expenses?**

**No.** Coverage Examples are **not** cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

**Can I use Coverage Examples to compare plans?**

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

**Are there other costs I should consider when comparing plans?**

- **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **co-pays**, **co-insurance**, and **reimbursement**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-521-2227 or visit us at [http://www.bcbstx.com/coverage/index.html](http://www.bcbstx.com/coverage/index.html).

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ohsa/pdf/SBCU/UniformGlossary.pdf](http://www.dol.gov/ohsa/pdf/SBCU/UniformGlossary.pdf) or call 1-855-756-4448 to request a copy.
Taking the lead and following through – that’s why Blue Cross and Blue Shield of Texas is the most trusted name in health care insurance. BCBSTX offers its members more than 80 years of invaluable experience by an insurer focused on their health and well-being.
## HEALTH PRODUCTS & SERVICES FOR THE 51–150 MARKET

<table>
<thead>
<tr>
<th>Employer Advantages</th>
<th>PPO PLANS</th>
<th>BLUEEDGE HSA CONSUMER-DIRECTED HEALTH PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The ability to introduce more cost sharing at time of services</td>
<td>• A way to help change employee behavior and help reduce total health care expenses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Investment vehicles for employees to pay for qualified health care expenses on a tax-free basis and to save for retirement</td>
</tr>
<tr>
<td>Employee Advantages</td>
<td>• Freedom to choose network or non-network providers for care (benefit levels will vary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Access to one of the largest networks of contracting doctors and hospitals in Texas and in the country</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No claims filing for covered in-network services or for services received through contracted out-of-network doctors and hospitals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• An employer- and/or employee-funded health savings account (HSA) from which an employee’s health care expenses are paid each year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More control over how health care dollars are spent</td>
</tr>
<tr>
<td>HEALTH PRODUCTS &amp; SERVICES FOR THE 51–150 MARKET</td>
<td>HMO PLANS</td>
<td>BLUEEDGE HCA CONSUMER-DIRECTED HEALTH PLANS</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Employer Advantages</td>
<td>• Found by some employers to be easier to understand and manage</td>
<td>• A way to reduce health care expenses by encouraging members to take a more proactive role in health care decision making</td>
</tr>
</tbody>
</table>
| Employee Advantages                           | • Simplicity—employees contact their primary care physician (PCP) when they need care and pay a set copayment at the time of service  
• An emphasis on preventive and wellness benefits  
• No deductible, coinsurance or claims to file | • An employer-funded health care account (HCA) from which a portion of employees’ health care expenses are paid each year  
• More control over how health care dollars are spent |
Nearly one in three Americans has health coverage with a Blue Cross and Blue Shield plan. For more than 80 years, we’ve provided innovative and affordable solutions to help employers manage their companies’ health plans.

**Choices**

Our focus on developing innovative solutions to meet the health care needs of our customers and members has earned Blue Cross and Blue Shield of Texas (BCBSTX) an enviable reputation. Flexible product combinations give employers more benefit design options at an affordable cost, without compromising the range of benefits and services that employers want. An array of wellness programs, online tools and other resources help guide and empower employees to make responsible health care decisions.

Choose from among the standard product categories noted in the table below to create a benefit plan portfolio that best suits the employer’s needs.

BlueChoice® PPO

Choose from a wide range of benefit designs that offer options for coinsurance, deductible and out-of-pocket maximums, as well as office visit and three-tier and four-tier drug card copayments. Participating provider organization (PPO) members are not required to select primary care physicians (PCPs). They have the freedom to choose a doctor whenever they need care, including specialists, from one of the largest PPO networks in Texas. When employees use contracting network doctors and hospitals, there are no claim forms to complete and because providers agree to accept BCBSTX’s negotiated rates, there is no balance billing.

Blue Advantage HMO

HMO options offer flexible plan designs and a wide range of benefits. Each covered family member can choose his or her own PCP and a medical group/Independent Practice Association (IPA). Female members may self refer to an obstetrician/gynecologist who is in the same medical group/IPA as the member’s PCP. Other advantages include predictable copayments, no claim forms or other paperwork, and no deductibles to meet. Blue Advantage HMO offers a broad network of PCPs and hospitals.

**Dual Option PPO** – Any two PPO, HCA or HSA plans. Four-tier Rx plans can be paired with another four-tier plan or an HSA.

**Dual Option PPO (Enhanced Rx)** – Any two Enhanced Rx plans. Enhanced Rx plans can be paired with an HSA plan.

**Multiple Option Product (MOP)** – One PPO, HSA or HCA plan (excluding Enhanced Rx and four-tier Rx plans), and an HMO plan

**Triple Option Product** – Three HSA and/or HCA plans are allowed; one of the following is required: HSA, HCA, or PPO plans RM32. Only one HMO plan is allowed.

**No Enhanced Rx plans are allowed unless all plans are Enhanced Rx, HSA plans or a combination of both.**

**Four Tier Rx plans can only be offered with an HSA.**

<table>
<thead>
<tr>
<th>PPO</th>
<th>HMO</th>
<th>CONSUMER-DIRECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueChoice PPO</td>
<td>HMO Blue Texas</td>
<td>BlueEdge℠ HSA (Health Savings Account)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BlueEdge HCA (Health Care Account)</td>
</tr>
</tbody>
</table>
Consumer-Directed Health Plans

BlueEdge℠ HSA and BlueEdge℠ HCA are PPO plans that include a Health Spending Account to help employees pay for medical expenses and meet the annual deductible.

Health Spending Accounts

A Health Savings Account (HSA) is a tax-exempt account available to employees covered by a high deductible health plan. Contributions, potential interest gains and distributions are tax free when used for qualified medical expenses. Deposits to the account can be made by the employee, the employer or both. Unspent funds in the account roll over year to year. The account is portable, which means it belongs to the employee even if he or she changes jobs, leaves the plan or retires.

With BlueEdge HSA family coverage, the employer chooses either an aggregate or embedded deductible option.

Aggregate – Entire family deductible must be met before health plan benefits begin for any covered family member.

Embedded* – Each family member has an individual deductible within the family deductible. This is the maximum deductible amount for which one person is responsible.

- If a member satisfies the individual deductible within the calendar year, that member is eligible for health plan benefits.
- Once the family deductible amount is met, all family members are eligible for health plan benefits, even if everyone has not met his/her individual deductible.

BlueEdge℠ HCA allows employers to set aside a specific amount of money in a health care account (HCA) for every covered employee each benefit year. With the standard BlueEdge HCA plan, the account pays for the member’s initial covered health care claims until the balance is depleted. The member then pays the remaining expenses until the deductible has been met.

With BlueEdge HCA, the employer chooses drug plans that are integrated (deductible and coinsurance) or non-integrated (copay).

Employers only fund claims as they are paid and any unused HCA balances remain part of the company’s cash flow.

*Minimal deductible limits apply per IRS notices and are subject to change. The embedded deductible must equal no less than the minimum family deductible amount.

Please note that Health Savings Accounts have tax and legal ramifications. Blue Cross and Blue Shield of Texas does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. Your clients should seek advice based on their particular circumstances from an independent tax advisor regarding the tax consequences of specific health plans or products.
Health Benefits Overview

MEDICAL CARE
The range of benefits includes coverage for:
- Well-child care
- Adult care
- Physician office visits
- Inpatient hospital services
- Outpatient surgery and diagnostic tests
- Outpatient hospital services
- Maternity care
- Behavioral health and substance abuse – inpatient and outpatient treatment
- Rehabilitative therapy such as physical, speech and occupational therapy

PREVENTIVE CARE
Employees and their covered dependents will enjoy preventive care benefits, such as routine physicals, screenings, tests and immunizations for children and adults. HMO members also receive reminders about scheduling flu shots, mammograms and Pap tests.

EMERGENCY CARE
If employees, as prudent laypersons with an average knowledge of health and medicine, need to go to the emergency room of any hospital, their care is covered subject to the plan’s deductible and any applicable copayments or coinsurance. HMO members should notify the primary care physician as soon as possible, especially if the member is admitted to the hospital. Any follow-up care for HMO members must be coordinated by the PCP. If the emergency results in a non-HMO member being admitted to a hospital, he or she may be required to notify BCBSTX for preauthorization.

NATIONAL AND INTERNATIONAL COVERAGE (NON-HMO MEMBERS)
Members have nationwide access to contracting providers linked through the BlueCard program when they or their covered dependents live, work or travel anywhere in the country. Network doctors and hospitals can be found at bcbstx.com or by calling 800-810-BLUE (800-810-2583).

When they use providers that contract in the BlueCard program, employees receive the highest level of benefits. They do not have to file claims, and they take advantage of the savings the local Plan has negotiated with area providers.

Members traveling outside the United States have access to providers that participate in the BlueCard Worldwide program in more than 200 countries. If care is received from a non-contracting provider, members will have to pay the doctor or hospital for care at the time of service and then submit a claim form for reimbursement.

OUT-OF-AREA COVERAGE (HMO MEMBERS)
HMO members have access to health care benefits when traveling or temporarily living out of state.

The Away From Home Care® (AFHC) Guest Membership program covers HMO members who are living out of the participating service area for at least 90 consecutive days. Employees can become guest members at an affiliated Blue Cross and Blue Shield HMO in another state. Guest membership is a particularly valuable benefit for covered students who are living out of state while attending school or for members on extended travel out of state. Members can sign up by calling Member Services using the phone number on the back of their ID cards.

The BlueCard program covers HMO members traveling outside of Texas who need medical attention for a condition that is not an emergency. Members can find contracting providers by calling 800-810-BLUE (800-810-2583) or visiting bcbstx.com.
Health Benefits Overview CONTINUED

PRESCRIPTION BENEFITS
Our Prescription Drug Program is not only cost-efficient, but also convenient for employers. Through seamless coordination with our Pharmacy Benefit Manager (PBM), BCBSTX provides consolidated billing, reporting and account management for employers who also select us for their health plan, reducing administration associated with multiple carriers.

All prescription drug offerings (except HSA plans and certain PPO plans) include three-tier copay plans with at least a $15 spread between generic, preferred and non-preferred copays. Four-tier copay plans are now available with an additional $8 copay tier.

MEDICAL PROGRAM INTEGRATION
Because our relationship with our PBM allows us to retain responsibility for local pharmacy network management and clinical pharmacy initiatives, we have fully integrated our prescription drug and medical programs to help identify opportunities for improving members’ health and lowering employers’ costs. For example, the Prescription Drug Program is coordinated with our Condition Management Programs to help participating members with chronic conditions, such as asthma, be compliant with related medications, and to identify medications that might be considered for coverage.

CONVENIENCE OF CHOICE
The Prescription Drug Program offers members comprehensive network access and a three-tier or four-tier copayment system for drug selection. There are more than 62,000 contracting retail pharmacies across the country. To access their prescription drug benefits, employees simply show their member ID cards at a contracting pharmacy convenient to them. The BCBSTX preferred drug list is a regularly updated list of preferred drugs selected by a committee, composed of current and former practicing physicians and pharmacists, who evaluate all U.S. Food and Drug Administration-approved drugs based on efficacy, safety, uniqueness and cost-effectiveness. The preferred drug list is designed so members have the lowest copayment amount for generic drugs and higher copayment amounts for preferred brand and non-preferred brand drugs. This system encourages members to select drugs that are less costly but equally effective, to help reduce overall prescription drug costs. The generic, preferred brand and non-preferred brand drug lists are reviewed and updated regularly to include new drugs in the market. The preferred drug list structure provides coverage for nearly all drugs, even those that are not on the preferred list.

MAIL SERVICE PROGRAM
Members can receive up to a 90-day supply of maintenance medication through the mail service programs.

DRUG UTILIZATION REVIEW
Our Drug Utilization Review program helps control costs by addressing inappropriate usage, such as early refills, incorrect dosage, average days’ supply, drug interactions, duplicate or concurrent therapy, under-utilization, and high utilization/fraud. We profile BCBSTX contracted physicians to generate comparative peer analyses, using standard benchmarks such as drug list compliance, generic drug utilization, and average number of prescriptions per member.

ONLINE TOOLS
Members and employers may access our website at bcbstx.com to review a current listing of preferred and non-preferred drugs, search for a network pharmacy, research drugs and their uses, place mail order refill requests, and more.

CUSTOMER SERVICE
Members, physicians and pharmacists may call pharmacy-dedicated customer service representatives toll free 24 hours a day, seven days a week. A registered pharmacist is available to answer physician and member questions.
Health Benefits Overview CONTINUED

BLUE CARE CONNECTION®

Blue Care Connection (BCC) provides personalized attention, support, online resources and health advocacy, helping members find the right resources, optimize their health care benefits and manage their medical conditions. Programs include:

- **24/7 Nurseline** – Around the clock, toll-free access to registered nurses for health information.
- **Lifestyle Management Programs** – Provide tools and information which may help members lose weight, quit smoking or reduce their risk for developing heart disease, stroke or diabetes.
- **Utilization Management** – Can help members and their doctors obtain information about benefits, navigate the health care system and help maximize benefits for covered services.
- **CCEISM Care Coordination and Early Intervention** – Uses advanced analytics and leading indicators of chronic disease to identify members who have an increased risk for avoidable hospital admissions, re-admissions and emergency room (ER) visits. Those members will receive interventions designed to improve health outcomes.
- **Condition Management** – Blue Care® Advisors (registered nurses and other health care professionals) work with members and their doctors to provide education, coaching and monitoring if you are at risk for or already have a chronic condition.
- **Special Beginnings®** – Maternity program offering expectant mothers ongoing support and education from prenatal to postpartum care, including convenient online and mobile tools and educational materials.
- **Case Management** – Case managers help members navigate complex medical situations and access the services they need.
- **Behavioral Health** – Licensed behavioral health professionals help members access services and offer support with co-existing medical conditions and disorders such as anxiety, depression, etc.

WELL ONTARGET®:
A NEW WAY TO EXPERIENCE WELLNESS

Well onTarget offers personalized tools and resources to help all members—no matter where they may be on the path to health and wellness. Services include:

- **Member Wellness Portal** – This engaging portal links members to a suite of innovative programs and tools.
  - onmytime Self-directed Courses – Online courses about nutrition, fitness, weight management, tobacco cessation and stress.
  - Health and Wellness Content – Health library teaches and empowers through evidence-based, user-friendly articles.
  - Tools and Trackers – Interactive tools help make wellness fun. Includes food and workout diaries, health calculators and medical and lifestyle trackers.
- **onmyway® Health Assessment (HA)** – The HA features adaptable questions so members can learn more about their health. After taking the HA, members receive a personal wellness report. The confidential record offers tips for healthy living.
- **Life Points Program** – Members earn points by taking part in wellness activities. Points can be redeemed in the new online shopping mall.
- **Fitness Program** – This flexible membership program provides unlimited access to a nationwide network of more than 8,000 fitness centers. Other program perks are:
  - No long-term contract required. Membership is month to month. Monthly fees are $25 per month per member, with a one-time enrollment fee of $25.
  - Automatic withdrawal of monthly fee.
  - Online tools for locating gyms and tracking visits.

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1 Register mark of Health Care Service Corporation, a Mutual Legal Reserve Company
2 onmyway is registered mark of Onlife Health.
3 Healthways, Inc. is an independent contractor which administers the Prime Network of fitness centers. The Prime Network is made up of independently-owned and managed fitness centers.
Health Benefits Overview CONTINUED

BLUE365®: A DISCOUNT PROGRAM FOR MEMBERS

Blue365 is just one more advantage of being a BCBSTX member. Blue365 offers members and covered dependents access to savings on a number of health care and wellness products and services. To learn more, visit the Blue365 website at blue365deals.com/BCBSTX. Services and products include:

**Davis Visionsm & TruVision®**
877-393-8844, 877-882-2020
Members can save on eyeglasses, as well as contact lenses, laser vision correction services, examinations and accessories. For a list of Davis Vision providers visit bcbstx.com, click Find a Doctor then select Find a Vision Provider. The Davis Vision network consists of major national and regional retail locations as well as independent ophthalmologists and optometrists. Members and eligible dependents can receive discounts on laser vision correction services through the TLC/TruVision network.

**Jenny Craig®**
877-JENNY70 (877-536-6970)
Jenny Craig can help members reach their weight loss goals by getting one-on-one support given by a trained weight loss expert who will provide a tailored program based on the essential components of successful weight management: food, body, mind. Members can meet with their consultants in person at a local center or enjoy the ease of the Jenny Craig At Home program.

**Life Time® Fitness**
Life Time Fitness offers members a total fitness experience. For new members, Life Time Fitness offers a $0 enrollment fee when you sign up online.

**Procter & Gamble (P&G) Dental Products**
877-333-0121
Members get savings on dental packages containing the latest in Oral B® power toothbrushes and Crest® products. The dental packages from P&G can help members improve the health of their teeth and gums. Packages may contain items such as an electric toothbrush, mouth rinse, floss and more.

TruHearing®
800-687-4617
Members save on digital hearing aids through TruHearing. They can get a hearing test at no extra charge when performed to fit a hearing aid. Members get a choice of hearing aid styles at a number of price levels and enough batteries to last a year when you buy a hearing aid. They also enjoy a 45-day, money-back guarantee and a three-year warranty.

The following Blue Care Connection features do not apply to HMO members:

- Utilization and Case Management Program
- Behavioral Health Program

The relationship between these vendors and Blue Cross and Blue Shield of Texas (BCBSTX) is that of independent contractors.

1 Blue365 is a discount program only for BCBSTX members. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program’s services or products. You may want to talk to your doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

2 Proof of Blue Cross and Blue Shield of Texas coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at blue365deals.com/BCBSTX. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members’ prices, dues and fees may change at any time. Offer expires September 1, 2014. Other rules may apply. Always check with the Life Time Fitness club in your area for the most up-to-date offer. Offer not available in Minnesota.

- All trademarks and service marks are property of their respective owners.
Online tools to help your accounts and their employees get the most from their health care benefit plan

FOR EMPLOYERS
Find helpful information and easy-to-use online services at Blue Access for Employers (BAE), our secure site at bcbstx.com*. Check employee eligibility as well as access and update membership information, such as enrolling new members, adding dependents, changing names and addresses, and canceling/reinstating employees. Employers can also view premium bills, weekly invoice details and monthly settlements, review standard customer reports and download forms.

FOR EMPLOYEES
Through Blue Access for Members™ (BAM), members can check the status of a claim, view the Explanation of Benefits (EOB) and receive email notification when a health or dental claim is finalized. (HMO members do not receive EOBs.) Members can use BAM to confirm who is covered under their plan. The Cost Estimator helps members obtain cost information for common health care services based on demographic and geographic data.

Members who have a Health Care Account can check current balances, payments made to date and year-to-year rollover amounts through BAM. Members whose HSA is administered by an HSA vendor with whom BCBSTX has a contractual arrangement, can check the account’s activity by signing on to BAM and linking directly to the administrator’s website.

*Dental, Life and Disability Options
BlueCare Dental FreedomSM is a passive dental plan that covers benefits at the same level whether services are provided by a contracting or non-contracting dentist. Existing indemnity dental plans can easily be replaced by our passive plan with minimal disruption to employees. Members may be subject to balance billing when services are provided by non-contracting providers. Dual option dental plans are available.

LIFE AND DISABILITY PLANS
A full range of life and disability products is available through Dearborn National.**

Term Life Coverage
- Group Term Life with an Accelerated Death Benefit
- Accidental Death and Dismemberment (AD&D)
- Dependent Life

Disability Coverage
- Short-term Disability
- Long-term Disability

Voluntary Coverage
- Portable Voluntary Life/Voluntary AD&D
- Voluntary Short- and Long-term Disability

**Life, disability and network dental insurance are marketed under the Dearborn National® brand and underwritten by Dearborn National Life Insurance Company®. Dearborn National Life Insurance Company does not provide Blue Cross and Blue Shield of Texas products or services and is a separate company. Dearborn National Life is solely responsible for the life, disability and network dental coverage provided.

Refer to the Dearborn National Products and BlueCare Dental Products sections of this guide for more details on dental, life and disability products.

Refer to the Online Tools and Resources section of this guide for more details about online tools.
## Benefit Plan Details

### BLUECHOICE®

<table>
<thead>
<tr>
<th>HEALTH PLAN #</th>
<th>DED IND/FAM</th>
<th>OFFICE COPAY</th>
<th>COINS % IN/OUT</th>
<th>OPX IND/FAM</th>
<th>PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>RM01</td>
<td>$250/$750</td>
<td>$15</td>
<td>90%/70%</td>
<td>$1250/$3750</td>
<td>$15/30/45</td>
</tr>
<tr>
<td>RM02</td>
<td>$500/$1500</td>
<td>$15</td>
<td>90%/70%</td>
<td>$2500/$7500</td>
<td>$15/30/45</td>
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<tr>
<td>RM03</td>
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<td>$45</td>
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<td>$20/40/60</td>
</tr>
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<td>$20</td>
<td>80%/60%</td>
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<td>$15/40/55</td>
</tr>
<tr>
<td>RBM2 ±</td>
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<td>80%/60%</td>
<td>$6350/$12700</td>
<td>$20/40/60</td>
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<td>80%/60%</td>
<td>$6000/$12700</td>
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</tr>
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<td>70%/50%</td>
<td>$6350/$12700</td>
<td>$20/40/60</td>
</tr>
</tbody>
</table>

± Copay applies to the physician office visit only; lab and X-ray are paid at coinsurance level.
▲ Copay applies to the physician office visit only; lab and X-ray are paid after deductible and coinsurance.
### BLUECHOICE® PPO FOUR TIER RX COPAY

<table>
<thead>
<tr>
<th>HEALTH PLAN #</th>
<th>DED IND/FAM</th>
<th>OFFICE COPAY</th>
<th>COINS % IN/OUT</th>
<th>OPX</th>
<th>PHARMACY*</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMF1</td>
<td>$3000/$9000</td>
<td>$30</td>
<td>100%/70%</td>
<td>$3500/$10500</td>
<td>$8/35/75/150</td>
</tr>
<tr>
<td>RMF2</td>
<td>$1000/$3000</td>
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<td>100%/70%</td>
<td>$1500/$4500</td>
<td>$8/35/75/150</td>
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<tr>
<td>RMF3</td>
<td>$2000/$6000</td>
<td>$20</td>
<td>80%/60%</td>
<td>$5000/$12700</td>
<td>$8/35/75/150</td>
</tr>
<tr>
<td>RMF4</td>
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<td>$6350/$12700</td>
<td>$8/35/75/150</td>
</tr>
<tr>
<td>RMF5</td>
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<td>80%/60%</td>
<td>$4000/$12000</td>
<td>$8/35/75/150</td>
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<tr>
<td>RMF6</td>
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<td>$30+</td>
<td>80%/60%</td>
<td>$4500/$12700</td>
<td>$10/35/75/150</td>
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<tr>
<td>RMF7</td>
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<td>$20+</td>
<td>80%/60%</td>
<td>$5000/$12700</td>
<td>$10/35/75/150</td>
</tr>
</tbody>
</table>

* Preferred Drug List 1 applies to all Middle Market Plans (bold) except Four Tier Rx Copay Plans which are subject to Preferred Drug List 2.

+ Copay applies to physician office visit only.

### BLUECHOICE® ENHANCED RX PLANS

<table>
<thead>
<tr>
<th>HEALTH PLAN #</th>
<th>DED IND/FAM</th>
<th>OFFICE COPAY</th>
<th>COINS % IN/OUT</th>
<th>OPX IND/FAM</th>
<th>PHARMACY</th>
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<tbody>
<tr>
<td>RME01</td>
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</tr>
<tr>
<td>RME03</td>
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<td>80%/60%</td>
<td>$3750/$11250</td>
<td>$15/30/45</td>
</tr>
<tr>
<td>RME04</td>
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<td>100%/70%</td>
<td>$1500/$4500</td>
<td>$15/30/45</td>
</tr>
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<tr>
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<td>$20/35/50</td>
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<tr>
<td>RME09</td>
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<td>100%/80%</td>
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<td>RME10</td>
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<td>100%/70%</td>
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<td>RME11</td>
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<td>70%/50%</td>
<td>$6350/$12700</td>
<td>$20/40/60</td>
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### BlueEdge HSA Plans – BlueChoice Network

<table>
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<tr>
<th>HEALTH PLAN #</th>
<th>DED IN/OUT INDIVIDUAL</th>
<th>DED IN/OUT FAMILY</th>
<th>OFFIC COPAY</th>
<th>COINS % IN/OUT</th>
<th>OUT-OF-POCKET MAXIMUM*</th>
<th>PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMH1</td>
<td>$2500/$5000</td>
<td>$5000/$10000</td>
<td>Ded &amp; Coins</td>
<td>100%/70%</td>
<td>$2500/$5000</td>
<td>100% after cal year deductible</td>
</tr>
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<td>RMH2</td>
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<td>$6000/$12000</td>
<td>Ded &amp; Coins</td>
<td>100%/70%</td>
<td>$3000/$6000</td>
<td>100% after cal year deductible</td>
</tr>
<tr>
<td>RMH3</td>
<td>$5000/$10000</td>
<td>$10000/$20000</td>
<td>Ded &amp; Coins</td>
<td>100%/70%</td>
<td>$5000/$10000</td>
<td>100% after cal year deductible</td>
</tr>
<tr>
<td>RMH6</td>
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<td>$7000/$14000</td>
<td>Ded &amp; Coins</td>
<td>80%/60%</td>
<td>$5000/$10000</td>
<td>80% after cal year deductible</td>
</tr>
<tr>
<td>RMH7</td>
<td>$2500/$5000</td>
<td>$5000/$10000</td>
<td>Ded &amp; Coins</td>
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<td>80% after cal year deductible</td>
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<tr>
<td>RMH8</td>
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<td>$8000/$16000</td>
<td>Ded &amp; Coins</td>
<td>100%/70%</td>
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<td>100% after cal year deductible</td>
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<td>RMH9</td>
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<td>$7000/$14000</td>
<td>Ded &amp; Coins</td>
<td>100%/70%</td>
<td>$3500/$7000</td>
<td>100% after cal year deductible</td>
</tr>
</tbody>
</table>

† Preferred Drug List 1 applies to all Middle Market Plans (bold) except (bold) Four Tier Rx Copay Plans which are subject to Preferred Drug List 2.

+ Copay applies to physician office visit only.

### AGGREGATE DEDUCTIBLE PLAN†

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<tr>
<th>HEALTH PLAN #</th>
<th>DED IN/OUT INDIVIDUAL</th>
<th>DED IN/OUT FAMILY</th>
<th>OFFIC COPAY</th>
<th>COINS % IN/OUT</th>
<th>OUT-OF-POCKET MAXIMUM*</th>
<th>PHARMACY</th>
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</thead>
<tbody>
<tr>
<td>RMH4</td>
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<td>100% after cal year deductible</td>
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</table>

† If family coverage is selected, the family deductible amount must be satisfied before any benefits are available under the HSA plan.

+ Deductible plus coinsurance stoploss equals out-of-pocket maximum

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
### BlueEdge HCA (Non-Integrated Drug Plans)

<table>
<thead>
<tr>
<th>Health Plan #</th>
<th>Office Copay</th>
<th>HCA Funding* Indiv/Family</th>
<th>Ded Indiv/Family</th>
<th>Coins % In/Out</th>
<th>OPX Indiv/Family</th>
<th>Pharmacy</th>
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*Health care account is funded by the employer.

### BlueEdge HCA (Integrated Drug Plans)

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<th>HCA Funding* Indiv/Family</th>
<th>Ded Indiv/Family</th>
<th>Coins % In/Out</th>
<th>OPX Indiv/Family</th>
<th>Pharmacy</th>
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<td>R9502R</td>
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*Health care account is funded by the employer.
## HMO Blue Texas Plans

<table>
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<th>HEALTH PLAN #</th>
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<th>IN-HOSPITAL COPAY</th>
<th>ER COPAY</th>
<th>OUT OF POCKET MAXIMUM</th>
<th>PDP COPAY</th>
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<tr>
<td>RPlan 29</td>
<td>$20 PCP/$20 Specialist</td>
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<td>$1500/$3000</td>
<td>PD10 $10/25/40</td>
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<tr>
<td>RPlan 31</td>
<td>$25 PCP/$25 Specialist</td>
<td>$750 per admission</td>
<td>$75 per visit</td>
<td>$2500/$5000</td>
<td>PD11 $15/30/45</td>
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<td>RPlan 32</td>
<td>$30 PCP/$30 Specialist</td>
<td>$1000 per admission</td>
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<td>PD12 $20/35/50</td>
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<td>RPlan33</td>
<td>$10 PCP/$30 Specialist</td>
<td>$350 per admission</td>
<td>$100 per visit</td>
<td>$1500/$3000</td>
<td>PD10 $10/25/40</td>
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<td>RPlan34</td>
<td>$15 PCP/$35 Specialist</td>
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<td>PD12 $20/35/50</td>
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<td>$3000/$6000</td>
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<td>$4000/$8000</td>
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<td>$4000/$8000</td>
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## HMO Options

<table>
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<th>DESCRIPTION</th>
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<tr>
<td>DM3</td>
<td>DME - No Copayment</td>
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<tr>
<td>DM4</td>
<td>DME - 20% Copayment</td>
</tr>
<tr>
<td>IM4</td>
<td>Inpatient Mental Health - Covered Same As Any Other Illness</td>
</tr>
<tr>
<td>O2</td>
<td>Vision Exam Only - $10 copay every 12 months; lens exam - $20 every 12 months – No Hardware</td>
</tr>
<tr>
<td>6</td>
<td>Vision Services – Eye exam - $3 copay every 12 months; varying copays for frames/lenses coverage every 12 months</td>
</tr>
<tr>
<td>IC</td>
<td>Vision Services – Eye glass exam is $5 copay every 12 months; lens exam included in cost of lenses w/exam every 12 months. Standard frames $5 copay every 24 months and non-standard frames have higher copays.</td>
</tr>
<tr>
<td>OC</td>
<td>Vision Services – Eye glass exam is $10 copay every 12 months; lens exam included in cost of lenses w/exam every 12 months. Standard frames $15 copay every 24 months and non-standard frames have higher copays.</td>
</tr>
<tr>
<td>SHO</td>
<td>Speech and Hearing Option</td>
</tr>
<tr>
<td>IVO</td>
<td>In Vitro Fertilization Option</td>
</tr>
</tbody>
</table>
Our Network

We have been building strong contractual and professional relationships with providers for more than 80 years.

We have built one of the largest networks of contracting providers in Texas, including more than 42,000 physicians and specialists in our HMO Blue Texas network and more than 62,000 in the BlueChoice PPO network. The PPO network is so extensive that employers who move from another health carrier experience very little, if any, network disruption.

We have also built a unique negotiating position with the provider community, resulting in consistently deeper discounts. For BlueChoice and HMO Blue Texas networks, statewide physician savings are at least 50 percent, and inpatient hospital savings are at least 50 percent.

In addition, we have agreements with many non-network providers who also accept our allowable amounts, file claims as needed and agree not to balance bill our members. Altogether, more than 81 percent of Texas physicians and 96 percent of Texas hospitals have contractual arrangements with BCBSTX – a significant advantage over other health plans and a tremendous benefit for members.

While we aggressively negotiate rates with providers, we are just as aggressive about responding to their needs. Our programs are designed to let doctors do their job – provide care. Our systems are designed to help them with their business needs, enabling such efficiencies as electronic claims filing and quick reimbursement.

### NETWORK HIGHLIGHTS

<table>
<thead>
<tr>
<th></th>
<th>PPO/CDHP</th>
<th>PAR</th>
<th>HMO Blue® Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATEWIDE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Name</td>
<td>BlueChoice®</td>
<td>ParPlan</td>
<td>HMO Blue® Texas</td>
</tr>
<tr>
<td>Service Area</td>
<td>Statewide**</td>
<td>Statewide</td>
<td>Statewide</td>
</tr>
<tr>
<td>PCPs</td>
<td>11,522</td>
<td>62,010</td>
<td>7,951</td>
</tr>
<tr>
<td>Specialists</td>
<td>52,225</td>
<td></td>
<td>43,135</td>
</tr>
<tr>
<td>Hospitals*</td>
<td>616</td>
<td>535</td>
<td>548</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>4,100</td>
<td>Not applicable</td>
<td>3,700</td>
</tr>
<tr>
<td>Percent of All Available Physicians</td>
<td>81%</td>
<td>81%</td>
<td>65%</td>
</tr>
<tr>
<td>Percent of All Available Hospitals</td>
<td>96%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>NATIONWIDE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Access (also D.C. and Puerto Rico)</td>
<td>50 States</td>
<td>49 States</td>
<td>Guest memberships are available in 32 states and the District of Columbia***</td>
</tr>
<tr>
<td>Physicians</td>
<td>More than 720,000</td>
<td>More than 740,000</td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>More than 6,300</td>
<td>More than 6,600</td>
<td></td>
</tr>
<tr>
<td>Pharmacies</td>
<td>62,000</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

September, 2013

* Hospital and provider numbers do not include behavioral health facilities/providers.

** Statewide represents all 254 Texas counties.

*** Away from Home Care® is not available in the following states: Alabama, Alaska, Idaho, Iowa, Kansas, Maryland, Mississippi, Montana, Nebraska, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia and Wyoming.
Reasons to Choose Blue Cross and Blue Shield of Texas

Our success in the health insurance industry is the result of proven, integrated management of several key elements, which differentiates our service from the competition.

**Account Management** – Our account staff will work closely with your clients to anticipate needs, offer strategic consultation and quickly resolve issues.

**Network Management** – Our strategy helps make the dollars your clients spend on employee health care benefits go further. Our strong relationships mean we can negotiate provider discounts for your clients and their employees.

**Medical Care Management** – The Blue Care Connection program includes education to help members take more responsibility for their health. The program also helps strengthen the doctor-patient relationship to improve health outcomes. Through online tools and other resources, we engage members by helping them be more proactive in their health care decisions.

**Consumer-Directed Product Options** – By promoting personal accountability among members, your employers can help their employees become more responsible health care decision makers. We offer the guidance to show members how easy it is to make the most of the health plan.

**Claims and Customer Advocacy** – Coordination through the national BlueCard program provides the same seamless claims administration for national accounts with multiple locations as it does for local accounts. Members can obtain convenient, self-service information through our secure website or personal service from customer advocates in our full service units.

For more information about our products, contact your Blue Cross and Blue Shield of Texas representative.
Blue Cross and Blue Shield of Texas: RM01

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: MM/DD/YYYY-MM/DD/YYYY

Coverage for: Individual/Family Plan Type: PPO

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.

Summary of Benefits and Coverage sheets (SBCs) are available in the 2014 Sample Summary of Benefits and Coverage.

2014 Mid-Market Group Products for the 51-150 Market

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.

2014 Sample Summary of Benefits and Coverage

Summary of Benefits and Coverage sheets (SBCs) are available in the Products and Forms section of Blue Access for Producers.

Blue Cross and Blue Shield of Texas: RM01

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: MM/DD/YYYY-MM/DD/YYYY

Coverage for: Individual/Family Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document or by calling 1-800-521-2227.

Important Questions: Answers to Your Concerns

Summary of Benefits and Coverage:

Blue Cross and Blue Shield of Texas: RM01 Coverage Period: MM/DD/YYYY-MM/DD/YYYY

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2014 Sample Summary of Benefits and Coverage

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Blue Cross and Blue Shield of Texas: RM01

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Important Questions: Answers to Your Concerns

Summary of Benefits and Coverage:

Blue Cross and Blue Shield of Texas: RM01 Coverage Period: MM/DD/YYYY-MM/DD/YYYY

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
### Blue Cross and Blue Shield of Texas: RM01

#### Summary of Benefits and Coverage

**Coverage Period:** MM/DD/YYYY-MM/DD/YYYY

**Coverage for: Individual/Family Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Service You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Amount</td>
<td>Amount</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance after $100 copay/visit</td>
<td>10% coinsurance after $100 copay/visit</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 copay/visit</td>
<td>$100 copay/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40 copay/visit</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>$15 copay per office visit or in lieu of coinsurance for In-Network. Certain services must be preauthorized; refer to benefit booklet for details.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>All services must be preauthorized.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>$15 copay per office visit in lieu of coinsurance for In-Network. Certain services must be preauthorized; refer to benefit booklet for details.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$15 copay/initial visit only</td>
<td>30% coinsurance</td>
<td>--none--</td>
</tr>
<tr>
<td></td>
<td>Delivery and inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Preauthorization is required.</td>
</tr>
</tbody>
</table>

#### Excluded Services & Other Covered Services:

- **Services Your Plan Does NOT Cover:** Check your policy or plan document for other excluded services.
- **Other Covered Services:** Check your policy or plan document for other covered services and your costs for these services.

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult)
- Dentist (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (only covered for the diagnosis of Diabetes)
- Weight loss programs
- Chiropractic care
- Hearing aids
- Infertility treatment (In vitro and Artificial Insemination are not covered unless shown in your plan document)
- Routine eye care (Adult)

#### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

Questions: Call 1-800-521-2227 or visit us at [http://www.bcbstx.com/coverage/group/index.html](http://www.bcbstx.com/coverage/group/index.html).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-855-756-4448 to request a copy.
For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
### Questions and answers about Coverage Examples:

#### What are some of the assumptions behind the Coverage Examples?
- Costs don't include *premiums*.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network *providers*, if the patient had received care from out-of-network *providers*, costs would have been higher.

#### What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how *deductibles*, *copayments*, and *coinsurance* can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

#### Does the Coverage Example predict my own care needs?
**No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

#### Does the Coverage Example predict my future expenses?
**No**. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your *providers* charge, and the reimbursement your health plan allows.

#### Can I use Coverage Examples to compare plans?
**Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

#### Are there other costs I should consider when comparing plans?
**Yes**. An important cost is the *premium* you pay. Generally, the lower your *premium*, the more you'll pay in out-of-pocket costs, such as *copayments*, *deductibles*, and *coinsurance*. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Questions: Call 1-800-521-2227 or visit us at [http://www.bcbstx.com/coverage/group/index.html](http://www.bcbstx.com/coverage/group/index.html). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUnifiedGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUnifiedGlossary.pdf) or call 1-855-756-4448 to request a copy.
2014 Dearborn National® Products

To complete a benefits package, a full range of life and disability insurance products is available from Dearborn National Life Insurance Company. This section contains highlights of Dearborn National products and services.

A complete list of Dearborn National products and services may be viewed at bcbstx.com/producer or dearbornnational.com

Strength. Independence. Solutions.

Dearborn’s values help define the way it does business.

Strength. The Dearborn National companies are financially strong and capable of fulfilling promises to producers, members and insureds.

Independence. Dearborn National is independent from the conventions and bureaucracy of Wall Street, so customers can depend on a stable company that will do the right thing in business relationships.

Solutions. Dearborn National builds relationships by listening to customers, providing big-company solutions with a small-company touch.

Financial Strength that Earns the Highest Ratings from Industry Analysts

Financial strength is a major component of Dearborn National’s success. This is evident in the financial strength ratings awarded to Dearborn National from independent insurance analysts.

• A+ (Superior) by A.M. Best Company, affirmed December 19, 2013¹
• A+ (Strong) by Standard and Poor’s, affirmed June 24, 2013¹

Strong ratings are one of the many reasons Dearborn National inspires confidence among its customers, group benefits producers and distribution partners.

Dearborn National

Ancillary insurance products marketed under the Dearborn National brand and star logo are underwritten by Dearborn National Life Insurance Company, which is a subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. HCSC is the largest non-investor-owned health insurer in the United States and the fourth largest health insurer in the country overall, operating health insurance plans in Illinois, Montana, New Mexico, Oklahoma and Texas.

Change is inevitable, but one thing remains the same—we treat our customers and producers as individuals who deserve our best.

¹ A.M. Best Company rates the overall financial condition of a company using a scale of A++ (Superior) to F (In Liquidation). Standard & Poor’s Insurer Financial Strength Rating uses a scale ranging from AAA (Extremely Strong) to R (Experienced Regulatory Action).

This piece is for agent use only and represents an invitation to inquire and not an invitation to contract. Only the insurance policies can provide the actual terms of coverage. The policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions, and other coverage conditions which may include a waiting period for pre-existing conditions.

BlueCross BlueShield of Texas

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) and certain of its affiliates. Dearborn National® Life Insurance Company is a separate company that does not provide Blue Cross and Blue Shield of Texas products or services. Dearborn National® Life Insurance Company is solely responsible for the life and disability products described in this book.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Group Products that Fill the Needs of Employers and Employees

Dearborn National’s competitive portfolio of group benefits insurance products can be offered as employer-paid or voluntary benefit programs to groups of all sizes. Dearborn’s products feature flexible plan designs and include benefit options that provide value and distinguish its product portfolio from the competition.

**GROUP BENEFITS INSURANCE PRODUCTS**

- Term Life, Supplemental Life, Accidental Death and Dismemberment (AD&D), and Dependent Life Insurance
- Short- and Long-term Disability Insurance
- Network Dental Insurance

**VOLUNTARY GROUP BENEFITS INSURANCE PRODUCTS**

- Voluntary Term Life, Dependent Life and AD&D Insurance
- Voluntary Short- and Long-term Disability Insurance

**ENHANCED PRODUCT SERVICES**

(features and availability may vary by group size)

- Beneficiary Resource Services™
- Disability Resource Services™
- Online Will Preparation
- Travel Resource Services™

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1 Beneficiary Resource Services are provided by Bensinger, DuPont & Associates which is not an affiliate of the Dearborn National brand companies. The Dearborn National brand companies do not provide any part of Beneficiary Resource Services.

2 Disability Resource Services are administered by ComPsych Corporation. These programs and/or any part of these services are not provided or insured by the Dearborn National brand companies. ComPsych does not provide insurance products of any kind.

3 Online Will Preparation is administered by ComPsych Corporation, an independent organization not affiliated with the Dearborn National brand companies. ComPsych does not provide insurance products of any kind.

4 Travel Resource Services are provided and administered solely by Europ Assistance USA, Inc. (EA). EA is an independent organization and is not affiliated with the Dearborn National brand companies.
Group Term Life Insurance

Dearborn National Life Insurance Company’s Group Term Life Insurance can be provided on a guarantee issue basis and includes Supplemental Life coverage. Best of all, a tailor-made plan can be designed to fit the needs of an organization.

GROUP TERM LIFE INSURANCE THAT IS FLEXIBLE AND AFFORDABLE

One hundred percent employee funded, voluntary life programs are available for those employers who want to offer benefits but cannot afford the expense associated with providing this valuable coverage. Dearborn National’s Group Term Life product fills the needs of employers and their employees.

HELP WITH THE COST OF TERMINAL ILLNESS: ACCELERATED DEATH BENEFIT

The accelerated death benefit pays a portion of the death benefit as a living benefit up to 75 percent of the Group Term and Supplemental Life benefit** to an employee with a terminal illness. The amount paid may vary by state.

*According to a LIMRA study, 50 percent of U.S. households say they need more life insurance.**

VALUABLE COVERAGE THAT EMPLOYERS CAN ADD TO THEIR GROUP TERM LIFE INSURANCE: ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

AD&D coverage pays benefits if an employee dies or is dismembered in an accident. Dearborn National’s AD&D plan includes these features:

Plegia Benefits
Benefits are payable for covered accidental injuries that result in quadriplegia, paraplegia, hemiplegia or uniplegia.**

Seat Belt Benefit
An additional benefit is paid if the accidental death occurs while driving or riding in an automobile and using a seat belt.

Air Bag Benefit
This benefit is paid if the accidental death occurs while driving or riding in an automobile with functioning air bags.

Repatriation Benefit
An additional benefit is paid for the transportation of the insured person’s body to a mortuary.

Education Benefit
In the event of an accidental death, this benefit reimburses the individual’s dependent student(s) for educational expenses in a school of higher education beyond the 12th grade1.


**Benefit may vary by group size.

1Benefit not available in all states.
Group Term Life Insurance CONTINUED

ADDITIONAL FEATURES

Waiver of Premium
If an employee is unable to engage in any occupation as a result of injury or sickness for a minimum of nine months, prior to age 60, premium will be waived until the employee is no longer disabled or reaches age 65.

Portability
Insureds can continue their Supplemental Life Insurance to age 65 without evidence of insurability (EOI) if coverage terminates due to termination of employment.

BENEFICIARY RESOURCE SERVICES™ – PROVIDING MORE THAN A CHECK TO A BENEFICIARY IN NEED1.

Support people need in time of loss – Beneficiary Resource Services is a program that combines grief, legal and financial counseling. Services are available to beneficiaries of an insured person who dies or to an insured who qualifies for an accelerated benefit.

Unlimited phone contact – For up to one year, the insured person or beneficiary has unlimited telephone access to grief counselors, legal advisors and financial counselors.

Face-to-face working sessions2 – Five face-to-face working sessions, or equivalent professional time, are available to the insured person or beneficiary.

PREPARATION FOR THE FUTURE

Dearborn National makes it easy for employers to give employees an opportunity to protect those they love.

Group Short-term Disability Insurance

SHORT-TERM DISABILITY INSURANCE CAN BE COSTLY

Bills and everyday needs don’t stop because someone can’t work. Short-term disability plans pay benefits when sickness or injury prevent an employee from working full-time.

FLEXIBLE SHORT-TERM DISABILITY (STD) PLANS

The strength of Dearborn National’s STD plans is flexibility. Employers with 10 or more employees can build an employer-paid or voluntary plan by choosing a benefit amount, an elimination period and a maximum period for which benefits are paid. It’s quick and easy to develop a customized plan to fit everyone’s needs.

| Benefit Percentage of Basic Weekly Income | 60% |
| Maximum Weekly Benefit                   | Up to $1,000 (higher amounts available to qualified groups) |
| Elimination Period                       | None for an accident and 7 days for illness. (many other options available) |
| Maximum Benefit Period (In Weeks)        | 13, 26, 52 |

DEFINING DISABILITY

Insured employees unable to continuously perform the material and substantial duties of their regular occupations on a full-time or part-time basis and who have disability earnings of less than 20 percent of pre-disability earnings are considered totally disabled.

LIMIT THE SHORT-TERM DISABILITIES THAT BECOME LONG-TERM DISABILITIES (LTD)

Employers who have LTD as well as STD plans with Dearborn National benefit from the integrated STD and LTD claims management. The claim management program focuses on a review of medical treatment, rehabilitation and return-to-work efforts. This program minimizes claimant paperwork and helps insure better claim outcomes.

Nearly eight in 10 Americans are living paycheck to paycheck.*

*Survey conducted by CareerBuilder, June, 2010

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Group Short-term Disability Insurance CONTINUED

STD PLANS INCLUDE BENEFITS FOR PARTIAL DISABILITY

Many employees want to return to work but may not be able to work to their full capacity. Dearborn National's STD plans include benefits for a partial disability. Partial disability means insured employees are working and because they are not totally disabled they:

• Can perform some but not all of the material and substantial duties of their regular occupation on a full-time or part-time basis.
• Are earning less than 80 percent of pre-disability earnings at the time the partial disability employment begins.

Employees who meet this definition can receive payments for a partial disability.

EMPLOYERS CAN VIEW STD CLAIMS HISTORY ONLINE

Our Benefits Manager portal saves employers' time. They can run STD claim reports and review information regarding a claim including date of loss, date of payment and payment amount.

ADDITIONAL BENEFIT FEATURES

Work Incentive Benefit allows a disabled employee to return to work and receive up to 100 percent of their pre-disability salary from a combination of earnings and benefits.

A Survivor Benefit provides an additional lump sum benefit payment to the eligible survivor of a claimant should the claimant pass away while receiving STD benefits.

A Worksite Modification Benefit provides a reimbursement to the employer for making changes to the workplace that allow a disabled employee to return to work.

Telephonic Claim Intake Mid-size and larger employers have the option of reporting their STD claims by telephone for quick, easy and accurate claim submission.

STD IS AN ATTRACTIVE EMPLOYEE BENEFIT

Employers compete to hire and keep the best employees. An employee benefit plan that includes STD can help attract the quality workers that help make an organization successful.

Premium will vary based on demographics of the group, benefit design, plan choice and additional features quoted.

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) and certain of its affiliates. Dearborn National® Life Insurance Company is a separate company that does not provide Blue Cross and Blue Shield of Texas products or services. Dearborn National® Life Insurance Company is solely responsible for the life and disability products described in this book.
Group Long-term Disability Insurance

A long-term disability impacts more than just disabled employees. The employees and their family members worry about the medical problem, treatment and how to meet day-to-day and future expenses. However, the effects of disability spread beyond the family. Employers may face employee morale issues and increased costs.*

Dearborn National’s Group Long-term Disability (LTD) insurance offers solutions for these concerns while offering competitive rates.

AN LTD CONTRACT FLEXIBLE ENOUGH TO MEET MANY NEEDS

The LTD contract was designed to meet the coverage needs of the work force and the cost requirements of the employer/employee. The result is a flexible plan with many outstanding features that are available on an employer-paid, core/buy-up or voluntary basis. Available to groups of 10 or more employees, Dearborn National’s LTD plan is an excellent choice for employers.

DEFINITION OF DISABILITY

During a total disability, Own Occupation is defined as loss of both the ability to perform all the functions of the individual’s job and loss of at least 80 percent of income. After the Own Occupation period expires, the Any Occupation definition applies. Total disability is then defined as loss of the ability to perform any job for which the individual is qualified by education, training and experience, as well as at least a loss of 80 percent of income. The definitions may vary by contract; please refer to the specific insurance policy for all definitions.

ELIMINATION PERIOD

Elimination period options ranging from 30 days to 365 days are available.

MAXIMUM MONTHLY BENEFIT

The standard maximum monthly benefit is $6,000. However, maximum amounts up to $15,000 are available on takeover cases.

BENEFIT PERCENTAGE

The standard benefit is 60 percent. Other options include 50 percent and 66 2/3 percent.

PRE-EXISTING CONDITIONS

The standard pre-existing limitation is 3/12. Other options include 12/12, 12/24, 3/6/12 and 12/6/24.

BENEFITS FOR PARTIAL DISABILITY

A work incentive benefit allows a disabled employee to work in some capacity and still receive disability benefits. Partial disability means insured employees are working, and because they are not totally disabled:

- During the Own Occupation period, are able to perform some, but not all, of the duties of their regular occupations and are earning between 20 and 80 percent of their indexed pre-disability earnings
- During the Any Occupation period, are unable to engage in any occupation that they are qualified for by education, training and experience and are earning between 20 and 60 percent of their indexed pre-disability earnings

Employees who meet these and other policy requirements can receive a work incentive benefit.

Dearborn National offers Own Occupation periods of 12 months, 24 months, 36 months, or for the duration of the claim.

**"Clear, Concise, Consistent – Exploring Employee Attitudes about Voluntary Worksite Benefits” from LIMRA International, December, 2012.**
**Group Long-term Disability Insurance**

**ADDITIONAL BENEFITS**

The flexibility of Dearborn National’s LTD plan allows employers to choose from a variety of options to enrich their plan.

**Worksite Modification Benefit** – Offered on a standard basis; reimburses the employer for approved changes to an employee’s work area, which helps return a disabled employee to work.

**Survivor Income Benefit** – Pays a benefit to the employee’s eligible survivor if the disabled employee dies after having received at least six months of benefits.

**Terminal Illness Benefit** – Offered on a standard basis, paid to a claimant diagnosed as terminally ill who has been totally disabled for at least six months.

**Family Income Benefit** – Pays a monthly amount to the employee’s eligible survivor for a period of one year after the death of the disabled individual.

**Cost of Living Adjustment (COLA)** – Adds an additional sum to monthly benefit payments after benefits have been paid for one year; the sum increases on each anniversary of benefit payment; multiple COLA amounts and durations are available.

**Education Benefit** – Pays an additional monthly benefit to those LTD claimants who have received at least six months of benefits and have dependent children.

**Accidental Dismemberment (AD) Benefit** – Pays a benefit upon dismemberment for insured individuals. The AD benefit can be paid without the employee meeting the definition of disability.

**Catastrophic Disability Benefit** – Provides an additional benefit of 10 percent up to $5,000 for someone who cannot perform two or more of the Activities of Daily Living.

- Caregiver Respite Benefit – If a person on disability has received home health care for six months, this benefit provides a reimbursement of $100 per day, up to 14 days per year, to pay for a substitute caregiver.

- Caregiver Training Benefit – Pays up to $500 for informal caregivers who incur expenses to be trained to take care of a claimant receiving the Catastrophic Disability Benefit.

- Emergency Alert System Benefit – Pays up to $25 per month to a claimant receiving the Catastrophic Disability Benefit who needs an emergency alert system to remain in his or her home.

**Rehabilitation Benefit** – Assists disabled persons on claim who want to reach their full potential. A claimant participating in a formal rehabilitation plan will receive an additional 5 percent of the monthly LTD benefit being paid, up to $500 per month.

**Retirement Plan Protection Benefit** – Pays a monthly benefit, up to 6 percent of the claimant’s earnings of the previous 12 months, to the employer on the claimant’s behalf for retirement benefits.

**NOT JUST BENEFITS - CLAIMS MANAGEMENT**

The right LTD plan doesn’t just pay claims; it manages them. If disabled employees can return to work, they should – under the right circumstances and at the right time. Dearborn National works hard to make this possible with a program that leads to better outcomes.

**OPTIONS**

- Options for employer-paid or voluntary plans
- Administrative Services Only (ASO) programs with competitive claim solutions for larger employers
- Variety of standard and customized plans with robust benefit options
- Flexibility for employers to design plan benefits that are affordable and right for their employees
Group Long-term Disability Insurance CONTINUED

RETURN-TO-WORK BENEFITS* – DESIGNED TO INCREASE EMPLOYEE CONFIDENCE AND DECREASE COSTS

Many people on disability are eager to return to work and employers are equally as eager to have them back. Dearborn National’s return-to-work benefits encourage returning to the work place and can lead to more satisfied and productive employees.

Work Incentive Benefit
This benefit is designed to encourage employees to return to work part-time. During the first 12 months of disability payment, the combination of disability earnings and monthly benefit can be up to 100 percent of the employee’s pre-disability income.**

Rehabilitation Incentive Income
In some cases, a disabled employee may be an ideal candidate for a rehabilitation program but is unable to pay the cost. If a disabled employee qualifies for and agrees to a rehabilitation program, the combination of disability earnings and monthly benefit can exceed 100 percent of the employee’s pre-disability income.**

*Not available in all states.
**After 12 months, benefits are reduced.

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) and certain of its affiliates. Dearborn National® Life Insurance Company is a separate company that does not provide Blue Cross and Blue Shield of Texas products or services. Dearborn National® Life Insurance Company is solely responsible for the life and disability products described in this book.
2014 BlueCare® Products

BCBSTX Has Offered Dental Coverage Since 1973

A wide range of standard plans are available for both small and large groups. Groups with more than 150 eligible employees can tailor a plan to meet their specific needs.

BCBSTX provides support through all phases of the dental program with comprehensive services and employee materials, such as ID cards, benefit booklets and easy-to-use claim forms.

BlueCare Dental ConnectionSM integrates dental care management and health care management with a focus on preventive care and individual involvement. This program provides members with education and intervention through support tools and educational mailings.

Highlights of BlueCare Dental products and services may be found in this section.

HISTORY OF SERVICE

When employers choose a dental plan from BCBSTX, they are in good company. That’s because BCBSTX has been offering dental coverage since 1973, and currently serves more than 1.1 million members. We have been providing health benefits longer than most companies have been in existence.

CHOICE OF PLANS

In today’s competitive environment, employers need to offer flexible, affordable health care plans, and dental coverage is an important part of any package. Standard plans are available for groups with 2–150 employees. Groups with more than 150 eligible employees can also customize plans to meet their specific needs. As a full-service carrier, BCBSTX offers a variety of dental plans to meet your clients’ needs:

• BlueCare Dental FreedomSM — allows members the opportunity to experience lower costs by using network dentists without a network differential in the benefit plan design — employer-paid voluntary employer (employer-paid)

THE BLUECARE® ADVANTAGE

• Focus on customer value and management of overall benefit costs
• Flexible dental plan designs with competitive rates
• Administrative ease with one point of contact for medical and dental
• A dedicated dental customer service center that provides exceptional service
• A proven track record of excellent customer service
• Large national network of more than 269,000 providers – more than 42,000 in Texas
• Lower out-of-pocket costs and no balance billing when using a network provider

With BCBSTX as their dental coverage provider, your clients will be starting off on the right foot with the company that millions have come to trust for service and dependability.

A complete list of BlueCare® Dental products and services may be viewed at bcbstx.com/producer.
Commitment and Quality in Every Plan

NETWORK ADVANTAGE
With more than 269,000 dentist access points throughout the United States and over 42,000 in Texas, BCBSTX offers employees flexibility when choosing a provider. In addition, we are continually expanding our network. We are working toward being one of the largest PPO networks in the marketplace. We individually negotiate aggressive discounts with our providers, offering employees significant savings when using the network.

BlueCare Dental Freedom plans offer members lower out-of-pocket costs when using a network dentist. To find a network dentist, members can:
- Visit the BCBSTX website at bcbstx.com and search for a dentist using Integrated Provider Finder
- Call customer service toll-free
- Look up a provider in the printed BlueCare Dental PPO provider directory

Members have the freedom to receive dental care from a non-contracting dentist, but the dentist can bill for the balance of charges above the allowable amount for that procedure, and may not file the claim for members.

A Specialized Approach to Serving Customers

DEDICATED TO SERVICE
We provide excellence in claims administration and customer service with a dedicated dental Customer Service Center. Representatives receive specialized training to deliver the quality service we consistently provide our dental members. Training programs are regularly monitored and tailored so that we can be sure the Customer Service Center is meeting the specific needs of BlueCare Dental plan members.

RELIABLE CUSTOMER SERVICE
Customer Service Center representatives assist members with eligibility, claims, coordination of benefits and provider information. The Customer Service Center is composed of knowledgeable and experienced claim processors, examiners, technicians and customer service representatives who are trained to process claims quickly and accurately, and are ready to answer your clients’ dental coverage questions.

Members may contact the Customer Service Center by calling the toll-free number on their ID card Monday through Friday, 8 a.m. to 8 p.m. CT.

EFFICIENT CLAIMS PROCESSING
BCBSTX’s customized claims system processes only dental claims, both quickly and efficiently. Electronic feed, front-end eligibility and claim data verification and edits allow for automated adjudication.

HIGH PERFORMANCE STANDARDS
- Loading eligibility by computer files or electronic feed
- Verifying all employee and dependent information for each claim, including dependent status
- Verifying treatment data against eligibility information
- Checking treatment history for tooth number, procedure code and date of service

Freedom to Choose
Members can see any licensed dentist anytime but may receive a higher level of discounts when using network dentists. Members may also visit providers who do not contract with Blue Cross and Blue Shield, however they will be responsible for paying any charges over the allowable amount.
WHY CHOOSE DENTAL COVERAGE FOR YOUR CUSTOMERS?

Dental benefits are the second most popular group plan requested by employees.

You can help your customers manage the rising costs of dental care by providing them with dental coverage from Blue Cross and Blue Shield of Texas. Not only is our coverage affordable, but members who enroll in one of our plans are encouraged to maintain good dental health.

That means they’ll also save money by taking care of small problems now, so they can avoid costly dental procedures later.

Putting It All Together

EFFICIENT AND ECONOMICAL

Dental pre-determination, claims review and provider monitoring are just some of the proactive ways we approach quality and cost management. BCBSTX’s local dental review staff oversees the program, including examining claims and treatment plans to ensure they are appropriate and within the scope of covered benefits.

ONE TEAM FOR ALL YOUR CLIENTS’ NEEDS

Dental coverage through BCBSTX lightens your clients’ administrative burden and helps manage their overall benefit costs. That’s because they will have the same account management team for both medical and dental issues — and your clients only have one bill to pay.

• Administrative ease
• Superior service
• Flexible, cost-effective plan designs

These are just a few reasons why more employers are choosing BlueCare Dental plans.

DENTAL PLAN FEATURES

With BCBSTX dental coverage, employees get more than just quality dental plans. They get the name that stands for reliability and trust.

Each time your clients’ employees need dental care, they can choose to:

<table>
<thead>
<tr>
<th>SEE A CONTRACTING DENTIST</th>
<th>SEE A NON-CONTRACTING DENTIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-pocket costs will generally be the least amount with BlueCare dentists who have contracted to accept a lower allowable amount as payment in full for eligible dental expenses. Out-of-pocket costs may be greater for DentaBlue dentists who have contracted at a higher allowable amount.</td>
<td>Out-of-pocket costs may be greater because non-contracting dentists have not entered into a contract with BCBSTX to accept any allowable amount determination as payment in full for eligible dental expenses.</td>
</tr>
<tr>
<td>Members are not required to file claim forms.</td>
<td>Members might be required to file their own claim forms.</td>
</tr>
<tr>
<td>Members are not balance billed for costs exceeding the BCBSTX allowable amount for BlueCare or DentaBlue dentists.</td>
<td>Members could be balance billed for costs exceeding the BCBSTX allowable amount.</td>
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</table>
BlueCare Dental Plans 2-50

<table>
<thead>
<tr>
<th>EXTERNAL MARKETING NAME</th>
<th>INTERNAL MARKETING ID OFF EXCHANGE</th>
<th>PLAN TYPE</th>
<th>OON REIMBURSEMENT</th>
<th>ORTHO COVERAGE TYPE &amp; LIFETIME MAXIMUM</th>
<th>ANNUAL MAXIMUM</th>
<th>DEDUCTIBLE (3X FAM)</th>
<th>PEDIATRIC DENTAL BENEFIT</th>
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<tbody>
<tr>
<td>BlueCare Dental 1A</td>
<td>DPFH03NATSTXP</td>
<td>Passive PPO</td>
<td>MAC</td>
<td>Ped Only</td>
<td>1,500</td>
<td>$700-1 Kid</td>
<td>$1,400-2+ Kids, No Ann Max (INN/OON)</td>
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<tr>
<td>BlueCare Dental 1B</td>
<td>DPFL03NATSTXP</td>
<td>Passive PPO</td>
<td>MAC</td>
<td>Ped Only</td>
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<td>$700-1 Kid</td>
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<tr>
<td>BlueCare Dental 1C</td>
<td>DPFH05NATSTXP</td>
<td>Passive PPO</td>
<td>R&amp;C</td>
<td>Full Ortho $1,500</td>
<td>1,500</td>
<td>$700-1 Kid</td>
<td>$1,400-2+ Kids, No Ann Max (INN/OON)</td>
</tr>
<tr>
<td>BlueCare Dental 1D</td>
<td>DPFL09NATSTXP</td>
<td>Passive PPO</td>
<td>R&amp;C</td>
<td>Ped Only</td>
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<td>$700-1 Kid</td>
<td>$1,400-2+ Kids, No Ann Max (INN/OON)</td>
</tr>
<tr>
<td>BlueCare Dental 1E</td>
<td>DPFH07NATSTXP</td>
<td>Passive PPO</td>
<td>R&amp;C</td>
<td>Full Ortho $2,000</td>
<td>2,000</td>
<td>$700-1 Kid</td>
<td>$1,400-2+ Kids, No Ann Max (INN/OON)</td>
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<td>BlueCare Dental 1F</td>
<td>DPFL12NATSTXP</td>
<td>Passive PPO</td>
<td>MAC</td>
<td>Ped Only</td>
<td>750</td>
<td>$700-1 Kid</td>
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<td>MAC</td>
<td>Ped Only</td>
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<td>$1,400-2+ Kids, No Ann Max (INN/OON)</td>
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<td>BlueCare Dental 4 Kids 1A</td>
<td>DPKL03NATSTXP</td>
<td>Passive PPO</td>
<td>MAC</td>
<td>Ped Only</td>
<td></td>
<td>$700-1 Kid</td>
<td>$1,400-2+ Kids, No Ann Max (INN/OON)</td>
</tr>
</tbody>
</table>

FOR GROUP SIZE OF 51–150

- A minimum of 75 percent employer contribution for employee cost is required
- A minimum of 75 percent employee participation is required
# BlueCare Dental Freedom℠ Plans 2-50

<table>
<thead>
<tr>
<th>External Marketing Name</th>
<th>Internal Marketing ID Off Exchange</th>
<th>Plan Type</th>
<th>Oon Reimbursement</th>
<th>Ortho Coverage Type &amp; Lifetime Maximum</th>
<th>Annual Maximum</th>
<th>Deductible (3x Fam)</th>
<th>Pediatric Dental Benefit</th>
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</thead>
<tbody>
<tr>
<td>BlueCare Dental 1A</td>
<td>DPH03NATSTXO</td>
<td>Passive PPO</td>
<td>MAC</td>
<td>Ped Only</td>
<td>1,500</td>
<td>In: $25 Out: $25</td>
<td>Per Cont OPX (INN/OON): $700-1 Kid $1,400-2+ Kids No Ann Max (INN/OON)</td>
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<tr>
<td>BlueCare Dental 1B</td>
<td>DPFL03NATSTXO</td>
<td>Passive PPO</td>
<td>MAC</td>
<td>Ped Only</td>
<td>1,000</td>
<td>In: $75 Out: $75</td>
<td>Per Cont OPX (INN/OON): $700-1 Kid $1,400-2+ Kids No Ann Max (INN/OON)</td>
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<tr>
<td>BlueCare Dental 1C</td>
<td>DPH05NATSTXO</td>
<td>Passive PPO</td>
<td>Full Ortho</td>
<td>Pediatric Dental Benefit</td>
<td>1,500</td>
<td>In: $25 Out: $25</td>
<td>Per Cont OPX (INN/OON): $700-1 Kid $1,400-2+ Kids No Ann Max (INN/OON)</td>
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<td>Passive PPO</td>
<td>R&amp;C</td>
<td>Ped Only</td>
<td>1,000</td>
<td>In: $75 Out: $75</td>
<td>Per Cont OPX (INN/OON): $700-1 Kid $1,400-2+ Kids No Ann Max (INN/OON)</td>
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<td>BlueCare Dental 1E</td>
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<td>Passive</td>
<td>R&amp;C</td>
<td>Full Ortho $2,000</td>
<td>2,000</td>
<td>In: $25 Out: $25</td>
<td>Per Cont OPX (INN/OON): $700-1 Kid $1,400-2+ Kids No Ann Max (INN/OON)</td>
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<td>In: $25 Out: $25</td>
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<td>Passive PPO</td>
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<td>Ped Only</td>
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<td>In: $75 Out: $75</td>
<td>Per Cont OPX (INN/OON): $700-1 Kid $1,400-2+ Kids No Ann Max (INN/OON)</td>
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## Plans 51-150

<table>
<thead>
<tr>
<th>PLAN</th>
<th>DEDUCTIBLE INDIV/FAMILY</th>
<th>ANNUAL MAX</th>
<th>BENEFIT LEVEL</th>
<th>ALLOCATION OF SERVICES</th>
<th>ORTHO %/ LIFEMAX</th>
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<tbody>
<tr>
<td>D501</td>
<td>$25/$75</td>
<td>$750</td>
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<td>Value</td>
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<td>100/80/50</td>
<td>Value</td>
<td>0%/$0</td>
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<tr>
<td>D602</td>
<td>$50/$150</td>
<td>$1,500</td>
<td>100/80/50</td>
<td>Value</td>
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</tr>
<tr>
<td>D701</td>
<td>$50/$150</td>
<td>$1,500</td>
<td>100/80/50</td>
<td>Value</td>
<td>50%/$1000</td>
</tr>
<tr>
<td>D702</td>
<td>$50/$150</td>
<td>$1,500</td>
<td>100/80/50</td>
<td>Value</td>
<td>50%/$1500</td>
</tr>
<tr>
<td>D801</td>
<td>$50/$150</td>
<td>$1,500</td>
<td>100/80/50</td>
<td>Deluxe</td>
<td>50%/$1500</td>
</tr>
<tr>
<td>D802</td>
<td>$50/$150</td>
<td>$2,000</td>
<td>100/80/50</td>
<td>Deluxe</td>
<td>50%/$1500</td>
</tr>
<tr>
<td>D803</td>
<td>$50/$150</td>
<td>$2,000</td>
<td>100/80/50</td>
<td>Deluxe</td>
<td>50%/$2000</td>
</tr>
<tr>
<td>D811</td>
<td>$50/$150</td>
<td>$1,000</td>
<td>100/80/50</td>
<td>Deluxe</td>
<td>0%/$0</td>
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<tr>
<td>D821</td>
<td>$50/$150</td>
<td>$1,000</td>
<td>100/80/50</td>
<td>Deluxe</td>
<td>50%/$1000</td>
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<td>D822</td>
<td>$50/$150</td>
<td>$1,500</td>
<td>100/80/50</td>
<td>Deluxe</td>
<td>50%/$1000</td>
</tr>
</tbody>
</table>

### ALLOWABLE COMBINATIONS FOR GROUP SIZE 51-150

- D501 and any other plan
- D601 and D801, D802, D803, D821 or D822
- D602 and D801, D802, D803, D821 or D822

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
National Network Providers
BLUECARE DENTAL FREEDOM™ AND BLUECARE
DENTAL PPO NATIONAL NETWORK PROVIDERS AND OVERALL STATE DISCOUNT

2014 BlueCare Dental PPO™ National Network
One of the Nation’s Largest Networks of Dental Access Points

Start With a Great Decision
Whichever plan your clients choose, you can be sure that BlueCare Dental plans offer flexible, affordable coverage that provides members with a wide range of services. Find out more about the BlueCare Dental programs by contacting your local BCBSTX sales office. You can also find listings of network dentists and check out other helpful resources by logging in to the BCBSTX website at bcbstx.com.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
BlueCare Dental Connection℠

A PROACTIVE APPROACH TO A DENTAL PLAN

BlueCare Dental Connection℠ is a dental program that does more than just pay claims. BCBSTX recognizes that when it comes to helping members take care of their oral health and overall health, administering dental benefits is a starting point. More than ever it’s critical to:

• Apply the knowledge gained from evidence-based dental research
• Create consumer-directed tools specific to dental care and dental benefits
• Use condition management programs to target members most in need of dental care

Many experts believe there may be a connection between good oral care and good overall health. Research shows a potential link between periodontal disease and other health problems such as heart disease, stroke, diabetes and premature birth.

SOMETHING TO SMILE ABOUT

Members with dental benefits through BCBSTX can access the resources of one of the nation’s largest health benefit companies with programs that provide:

• Consumer-directed online tools
• Targeted education designed to promote reduced dental disease
• Information and education designed to promote improved overall health

BlueCare Dental Connection is a proactive approach that empowers members to make informed decisions about where and when to receive care. Studies show that informed decisions may result in better health outcomes and reduced costs.

Estimates show that nearly 80 percent of adults in the U.S. have some form of periodontal disease.* That’s why we have created a proactive approach that focuses on more than just teeth.

Solutions at Members’ Fingertips

BlueCare Dental Connection includes member access to The Dental Wellness Center, a source of online consumer-directed tools available 24 hours a day. Members can find educational information on subjects ranging from pediatric care and cosmetic dentistry, to prevention and dental treatments. The Dental Wellness Center also allows members to:

• Ask dentists dental-related questions through Ask A Dentist
• Locate a network general dentist or specialist with Integrated Provider Finder
• Determine approximate dental fees in the marketplace with the Dental Cost Advisor™

In addition, BlueCare Dental Connection includes the following programs:

PROGRAMS DESIGNED TO PROMOTE IMPROVED DENTAL HEALTH

According to the Centers for Disease Control, nearly half of all children experience tooth decay — a condition that can usually be prevented by sealants.**

Our Decay Management Program provides parents with educational mailings about sealants and other proactive measures.

Our Periodontal Disease Management Program provides educational mailings about anti-gingivitis rinses and toothpastes and sonic-powered toothbrushes to members undergoing treatment.

Programs Designed to Promote Improved Overall Health

Evidence shows potential links between periodontal disease and complications with:

- Diabetes
- Cardiovascular disease
- Stroke
- Pre-term and low birth weight babies

For members with both medical and dental coverage through BCBSTX, BlueCare Dental Connection works to identify members with these select medical conditions. Educational material is mailed to members about regular dental care and the early diagnosis of periodontal disease.

Member Empowerment

As always, treatment decisions remain between members and their providers. Coverage for treatments varies depending on the member’s benefit plan.

Call Today

For more information about BlueCare Dental Connection, contact your local BCBSTX representative or log in to our website at bcbstx.com. Some features are provided by independent companies.
Online Tools and Resources

Work faster and simpler with online tools and resources tailored for Blue Cross and Blue Shield of Texas (BCBSTX) producers. BCBSTX provides a broad range of online tools and information combined with customer service excellence to more than 12,000 producers/business partners. Our websites are designed to help each producer develop and maintain BCBSTX business.

The producer section provides a variety of helpful and timely information — bcbstx.com/producer.

PRODUCT INFORMATION
Read about employer group health products organized by market size: 2-50, 51-150, and 151+ employees.

FORMS
Download forms for groups, small groups, and individual and Medicare supplement categories.

NEWS AND UPDATES
Learn about products, services, online features and important news and announcements that impact you and your accounts.

CONTACT INFORMATION
Find local and regional BCBSTX sales office phone numbers, or look up BCBSTX contact information by product type.

INTEGRATED PROVIDER FINDER
Look up contracting physicians, specialists, hospitals and facilities and dentists.

PHARMACY INFORMATION
Download drug lists and connect to more information about drug costs and network pharmacy locations.

LEGISLATIVE INFORMATION
Stay informed about health care legislation and regulatory requirements such as creditable coverage disclosure, HIPAA, timely notification requirements and more.
Blue Access for Producers℠

Blue Access for Producers is the secure online source for producer tools and information. Obtain quotes, maintain employer groups or view monthly commission statements. Blue Access for Producers is secured to protect your information. Register today to gain access to tools and features that help you conduct your BCBSTX business.

eSALES TOOLS INTRODUCTION

eSales Tools is a suite of applications that help you quote and enroll small groups. You can run instant quotes on all BCBSTX small group products (2-50 employees) and send quotes directly to an employer group without delay. Save time and reduce paperwork by using online enrollment. Please see the eSales Tools section for more detail.

BLUE ACCESS FOR EMPLOYERS℠ GATEWAY

Blue Access for Producers provides a secure gateway directly into Blue Access for Employers℠, allowing you to perform inquiries and maintenance on your fully-insured groups.*

In Blue Access for Employers you can:

• Verify employee eligibility
• Enroll, cancel or reinstate members
• Change member names and addresses
• Add new dependents
• Request ID cards
• View billing information
• Go directly into the Dearborn National secure portal

Commission Statements

View and print your BCBSTX commission statements online. You can also download or export your group and individual under 65 commission data in a variety of formats including Excel and PDF.

Product Information

Product information is also available in the secure producer portal, organized by group size: 2-50, 51-150 and 151+ employees.

Blue Ribbon Producer Bonus Program

Learn more about the Blue Ribbon Producer Bonus Program, developed to reward producers who consistently sell new BCBSTX business and retain existing accounts. Learn about eligibility and benefits and get current program information.

Password Manager

You can manage your own password and add users to your Blue Access portal by using the Password Manager. You can provide specific website features to your associates and maintain your added users.

User Profile

Use the online User Profile section to change your phone and fax numbers, email address or primary and secondary mailing addresses on file with BCBSTX.

Contact Information

Find local and regional BCBSTX sales office phone numbers or look up BCBSTX contact information by product type.

GETTING STARTED WITH BLUE ACCESS FOR PRODUCERS

Sign up today at bcbstx.com/producer. If you have trouble logging in to the site or have questions, please contact the Internet Help Desk at 888-706-0583, Monday through Friday from 7 a.m. to 10 p.m. CT and Saturday from 7 a.m. to 3:30 p.m. CT.

*Gateway access is for fully-insured groups only and access can be controlled by each individual employer group. Producers may notify employers of this service at their discretion.
eSales Tools Applications

eSales Tools automates quoting and enrollment of accounts with 2-50 employees. eSales Tools includes the following components, after logging in to Blue Access for Producers:

1. Quote a Group
2. Track a Group (BlueTrack)
3. Enroll a Group
4. Benefit Plans

QUOTE A GROUP

Quoting generates proposals based on demographics for groups with 2-50 employees. When a user selects Quote a Group on the Producer home page, the Quoting home page opens.

Quoting generates quotes for:
- Small group health plans
- Dearborn National Life short-term disability and life products
- Dental Plans

The Quoting application guides the user through the steps required to prepare a proposal and produce it in PDF format. A user can search for and review the contents of any previously entered proposal. The census is retained for each account. When a user generates additional quotes for an account, Quoting offers the option of using all or part of the previously entered census or entering a new census.

TRACK A GROUP (BLUETRACK)

BlueTrack displays account enrollment status to authorized brokers and internal BCBSTX users. BlueTrack displays all accounts with which the broker is associated, and ensures that the accounts cannot be viewed by another broker.

The Activity column shows the most recently completed activity for an account and provides a link to the Account History page, which contains a log of actions performed on the account, along with the current activity.

The Notes column contains a link to notes entered for the account, such as messages to the broker from BCBSTX staff performing enrollment activities.

The View Workflow Process link in the upper portion of the page displays the entire enrollment procedure or Medical Preliminary Request so the user can determine where an account is in the process.
eSales Tools Applications (CONTINUED)

ENROLL A GROUP
Enrollment uses information from Quoting or Medical Preliminary Request and supplements it with input entered by a broker and/or BCBSTX staff. After all data has been collected, Enrollment releases the account to BCBSTX to undergo internal processing, during which member ID cards will be distributed.

BENEFIT PLANS
Benefit Plans shows available plans according to:

- Effective date
- Plan type
- Network (if applicable) and allows the user to produce a benefit highlight document for a plan in PDF format in either English or Spanish.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Online Tools for Employer Groups and Members

A set of online tools is also available to your employer groups and their employees:

**Blue Access for Employers℠**

Blue Access for Employers enables group administrators to conduct a variety of membership, enrollment, reporting, administrative and billing transactions online. Transactions are secured by login. An online presentation and demonstration is available at bcbstx.com/employer.

### ONLINE, REAL-TIME SERVICES

BCBSTX employer groups can go online to:

- Enroll, cancel or reinstate employees and dependents for coverage
- Check member eligibility
- Change names and addresses for members
- Request ID cards
- Maintain a member’s benefit selection
- Make characteristic or category transfers such as benefit plan changes
- View online activity on a member’s record
- Pay online (premium accounts only)

### KEEP EXPENSES ON TRACK

Blue Access for Employers gives employers tools to track company exposure with easy-to-read report screens that display charges for each coverage category and number of subscribers by tier.

Advanced billing features allow employers to control the way their bills are viewed and managed. Fully-insured groups may also use Online Bill Payment. Member charges are immediately reflected in the amount due on the billing window, which means employers do not have to wait until the next billing cycle to see the impact of member charges.

Secure access to online billing services provides key benefits:

- Reduced review and reconciliation time
- Paperless billing
- Payment scheduling
- Bill summary
- Employee fee adjustments
- Changes since the last bill generated
- Payment and bill history

### FOR ADMINISTRATIVE SERVICE ONLY (ASO) GROUPS

ASO accounts may use the monthly settlement statement feature as a simple reporting tool to help evaluate the group’s settlement statement summary, summary of charges and cash that has been applied with adjustments. Also, ASO accounts can use Online Bill Pay if they receive a weekly invoice online.

### ONLINE REPORTING

Employers (and producers when authorized by their accounts) can access reports using the Blue Insight reporting tool* to view information about their plan design, including health, pharmacy and dental.

Electronic notifications alert employers and producers when a new report is available online. Informative, timely reports keep employers and producers up-to-date on the latest trends in health care costs to assist with making informed decisions about benefit plans.

*Please contact your BCBSTX representative for eligibility information.
Blue Access for Members<sup>SM</sup>

Blue Access for Members gives members secure, confidential access to their BCBSTX health care coverage information.

PERSONALIZED INFORMATION

BCBSTX members can go online to:

- Check claim status and history
- Confirm dependent coverage under the plan
- View and print an explanation of benefits (EOB) for a claim
- Locate network providers and facilities
- Elect claim status email alerts
- Order a member ID card or print a temporary member ID card

DISCOVER BLUE ACCESS FOR EMPLOYERS

Blue Access for Employers is available Monday through Friday, from 6 a.m. to 3 a.m. CT and on Saturday from 6 a.m. to 6 p.m.

If you have trouble using the portal, please contact the Internet Help Desk at 888-706-0583, Monday through Friday from 7 a.m. to 10 p.m. CT and Saturday from 7 a.m. to 3:30 p.m. CT.

WELL ONTARGET<sup>®</sup> EMPLOYER ONLINE TOOL - ONDEMAND EMPLOYER WELLNESS PORTAL

For employee wellness programs to make a difference, employees must be engaged. The ondemand Employer Wellness Portal offers communication and training solutions to help employers get the most out of the Well onTarget program.

The ondemand Employer Wellness Portal delivers an interactive web experience for employers, with access to a rich repository of pre-planned communication materials. Available materials include:

- Wellness calendar
- Pre-built engagement resources
- Training guides
- Comprehensive suite of activity reports

Any or all of these four ondemand categories offer detailed information so that you can develop a customized, turn-key engagement solution that fits your enterprise culture.
**Cost Estimator and Dental Cost Advisor™ Tools**

**COST ESTIMATOR**
The Cost Estimator tool is available for PPO plans. This online tool allows members to estimate costs for common medical procedures.

**DENTAL COST ADVISOR**
Members can use the Dental Cost Advisor tool to research estimated costs of a typical dental procedure. The tool is part of the BCBSTX BlueCare Dental Connection™ website, accessible through Blue Access for Members.

*The Cost Estimator tool is intended for general use only and is not a substitute for medical advice or treatment for specific medical conditions. Members should seek prompt medical care for any specific health issues and consult their physician before taking any action on their health conditions. Use of this online service is subject to the Terms and Conditions.*

**DISCOVER BLUE ACCESS FOR MEMBERS**
Blue Access for Members is available 24/7. Members may contact the Internet Help Desk for assistance at (888) 706-0583 Monday through Friday from 7 a.m. - 10 p.m. (CT) and on Saturday from 7 a.m. - 3:30 p.m. (CT).
Small Group Underwriting

Small Group Medical
Underwriting Guidelines

REQUESTS FOR PROPOSAL
BCBSTX will provide timely, competitive responses to requests for proposal (RFPs) received through eSales Tools, fax or email. The following guidelines will help you prepare quote requests for small group (2–50) business, and obtain the most accurate prescreen rates possible.

EMPLOYER SIZE FOR RATES
For rating purposes, size will be determined by the total number of employees. The following formula can be used to determine whether a group is eligible to be rated as a small group (2–50).

Senate Bill 1332 defines a “small employer” as a person who employed an average of at least two employees but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

Total number of employees on payroll
+ New hires not yet on payroll
  – Terminated employees
  – 1099 (Contract employees)

= Result

A result between two and 50 indicates that the business is a candidate for small employer group coverage.

A result greater than 50 indicates that the business may not be a candidate for a small group coverage plan. Please contact the Small Business Service Center (SBSC) at 800-399-5831 to discuss other coverage options.

ELIGIBLE EMPLOYEE DEFINITION
An eligible employee is defined as:

An employee who works full time and who usually works at least 30 hours a week. The term also includes a sole proprietor, a partner or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small or large employer. The term does not include: an employee who works on a part-time, temporary, seasonal or substitute basis, or an employee covered under:

• Another group health benefit plan
• A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.)
• The Medicaid program, if the employee elects not to be covered
• Another federal program, including the CHAMPUS program or Medicare program, if the employee elects not to be covered
• A benefit plan established in another country if the employee elects not to be covered

ADDITIONAL CONSIDERATIONS

Subsidiaries
When determining whether a group is large or small, special importance is placed on whether the group is a subsidiary or has a financial relationship with another entity or has subsidiaries of its own.

DATA REQUIREMENTS
Whether you are generating proposals directly from eSales Tools or submitting quote requests by email or fax, you can expect the best possible results when all of the following required data is included with your request:

Company Information
• Business name and address
• The four-digit Standard Industry Code (SIC) - required for Life only
• Employer Identification Number (EIN) –
  Note: the EIN is preferred for quotes, but will be required to enroll a sold group
• Public entity designation (if applicable)
• Do mental health parity regulations apply? (Did you employ an average of more than 50 total employees, including full-time, part-time seasonal or partners, in the preceding calendar year?)
Small Group Medical Underwriting Guidelines (CONTINUED)

CENSUS DATA
The preferred format for submitting a census is Microsoft Excel, which allows BCBSTX to process requests more quickly than with other formats, such as PDFs.

Each census should include all eligible participants, including:
- COBRA and continuation-eligible participants, whether applying for or declining coverage
- All those applying for or declining coverage; please remember to include:
  - New hires
  - Employees serving the new hire waiting period
  - Employees with other group or individual coverage
  - Employees covered by Medicare

Retirees are not eligible for BlueChoice (2-50 group coverage) options.

Group rates will be determined based on demographic characteristics (group location, age, county, effective date, plan design) provided to BCBSTX. The Underwriting department will make final rate determination.

Include the following data for each employee:
- Name
- Gender of employee and dependents
- Dates of birth for employee and dependents
- Home ZIP code of employee and/or dependents, if different
- Salary – if a quote for life, short- or long-term disability coverage based on salary is requested
- Type of coverage, including coverage code*
- Employee status (full-time, part-time, in waiting period, declining/other coverage, COBRA participant)

*RISK DATA FOR MEDICAL UNDERWRITING
BCBSTX small group underwriting guidelines were developed specifically for the underwriting of small groups and provide allowances for gradations of more serious medical conditions. A group’s medical rating reflects consideration of potential expected claims, potential complications and/or costs for other conditions that may be associated with the original condition.

Groups are underwritten on a whole group basis. This means when medical conditions are evaluated, the risk is spread evenly to the entire group. Individuals cannot be asked or compelled to decline coverage by the group, producer or carrier. The entire group’s risk characteristics will be evaluated based on BCBSTX small group underwriting standards. This evaluation will determine the medical load to be assessed for the group. The medical load will be used to determine the appropriate rates for the small group.

To determine the appropriate rates, the Underwriting department will assess the risk based on the information provided to BCBSTX. These conditions may represent an increase to the solicitation rates, but may not result in declination of group coverage. BCBSTX reserves the right to use all information available to assess the risk.

RATING POLICY
Proposal rates will not be approved until the Underwriting department has evaluated all enrollment materials. Premium rate adjustments will be made by Underwriting and communicated in writing to the producer.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Small Group Medical Underwriting Guidelines (CONTINUED)

REASONS QUOTED RATES MAY BE ADJUSTED
BCBSTX reserves the right to adjust rates for demographic characteristics and medical risks. Some reasons quoted rates may be adjusted include changes to:

- The requested effective date
- The group’s disclosed Medicare Secondary Payer (MSP) status
- Elected health coverage type
- Addition of HMO options and offers
- Member demographics (dates of birth)
- Group demographic (County Code, ZIP code)

After the group approves the new rates, coverage will be issued.

EFFECTIVE DATE
The effective date of the policy for small group coverage will be the first or the 15th of the month. HMO plans only become effective on the first day of the month. The effective date should not be a prior date, but can be up to 90 days in the future. If no effective date is specified, the following guidelines will be used:

<table>
<thead>
<tr>
<th>IF</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>The RFP is received on or before the 20th day of the month, (Example: June 15)</td>
<td>The effective date used is the first day of the next month, (Example: July 1)</td>
</tr>
<tr>
<td>The RFP is received after the 20th day of the month, (Example: June 21)</td>
<td>The effective date used is the first day of the month following the next month, (Example: August 1)</td>
</tr>
</tbody>
</table>

OTHER CONSIDERATIONS
Other considerations may affect the quoted rates. Include as much information as possible regarding:

TEFRA Mandates
The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) applies when an employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar years.

If TEFRA applies to your prospect, be sure to include that information when submitting the quote request or entering the prospect in eSales Tools.

IN-VITRO FERTILIZATION (IVF)
IVF is an additional mandated benefit that may be added at an additional premium cost.

PEDIATRIC VISION BENEFITS
Pediatric Vision Benefits are available to members of dependents under the age of 19 as an Essential Health Benefits (EHB). These are embedded in each medical plan premium, which is included in the medical rate.

PEDIATRIC DENTAL BENEFITS
The Affordable Care Act (ACA) requires that each employee and dependent (enrolled in applicable medical plan) must have pediatric dental EHB coverage even if that employee or dependent is not eligible for the services. However, employees or dependents who are not eligible for the services will not pay a premium for the coverage.

The law requires pediatric dental coverage as an EHB for non-grandfathered fully insured small group plans and with plan/policy years beginning on or after January 1, 2014. Pediatric dental will be automatically added to ALL regulated small groups (RSG) non-grandfathered (2-50) groups off-exchange. These groups must attest they have this EHB elsewhere for it to be removed. Pediatric dental rates include ACA taxes and fees.

The attestation notice/form confirms that a basic pediatric dental plan will be added to the medical plan if you do NOT attest that you have pediatric dental elsewhere.
General Underwriting Provisions

GROUP ELIGIBILITY

All employees must be on a common payroll, except when affiliated companies are enrolled together. All employers will be required to submit documented proof of employee compensation such as the Texas Wage and Tax Report (sometimes called the TWC Report) or a W-2 or W-4 form. A Texas Supplemental Employment Verification (TSEV) form may be used for those employees not appearing on tax reports (new employees, owners, contract labor). It cannot be used to replace the Texas Wage and Tax Report, or separately to establish proof of employment. Refer to the Small Group Submission/Sold Group Paperwork section for more details on submission requirements.

While the BCBSTX small group program may include participants residing in other states, the majority of eligible employees, as well as the decision maker, must reside in Texas. If participants reside in multiple states and no one state contains a majority of the eligible employees, the primary business location with the largest number of employees, as well as the decision maker, must be in Texas. HMO Blue Texas participants must reside or work in the HMO Blue Texas service area. Requests received for companies with headquarters in Texas that have a majority of employees in a neighboring state can be evaluated for eligibility case by case.

PARTICIPATION REQUIREMENTS

To meet the employee participation requirements of the small group (2–50) program, 75 percent of eligible employees will be required to enroll in the small group coverage plan, unless in special enrollment period 11-15 to 12-15.

Using the formula under Group Size for Rates at the beginning of this section to determine whether the enrollment census meets the small group (2–50) participation requirement.

Total number of employees on payroll:

+ New hires not yet on payroll
  − Part-time employees (i.e., employees who work less than 30 hours per week)
  − Seasonal employees
  − Temporary employees
  − Employees with other coverage
  − Terminated employees

= Result

The result multiplied by .75 equals the number of employees who must enroll in the small group coverage plan. The number of employees who must enroll is reported as a whole number that is always rounded down.

Example:

<table>
<thead>
<tr>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total employees on payroll</td>
<td>75</td>
</tr>
<tr>
<td>New hires (not yet on payroll)</td>
<td>2</td>
</tr>
<tr>
<td>Part-time employees</td>
<td>30</td>
</tr>
<tr>
<td>Seasonal employees</td>
<td>0</td>
</tr>
<tr>
<td>Temporary employees</td>
<td>0</td>
</tr>
<tr>
<td>Employee declining because of having other coverage</td>
<td>1</td>
</tr>
<tr>
<td>Recently terminated employees</td>
<td>2</td>
</tr>
<tr>
<td>Employees serving the group’s new-hire waiting period</td>
<td>5</td>
</tr>
</tbody>
</table>

= 39 Eligible employees

39 multiplied by .75 = 29.25. The minimum number of employees who must enroll in the small employer group health plan is 29.

BCBSTX reserves the right to: 1) restrict new business enrollment in health insurance coverage to open on special enrollment periods unless 50 percent minimum employer contribution is met and least 75 percent of eligible employees (less valid waivers) have enrolled for coverage; and 2) review participation and contribution on existing business and non-renew or discontinue health coverage if the 50 percent minimum employer contribution is not met and/or less 75 percent of eligible persons (less valid waivers) are enrolled for coverage six consecutive months.

If applicable, BCBSTX reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of employees/subscribers covered changes by 10 percent or more over a 30-day period or 25 percent or more over a 90-day period.

Employer will promptly notify BCBSTX of any changes in participation and employer contribution.
General Underwriting Provisions

VALIDATING ELIGIBILITY STATUS
To validate eligibility status and ensure that the minimum enrollment requirement is met, it is necessary to indicate when employees are declining coverage for themselves and/or their dependents because they have other group coverage. To avoid unnecessary delays, when other group coverage exists, list the members who are declining coverage as well as the other carrier name and effective date in the appropriate data collection field on the Enrollment Application/Change form. If submitting an enrollment spreadsheet, list the names of the insured and of the other group carrier in the comments column. Under certain circumstances, additional documentation (e.g., copies of other carrier ID cards) may be requested.

EMPLOYER CONTRIBUTION
The employer must contribute a minimum of 50 percent of the employee-only health rate and maintain 75 percent of the eligible employees participating in the plan as allowed in the Texas Insurance Code. This contribution helps maintain the required participation levels in the small group plan and ensures reasonable risk spread.

WAITING PERIODS
Each group may select a 0-, 30- or 60-day waiting period for all eligible employees.

Small groups may elect to waive the waiting period upon initial enrollment. Thereafter, waiting periods should only be changed on the group’s anniversary date. The new waiting period will apply to employees hired on or after the effective date of the waiting period change.

Multiple waiting periods (e.g., managerial/professional employees, 0 days; hourly employees, 60 days) are not supported by the small group benefit program.

GROUP CLASSIFICATION
A group’s classification is based on the following:

• A standard group includes all the employees of a single employer.
• A conglomerate (affiliate) includes, for consideration of eligibility, all the employees of a controlling employer and all subsidiaries.

In addition, when determining whether a group is large or small, special attention will be paid to whether the group is a subsidiary, has a financial relationship with another entity or has subsidiaries of its own. Articles of incorporation and a site-specific Texas Wage and Tax Report do not prove that a small group is a stand-alone entity. If financial statements include other entities, then all entities involved need to be included in the group review for a small employer group plan.

Example: ABC Corporation has five employees on its Texas Wage and Tax Report and articles of incorporation in Texas. However, ABC Corporation would like to offer COBRA because it has a parent company in another location that would make ABC subject to COBRA. In determining whether this group is a small employer, all locations that would be involved in the COBRA determination, and that have the same federal tax ID number, must be considered.

MATERIAL CHANGES TO EXISTING GROUPS

New Ownership
If a group comes under new ownership, the group’s coverage will be subject to review, including the possibility of a change in rates or benefit plan if the new owner wants to continue coverage. All affiliates must be considered in the rate determination process.

Group Audits/Certification
Groups may be selected for audit of payroll records to confirm eligibility, employee participation and employer contribution. BCBSTX may require the group to complete a recertification prior to renewal to ensure the group continues to meet contract guidelines. Recertification will be conducted at random or based upon enrollment changes within a group.

When insurance regulations are revised, BCBSTX reserves the right to implement new requirements in procedures without prior revision of all guides.

In some cases, BCBSTX may notify the group about participants that BCBSTX believes are ineligible for the coverage purchased. If proof of eligibility cannot be confirmed, BCBSTX may void the coverage. Any benefits paid on behalf of an ineligible participant will become the responsibility of that individual. To approve and maintain coverage of eligible participants, enrolled groups will be responsible for providing BCBSTX accurate eligibility and enrollment data.

It is the group’s responsibility to maintain the required employee participation level. If the participation of the enrolled group falls below the minimum enrollment requirements, a cancellation notice will be issued on the anniversary date and no renewal offer will be extended to the group.
Small Group Underwriting

General Underwriting Provisions (CONTINUED)

Increasing Enrollment
Each group is reviewed on its anniversary date to determine continued eligibility under the small group program. Groups that have increased in size and appear to no longer meet the definition of a small employer will be notified upon renewal.

These groups may continue their current coverages as long as there is no change to their existing contracts; therefore, no optional plans will be provided at renewal. If a group changes benefits or carriers, it will no longer be governed by the small group program.

Decreasing Enrollment
If a large employer appears to meet the definition of a small employer on its anniversary date, the group will be notified upon its renewal. These groups may continue their coverage in the large group category as long as there is no change to their existing contracts. Any benefit changes will require these groups to purchase one of BCBSTX’s current small employer options.

Group Cancellation
Under the following situations, group termination/cancellation will occur following a 31-day advance notice:

• Noncompliance with the small group employer plan provisions, which include maintaining a minimum participation of 75 percent enrollment of the eligible employees and a minimum employer contribution of 50 percent of the employee-only health rate.
• Fraud or misrepresentation by the small group employer.

Group Termination
• Nonpayment of premiums will cause group termination to be effective on the last date for which a premium was paid.
• Enrollment of less than two employees for any period of six consecutive months may result in termination on the next renewal date.

Employer-Requested Termination
The employer may terminate coverage by giving BCBSTX 31 days’ advance written notice. Such termination is to be effective on the date specified in that notice, provided that the premium is paid through the specified date. The HMO Blue Texas contract may be terminated by the employer with a 60-day written notice.

RENEWALS

Renewal Notification
A group’s renewal date will ordinarily be assigned as the anniversary of the original effective date. The renewal package, which includes renewal rates, optional plans and updates on applicable product and legislative changes, will be released to the group at least 60 days prior to the renewal date. A copy is also sent to the producer of record.

Grandfathered Groups - Renewal Rating Factors
The following four rate change components, or renewal rating factors are included with each annual renewal. Remember to multiply, not add, to arrive at the total rate change.

• Health status: Claims experience has relatively low significance in small group renewal ratings. Instead, diagnoses on filed claims are used to assess the risk for future claims and predict health status for the upcoming plan year. If a diagnosis represents a higher- or lower-than-average risk, then that impact will be noted in the health status rate change component.
• Demographics: Census or other changes since the group was last rated are reflected in the demographics rate change component.
• Manual without trend: Changes to the base rate that reflect changes in the value of the benefit plan
• Trend: Forces within the marketplace, like medical cost inflation and increased usage, that become part of the formula that determines rates. Other factors that can drive trend include the economy, health trends and new technology.

Claims experience is a very small part of BCBSTX’s small group renewal calculation and it is important to note that the state-mandated claims vs. premium report does not provide all of the information taken into consideration.

Effective Date of Rates
Renewal rates are effective for the 12-month period beginning with the group’s anniversary date.

Benefit Changes at Renewal
Groups may elect to make plan design changes concurrent with their anniversary dates. Optional plans for health and dental are provided with each renewal.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
General Underwriting Provisions

If a group has more than 50 active subscribers at the time of its renewal, optional plans may not be provided, but may be requested by contacting your BCBSTX representative. Optional plans will be provided if the group still meets the definition of a small employer as defined by TDI. Any changes the group elects should be from the selection of current benefit plans and/or options included with the renewal exhibit. A group may renew its existing plan provided no other benefit or eligibility changes are requested. All benefit changes should be submitted 15 days prior to the effective date of change.

PAPERWORK FOR BENEFIT CHANGES
Groups requesting any of the following changes must submit a Small Group Employer Application for Amendment directly to the Small Business Service Center (SBSC) for processing:

- Benefit plan
- Options and offerings
- Addition of, or changes to dental plans
- Group name (including buy-outs and acquisitions)
- Waiting period
- Anniversary date
- Addition of an affiliate or subsidiary
- COBRA or Medicare Secondary Payer (MSP) status

If a business changes its name, BCBSTX will need the completed Small Employer Benefit Program Application (Application for Amendment). Additional documentation showing that the name change has been filed with the state of Texas may be required.

DUAL OPTION AND TRIPLE OPTION CHANGES
Dual Option and Triple Option plan changes for health or dental coverage require a group census. The census should list each current member and indicate the plan he or she elects, as well as the type of coverage (e.g., employee only, employee and spouse, employee and child(ren), or employee and family). Enrollment Application/Change forms are required for employees applying for new coverage, waiving coverage, cancelling existing coverage, or adding or dropping dependents.

The group’s new-hire waiting period will apply to any new employees applying for coverage.
Small Group Submission/Sold Group Paperwork

Since 1993, Small Group Reform has mandated guarantee issue in the Small Group market as well as rating requirements for both new and renewing groups. Documentation is required to verify that a group qualifies for Small Employer status.

Employer groups must be headquartered in Texas before BCBSTX may write policies. It is the group’s responsibility to provide these business documents to BCBSTX to verify Small Employer status. A Small Employer that is owned by a larger entity is considered a carve out and is not eligible for small group products.

Proof of Business
Examples of acceptable forms of proof of business:

- Most current quarterly wage report from the Texas Workforce Commission (TWC), including the cover page
- All pages of any of the following documents filed with the state:
  - Articles of incorporation
  - Articles of organization
  - Certificate of organization
  - Certificate of limited partnership
  - Limited liability company organizational documents

Other Records to Document a Business Entity
The following documents and records may also be requested to document a business entity when there is no TWC:

1. Building lease
2. W-4 forms for new employees
3. Documentation of contractor agreements (e.g., 1099 forms or copies of independent contractor agreements)
4. Copies of bills indicating the business operating under the name submitted as the legal company name for application purposes
5. Income tax filing (if the Texas Wage & Tax Report is not filed; as in the case of a family business). This is used to substantiate that the group is truly a business and/or part of a larger business entity.

Other documents may be accepted as proof of business. Those listed here are examples of commonly used proof of business documentation. When submitting other legal business documents, please ensure that the document(s) clearly address the following factors:

- Is the group incorporated in the state of Texas? If not, what is the Texas connection?
- Is the group a foreign corporation?
- Does the document suggest that the group has a parent company? If so, the group is considered a carve out and is not eligible for Small Group products.
- Who is the decision-maker? Is he or she enrolling? If not, why?

Other documents may be accepted for proof of business. Those listed here are the examples of commonly used proof of business documentation. If you have questions concerning the documentation, call 800-399-5831.
**Proof of Wages and Texas Supplemental Employee Verification Form**

**Examples of Acceptable Forms of Proof of Wages:**
- The quarterly wage report from the TWC
  - OR
- The most recent quarterly payroll reports, which must show the company name and the number of employees for each month in the prior quarter; (at least three months)
  - OR
- W-2s for existing employees and W-4s for new hires (boxes 8 and 10 on each W-4 are required)
- When a new hire is acquired to establish two eligible employees, 30 days of payroll is required for the new employee
- 1099 forms are an acceptable proof of wages for contract employees.
  - Groups must have one eligible enrolling employee prior to offering coverage to a 1099 employee
  - If the employer offers coverage to 1099 employees, these employees would follow the same eligibility requirements as W2 employees

On any employee listing (for example, the quarterly wage report) please indicate employees who are part-time, seasonal, or terminated.

A Texas Supplemental Employment Verification (TSEV) form is required when an owner or other individual is employed, but not listed on the TWC wage report, or a payroll report.

**WAGE AND TAX REPORT**

When submitting Wage and Tax Reports, please confirm that the following information is included:
- Federal Information Page (page 1), which provides the total number of employees for the three months of each quarter
- Texas address
- NAICS/SIC codes that match the NAICS/SIC codes provided on the Small Group Employer Application
- Employer name that matches the legal name of the group
- Each listed employee identified as full time, part time, seasonal, temporary, covered by other group coverage or terminated; applications or waivers must be submitted for all eligible employees on the list

**Also Consider:**
- Out-of-state employees will not be listed on the Wage and Tax Report. The group must submit a Wage and Tax Statement for these employees from the state in which they work.
- Is there any information that indicates that the group might be part of a larger entity? If yes, then the group is a carve out and is not eligible for small group products.

**PAYROLL RECORDS, W-2s AND W-4s**

When submitting payroll records, W-2s and W-4s, please confirm that the following information is included:
- Where and by whom is the payroll issued?
- Does it verify the number of employees enrolling?
- Does the name of the employer match? This is of particular importance when using payroll records for proof of employment.
- Does the employer information on the W-2 and W-4 include the employer’s name and address?
In addition to proof of business and proof of wages, the following documents are required for new group submission:

**Small Employer Benefit Program Application (BPA)**
- Each field must be completed.
- Page 1 asks for the legal name of the company. The legal company name provided on this document should be consistent with the company name on all other documentation provided. An assumed name certificate is needed if the company name on proof of business documentation does not match the legal company name.
- The Small Employer Benefit Program Application and the Employer Group Information form included with it have multiple references to the total number of employees. Please make sure that all these responses match.
- An employer group executive may be aware of the group having an ERISA plan year that is different from the group’s requested health care contract effective date. If that is the case, please indicate the ERISA plan year.

**Employee Enrollment Applications**
- Each field in the Enrollment Application/Change Form must be completed. Agents should review employee applications and obtain any missing information before submitting them to BCBSTX.
- Validate the following sections for consistency: Select your Coverage, Coverage Options and Declination of Health Coverage.
- All fields in the Previous Coverage Information section must be completed in order for employees to receive credit for prior coverage.
- When completing the Declination of Health Coverage section, ensure that the reason for declining coverage is selected when appropriate.
- For continuation coverage, two (2) forms must be submitted per applicant: the Enrollment Application/Change Form and one of the following:
  - COBRA Application (group must be COBRA eligible)
  - Texas Nine (9) Month State Continuation Application (group is not COBRA eligible)
  - Dependent State Continuation Application (18-36 months due to retirement, death or divorce)
  - Texas Six (6) Month State Continuation Application (COBRA coverage exhausted)

**Signed Small Group Proposal**
Please submit the page from the proposal that includes the group administrator’s signature, the date and the plan(s) selected.

**Employer Group Information Form** *(included with the BPA)*
- Each field must be completed
- The Small Group Employer BPA and the Small Group Information form have multiple references to the total number of employees. Please make sure that all of these responses match

**Proxy** *(included with BPA)*
The proxy should be completed by employers so that the Health Care Service Corporation Board of Directors can act on the member’s behalf at board meetings.

**Premium Payment Check**
- A check from the small employer group business should be made payable to Blue Cross and Blue Shield of Texas, or BCBSTX, for the health/dental premium. When life coverage is purchased, a separate check for the premium payment should be made to Dearborn National Life Insurance Company.
- Temporary checks are not preferred, but will be accepted if necessary.
- Provide an explanation if the company’s address on the check is out of state.

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
The following examples may also be helpful in illustrating small employer status and documentation requirements. Underwriting will verify groups applying for Small Group coverage using the documentation received, Dunn and Bradstreet (sbs.dnb.com) and the Internet when needed.

**Professional Employer Organization (PEO)/Staff Leasing**

- BCBSTX will accept a group that is a PEO if:
  - The enrollees are verified employees of the PEO
  - The number of eligible employees does not exceed 50
  - The enrollees are not a client group or part of a client group of the PEO

No client groups will be added after the PEO coverage is issued (a client group uses services provided by the PEO).

Assuming that eligibility and participation requirements are met, BCBSTX will accept a group that is contracted with a PEO and applying for coverage independent of the PEO. In some instances BCBSTX may request the PEO/Client agreement or PEO/Client agreement termination letter.

**Sole Proprietorship**

A sole proprietorship has one owner. If an owner elects to cover their spouse, the spouse must be an employee of the company and proof of wages for the spouse, from the company, is required.

One form of proof of business is needed. Examples of acceptable forms are listed in the proof of business section. Some additional proof of business documents that might be unique for sole proprietors are listed below:

- Profit or loss from business (IRS Form-Schedule C)
  OR
- Net profit from business (IRS Form-Schedule C-EZ)
  OR
- Self-Employment Tax Schedule SE (IRS Form-Schedule SE)

**Small Employer Health Coalitions**

The 78th Texas Legislature enacted legislation that authorized small employer health coalitions – another type of the private purchasing cooperatives addressed in the Texas Insurance Code. These coalitions are limited in size to 2–50 eligible employees, just like a single small employer, and, accordingly, the law extends to them the protection of the small employer law.

**PAPERWORK REQUIRED**

- A copy of the Small Employer Health Coalition’s organizational documents approved by the Texas Secretary of State and filed with the Texas Department of Insurance (TDI)
- A copy of the Small Employer Health Coalition’s bylaws
- An employer application filled out by the Small Employer Health Coalition
- An employer application completed by each entity in the Small Employer Health Coalition
- Appropriate documentation verifying that each entity in the Small Employer Health Coalition is a small employer by TDI definition (i.e. Texas Wage & Tax Report for each entity)

**UNDERWRITING GUIDELINES**

- Each entity in the Small Employer Health Coalition must meet the TDI definition of small employer.
- The Small Employer Health Coalition as an aggregate must meet the TDI definition of small employer.
- Each entity in the Small Employer Health Coalition must contribute a minimum of 50 percent toward the employee-only premium cost.
- Each entity in the Small Employer Health Coalition must enroll a minimum of 75 percent of the eligible employees.
- All entities in the coalition must apply for coverage.
- Current BCBSTX group customers could re-apply for coverage as part of a coalition and be subject to the same underwriting requirements.
- Once the Small Employer Health Coalition has enrolled with BCBSTX, the coalition cannot add a new entity to the existing coalition during the plan year or at renewal; however, an employer group can leave the coalition and reapply with BCBSTX as an individual group. Note: New hires and dependents who are eligible for the benefit program for individual entities currently a part of the coalition can be added at the appropriate contractual time. One bill will be sent to the Small Employer Health Coalition and one payment in full for the entire premium will be received by BCBSTX from the coalition. The coalition billing can be set up in sections to better identify each employer entity in the coalition.
Small Employer Health Coalitions

(CONTINUED)

- Corporate delinquency rules will be applied to the Small Employer Health Coalition.
- Current Small Group guidelines for re-rating of premiums due to significant changes in enrollment will apply to the Small Employer Health Coalition.
- The Small Employer Health Coalition will be given only one product plan option (i.e., PPO, HSA, HMO, MOP, Dual Option or Triple Option).
- The Small Employer Health Coalition will be rated in aggregate by combining demographics of all entities participating in the coalition.

STANDARD INDUSTRIAL CLASSIFICATION (SIC): (also known as Standard Industry Code)

If commonly owned multiple companies are being combined under one group policy, then the SIC for the company with the highest number of enrolling employees will be used.
Mid-Market (51-150) Group Underwriting

Requests for Proposal

BCBSTX will provide timely, competitive responses to requests for proposal (RFPs) received through your BCBSTX representative. The following guidelines will help you prepare quote requests for mid-market (51-150) business, and obtain the most accurate rates possible.

BCBSTX will respond to multiple RFPs received for prospects without designated agents of record. When multiple quote requests are received, all resultant proposals will be released with consistent rates; therefore, all submitted proposal data will be reviewed for consistency before a proposal is released. BCBSTX Underwriting will research any variations in the submitted RFPs, including any medical conditions, and your BCBSTX representative will coordinate with you as necessary to achieve consistency.

Group Size for Rates

For rating purposes, group size will be determined by the number of eligible enrolled employees.

Senate Bill 1332 (SB1332) defines a “large employer” as a person who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

Use this formula for groups that employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

Total number of employees on payroll:
(includes those in waiting period)

- Part-time employees (less than 30 hours per week)
- Employees declining due to other coverage

= Result

A result between 51 and 150 indicates that the business is a candidate for a mid-market (51-150) proposal.

If the result is 50 or fewer, then the RFP and census may be required to be submitted for a Small Group (2-50) proposal. If the result exceeds 150, the RFP and census may be required to be submitted for a large group proposal. Please contact your BCBSTX representative.

Eligible Employee Definition

For the purposes of determining group size, an eligible employee is defined as an employee who works full-time and who usually works at least 30 hours a week. The term also includes a sole proprietor, a partner and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small or large employer. The term does not include an employee who works on a part-time, temporary, seasonal or substitute basis, or an employee covered under:

- Another group health benefit plan
- A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.)
- The Medicaid program, if the employee elects not to be covered
- Another federal program including the CHAMPUS program or Medicare program, if the employee elects not to be covered
- A benefit plan established in another country if the employee elects not to be covered
**Additional Considerations**

**SUBSIDIARIES**
When determining whether a group is large or small, special importance is placed on whether the group is a subsidiary, has a financial relationship with another entity or has subsidiaries of its own.

**RFP DATA REQUIREMENTS**
Your BCBSTX representative will need the following data to provide you with the most timely, accurate proposal possible.

- Group’s name
- Group’s headquarters
- Group’s address, including ZIP code
- Copy of prospect’s current benefits
- Group’s current rates (billing copies accepted)
- Group’s renewal rates
- Claims experience for the current 12 months
- Large claims (more than $15,000) for the current 12 months
- Current three years of carrier history (if less than three years with current carrier, provide prior carrier information to total three years of coverage history)
- Risk data
- Agent of record designation, if applicable

**CENSUS DATA**
The preferred format for submitting a census is Microsoft Excel, which allows BCBSTX to process requests more quickly than with other formats, such as PDFs. Each census should include all eligible participants:

- Full- and part-time employees
- COBRA-eligible participants, whether applying for or declining coverage
- All those applying for or declining coverage; please remember to include:
  - New hires
  - Employees serving the new hire waiting period
  - Employees with other group or individual coverage
  - Employees covered by Medicare

Include the following data for each employee

- Dates of birth for employee and dependents
- Gender of employee
- Type of coverage (employee only, employee/spouse/child/family)
- Home ZIP codes of employee and dependents, if different
- Employee status (full-time, part-time, in waiting period, declining/other coverage, retiree, COBRA participant)

**RISK DATA FOR MEDICAL UNDERWRITING**
Groups are underwritten on a whole group basis. This means when medical conditions are evaluated, the risk is spread evenly to the entire group. Individuals cannot be asked or compelled to decline coverage by the group, producer or carrier. The entire group’s risk characteristics will be evaluated based on BCBSTX group underwriting standards. This evaluation will determine the medical load to be assessed for the group. The medical load will be used to determine the appropriate total rates for the group.

Underwriting will determine the appropriate total group rate based on the risk data provided to BCBSTX. Some conditions may result in a rate adjustment. BCBSTX reserves the right to use all available information to assess the risk.

Group rates will be determined based on risk factors along with demographic characteristics (enrolled census, location, size and industry) and the evaluation of the medical information provided to BCBSTX. The Underwriting department will make final rate determination.
RISK DATA

The main source of medical information is the Risk Data section of the RFP. Sample questions are referenced in the Risk Data Table below. Each question should be answered using information provided by the employer or the employer’s appointee. All information should be provided to the best of the employer’s or appointee’s knowledge of the group’s overall medical conditions.

The employer is responsible for providing complete and accurate information. Nondisclosure of a known medical condition may result in legal consequences. As previously noted, BCBSTX will use any known history or information provided by other sources and from current and prior membership and claims history to assess risk.

### RISK DATA TABLE

For all participants, including active members, COBRA participants, retirees and dependents:

In the past 12 months, has a claim been submitted in excess of $10,000?  
☐ Yes  ☐ No

Note: Group size will determine which statement appears.

- $5,000 (<50 employees)
- $10,000 (50-100 employees)
- $20,000 (100+ employees)

Is any treatment expected in the next 12 months for the above amount?  
☐ Yes  ☐ No

Are any participants disabled or not actively at work?  
☐ Yes  ☐ No

Has any participant been diagnosed as having a high-risk condition?  
☐ Yes  ☐ No

Examples: Cancer, heart-related problems, AIDS, drug abuse, mental/nervous

### Medical Information and Records

BCBSTX Group Underwriting assesses the risk for groups based on the information provided and available to BCBSTX. Information may include, but is not limited to:

- Information submitted during the request for proposal process from all sources.
- Prior and current membership information.
- Prior and current claims information.

BCBSTX does not contact attending physicians or medical providers for medical records. Attending Physicians Statements (APS) are not required for the underwriting groups.

### Rating Policy

A one-year rate guarantee will be in effect; however, groups will be reviewed periodically to determine whether an adjustment for demographics is needed. Rates may be adjusted if a significant change occurs in group size, demographics, SIC code or location.

### High-Risk Medical Conditions

The medical conditions listed in the table below may result in a rate adjustment by addition of a medical load. The list is not all-inclusive and any medical conditions indicated on the Request for Proposal will be evaluated and rated based upon the information provided.

Providing additional details will enable BCBSTX Underwriting to determine the severity of the medical conditions and to more appropriately assess the risk factors. Generally, the more information obtained (e.g., treatment plan, prescribed medications and prognoses), the more accurate the underwriting rating will be. Less detailed information may result in greater assumptions regarding the risk of disclosed medical conditions.

**HIGH-RISK MEDICAL CONDITIONS**

<table>
<thead>
<tr>
<th>AIDS, AIDS Related Complex (ARC), HIV or HTLV Positive</th>
<th>Chronic Bronchitis</th>
<th>Hemophilia</th>
<th>Multiple Sclerosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Abuse</td>
<td>Circulatory Disorders/Peripheral Vascular Disease, Heart Attack (Myocardial Infarction), Pacemaker, Valve Replacement, Stroke</td>
<td>Hepatitis C</td>
<td>Muscular Dystrophy</td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td>Cirrhosis</td>
<td>Kidney Disease/Failure</td>
<td>Paralysis</td>
</tr>
<tr>
<td>Aneurysm (Any location)</td>
<td>Coronary Artery Disease, Angioplasty/Stints, Bypass Surgery</td>
<td>Leukemia</td>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>Cancer, Leukemia, Melanoma, etc.</td>
<td>Cystic Fibrosis</td>
<td>Liver Disease/Disorder</td>
<td>Sickle Cell Anemia</td>
</tr>
<tr>
<td>Cardiovascular Disorders</td>
<td>Diabetes</td>
<td>Lupus (Systemic)</td>
<td>Transplants</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>Emphysema/Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Major Depression, Schizophrenia, Bipolar</td>
<td>Ulcerative Colitis</td>
</tr>
</tbody>
</table>
Product Selection

BCBSTX offers an array of product options that allow you to create the health care benefit plan that is right for your group. Choose from among the standard product categories detailed in the Mid-Market Group (51–150) Products section of this toolkit to create a benefit plan portfolio that best suits the employer’s needs.

Keep the following guidelines in mind when creating dual, triple, or multiple option plan portfolios:

- **Dual Option PPO** – Any two PPO or HSA plans. Four-tier Rx plans can be paired with another four-tier plan or an HSA.
- **Dual Option PPO (Enhanced Rx)** – Any two Enhanced Rx plans. Enhanced Rx plans can be paired with an HSA plan.
- **Multiple Option Product (MOP)** – One PPO, HSA or HCA plan (excluding Enhanced Rx and four-tier Rx plans), and an HMO plan
- **Triple Option Product** – Three HSA and/or HCA plans are allowed; one of the following is required: HSA, HCA, or PPO plans RM32, RM33 or RM34. Only one HMO plan is allowed.
- No Enhanced Rx plans are allowed, unless all plans are Enhanced Rx or HSA plans or a combination of both.
- Four Tier Rx plans can only be offered with an HSA.

General Underwriting Provisions

**PARTICIPATION REQUIREMENTS**

To meet the employee participation requirements of the mid-market (51–150) group program, 75 percent of all eligible employees will be required to enroll in the group coverage plan.

To determine whether the final enrollment census meets the mid-market (51–150) participation requirement:

**Total number of employees on payroll:**

- COBRA participants
- Retirees
  - Part-time employees (less than 30 hours a week)
  - Employees declining due to other coverage
  - Employees serving the waiting period

**Example:**

144 Total employees on payroll (including employees serving the waiting period)
+ 2 COBRA participants
– 1 Employee declining due to other coverage
– 5 Employees serving the waiting period

Result multiplied by .75 equals the minimum number of employees who must enroll. Report this as a whole number.

**VALIDATING ELIGIBILITY STATUS**

To validate eligibility status and ensure that the minimum enrollment requirement is met, it is necessary to indicate when employees are declining coverage for themselves and/or their dependents because they have other group coverage. To avoid unnecessary delays, when other group coverage exists, list the members who are declining coverage as well as the other carrier name and effective date in the appropriate data collection field on the Enrollment Application/Change form. If submitting an enrollment spreadsheet, list the names of the insured and of the other group carrier in the comments column.

Under certain circumstances, additional documentation (e.g., copies of other carrier ID cards) may be requested.

**EMPLOYER CONTRIBUTION**

The employer must contribute a minimum of 75 percent of the employee-only health rate and maintain 75 percent of the eligible employees participating in the plan. This contribution helps maintain the required participation levels in the mid-market (51–150) group plan and ensures reasonable risk spread.
General Underwriting Provisions

(WAITING PERIODS)
Each group may select a 0-, 30- or 60-day waiting period for all newly eligible employees. Underwriting will review and consider requests for longer waiting periods on a case-by-case basis. When a waiting period has been selected, employees will become effective on the next premium due date following satisfaction of the applicable waiting period.

Groups may elect to waive the waiting period upon initial enrollment. Thereafter, waiting periods should only be changed on the group’s anniversary date. The new waiting period will apply to employees hired on or after the effective date of the waiting period change.

The mid-market (51–150) group benefit program can support multiple waiting periods (e.g., managerial/professional employees, 0 days; hourly employees, 90 days).

GROUP CLASSIFICATION
A group’s classification is based on the following:

- A standard group includes all the employees of a single employer.
- A conglomerate (affiliate) includes, for consideration of eligibility, all the employees of a controlling employer and all subsidiaries.

BCBSTX offers coverage to mid-market (51–150) groups on a total replacement basis; however, consideration is given to the following:

Geographic Carve-Outs are established when a national company headquartered in another Blue Cross licensee service area requests that the population within the BCBSTX licensed service areas be underwritten as a separate policy issued by BCBSTX. Such carve-outs may be considered when the following criteria are met:

- A minimum of 500 employees must be enrolled nationwide.
- A minimum of 100 employees must be enrolled in the BCBSTX licensed service area.
- All in-state locations must be included.
- The group may not be a public entity.
- All employees to be covered must be residents of the BCBSTX licensed service area.
- The carve-out must be a total replacement product for the employees who reside in the BCBSTX licensed service area.
- A decision-maker for the group must reside in the BCBSTX licensed service area.
- The employer contribution must be comparable to the group’s nationwide program and equal to at least 75 percent of the total employee-only coverage premium.
- The minimum enrollment must equal at least 75 percent of all eligible employees.
- The quoted benefit combinations must ensure consistency between HMO and PPO benefit offerings.
- Commissions must be identical for all coverage options offered.
- New members must meet the eligibility criteria.
- The benefit offering must be comparable to the group’s nationwide plan.

Management Carve-Outs are established when coverage is offered only to employees meeting the group’s definition of a management employee. Management carve-outs are reviewed case by case and may be considered when the following criteria are met:

- A minimum of 50 eligible management staff must be enrolled.
- The carve-out must be a total replacement product for all available product options (e.g., HMO, PPO).
- Medical-only coverage options are available for carve-out.
- Standard benefits will apply to accounts with 150 or fewer enrolled eligible employees.
- The employer contribution must equal 100 percent of the employee only coverage premium.
- The minimum enrollment must equal 100 percent of all eligible management employees.
- Retirees are ineligible.
- The group must provide a clear and easily identifiable definition of its management class to facilitate subsequent new employee enrollment.
- All ongoing medical conditions must be disclosed during the RFP process.
Underwriting for Existing Groups

MATERIAL CHANGES TO EXISTING ACCOUNTS

Group Audits/Certification

Groups may be selected for audit of payroll records to confirm eligibility, employee participation and employer contribution. BCBSTX may require the group to complete a recertification prior to renewal to ensure that the group continues to meet contract guidelines. Recertification will be conducted at random or based upon enrollment changes within a group.

In some cases, BCBSTX may notify the group about participants that BCBSTX believes are ineligible for the coverage purchased. If proof of eligibility cannot be confirmed, BCBSTX may void the coverage. Any benefits paid on behalf of an ineligible participant will become the responsibility of that individual. To approve and maintain coverage of eligible participants, enrolled groups will be responsible for providing BCBSTX with accurate eligibility and enrollment data.

It is the group’s responsibility to maintain the required employee participation level. If the participation of the enrolled group falls below the minimum enrollment requirements, a cancellation notice may be issued on the anniversary date and no renewal offer will be extended to the group.

When insurance regulations are revised, BCBSTX reserves the right to implement new requirements in procedures without prior revision of all guides.

Increasing Enrollment

Each group is reviewed on its anniversary date to determine continued eligibility under the existing group program. Groups that have increased in size and no longer appear to meet the definition of a mid-market (51–150) group employer will be notified upon renewal.

- BCBSTX reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the enrolled participation and employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of 50%, and at least a 75% participation of eligible employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or 3) non-renew or discontinue coverage unless the 50% minimum employer contribution is met and at least 75% of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify BCBSTX of any change in participation and Employer contribution.

- BCBSTX reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

- Rates provided assume an enrollment of 75% or greater of the eligible employees (less valid waivers). These rates will only be valid if the final enrolled participation is 75% or greater.

For groups with <75% final enrolled participation

- Rates will be adjusted in accordance with the final participation level and quoted rate factor as follows:

<table>
<thead>
<tr>
<th>Final Participation Level</th>
<th>Rate Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25%</td>
<td>2.50</td>
</tr>
<tr>
<td>25% to 49.9%</td>
<td>1.67</td>
</tr>
<tr>
<td>50% to 74.9%</td>
<td>1.25</td>
</tr>
</tbody>
</table>

- Final enrollment paperwork must be submitted to BCBSTX no later than 30 days prior to the requested effective date to avoid the effective date being deferred to the following month and potentially further impacting rates.

Group Cancellation

Under the following situations, group termination/cancellation will occur following a 31-day advance notice:

- Noncompliance with the employer plan provisions, which include maintaining a minimum participation of 75 percent enrollment of the eligible employees and a minimum employer contribution of 75 percent of the employee only health rate.

- Fraud or misrepresentation by the employer.

Group Termination

Nonpayment of premiums will cause group termination to be effective on the last date for which a premium was paid.

Employer-Requested Termination

The employer may terminate coverage by giving BCBSTX 31 days’ advance written notice. Such termination is to be effective on the date specified in such notice, provided the premium is paid through the specified date. The HMO Blue Texas contract may be terminated by the employer with a 60-day written notice.
Underwriting for Existing Groups  
CONTINUED

RENEWALS

Renewal Notification
A group’s renewal date will ordinarily be assigned as the anniversary of the original effective date. The renewal package, which normally includes renewal rates, alternate benefit plans, and updates on applicable product and legislative updates, will be released to the group at least 60 days prior to the renewal date. A copy is also sent to the producer of record.

Effective Date of Rates
Renewal rates are effective for the 12-month period beginning with the group’s anniversary date.

Benefit Changes at Renewal
Groups may elect to make plan design changes concurrent with their anniversary dates. Optional health and dental plans are normally provided with each renewal.

If a group has fewer than 51 active subscribers at the time of renewal, optional plans will not be provided, but may be requested by contacting your BCBSTX representative and providing information to validate that the group meets participation requirements for a mid-market (51–150) group. Any changes the group elects should be from the selection of current benefit plans and/or options included with the renewal exhibit. A group may renew on its existing plan provided no other benefit or eligibility changes are requested. All benefit changes should be submitted 15 days prior to the effective date of change.

PAPERWORK FOR BENEFIT CHANGES
Groups requesting any of the following changes may submit a written request to their BCBSTX account representative for processing:

- Benefit plan
- Options and offerings (for HMO)
- Addition of or changes to dental plans
- Group name (including buy-outs and acquisitions)
- Waiting periods
- Anniversary date
- Addition of an affiliate or subsidiary
- Medicare Secondary Payer (MSP) status

DUAL OPTION AND TRIPLE OPTION CHANGES
Addition of, or changes to existing Dual Option or Triple Option health or dental plans require a group list. The list will be used to identify which option each employee elects, as well as the type of coverage (e.g., employee only, employee and spouse, employee and child(ren), or employee and family). Enrollment Application/Change forms are required for employees applying for new coverage, waiving coverage, cancelling existing coverage, or adding/dropping dependents.
Glossary of Terms

BestChoice® PPO
Small Group (2–50) plan allowing members access to the BlueChoice network and the highest level of benefits. Members may choose to seek care from a non-network or ParPlan provider and receive a reduced level of benefits.

Blue Access for EmployersSM (BAE)
A set of self-service tools available to accounts on the BCBSTX website that allows groups to perform secure electronic transactions on the Internet.

Blue Access for MembersSM (BAM)
The secure member portal that allows BCBSTX members immediate online access to claims status, ID cards, coverage details and much more.

Blue Access for ProducersSM (BAP)
An online service that allows BCBSTX producers to access product, market and legislative information, and administrative guidelines and materials through the Internet.

Blue Access MobileSM
Provides members with convenient, secure access to the member portal, Blue Access for MembersSM, while on the go via mobile phone. Additional mobile offerings are available to the public including a free, GPS-enabled Provider Finder application (app) and online shopping and quoting tools.

BlueCard®
BlueCard is the system through which claims are processed for members who obtain health care services while traveling or living in another Blue Cross and/or Blue Shield plan’s service area.

BlueCard Worldwide®
An international program that allows individuals traveling or living abroad to receive covered inpatient health care from participating hospitals in countries around the world.

Blue Care® Advisor
A registered nurse consultant assigned to members who are identified through predictive modeling, medical and claims data, etc., to identify opportunities to improve a member’s overall health care experience. Advisors suggest membership enrollment in condition management programs where practical, and inform members of BCBSTX programs and services that may improve the member’s health and reduce future health care spending.

Blue Care Connection®
A patient-outreach program that integrates all individual components of our Medical Care Management Programs, such as condition management, case management and care management.

BlueCare Dental ConnectionSM
A program with a proactive approach that applies knowledge gained from evidence-based dental research. It empowers members to use the consumer-directed tools specific to dental care and dental benefits to make informed decisions about where and when to receive dental care. It also uses condition management programs to target members most in need of dental care.

Blue Chip
The BCBSTX claims system of applications used for adjudicating Health Care Service Corporation medical claims.

BlueChoice®
A managed care program for employers who have more than 50 employees. Provides clients with health coverage through a Preferred Provider Organization (PPO) or other products using the BlueChoice network. No primary care physician is required.

BlueChoice® Network
Statewide provider network for all BlueChoice PPO and BlueEdgeSM plans.

BlueCompareSM
A feature of BCBSTX’s online Provider Finder tool that provides performance information about providers in the BlueChoice network. BlueCompare uses claims and member data to compare physician performance on evidence-based measures. BlueCompare uses data that hospitals report to help compare general acute-care hospitals’ performance and affordability.

Blue Cross
Hospital care services.

BlueEdge HSA®
The health savings account (HSA) offered by BCBSTX. The HSA is integrated for HCSC through different banks. The account can be funded by the employer and/or the employee.
Glossary of Terms

Blue365®
This discount program enables all BCBSTX members to save money on value-added health care products and services that help support healthy lifestyles. These discounts are for health care products and services not usually covered by the benefit plan.

Blue Distinction®
Blue Distinction is a nationwide program that is creating an unprecedented level of health care transparency with two goals: engaging consumers to enable more informed health care decisions and collaborating with providers to improve quality outcomes and affordability.

Blue Line
Blue Line is a dedicated producer service phone line available to assist producers with escalated claims, eligibility and benefits questions concerning group business: 800-971-8212. The number is available Monday through Friday, 8 a.m. to 5 p.m. CT.

BlueOutlook
A Web-based reporting system available through Blue Access for Employers that includes standardized reports with summarized account level information available to all eligible groups.

BlueResource®SM
This communication program is a library of electronic member-targeted messages and artwork files covering health and wellness topics that can assist employers in developing employee health care communications campaigns.

BlueReview
The quarterly BCBSTX electronic newsletter for providers.

Blue Ribbon
The BCBSTX producer bonus program that outlines all the bonus programs and other financial benefits available to appointed and contracted brokers.

Blue Shield
Other professional care services (physician services).

BlueSTAR
The BlueSTAR system is a client/server–based application with a graphical user interface to accounts, billing and membership data. This system provides rapid, reliable, and up-to-date customer information in an online, real-time environment.

BlueTrack
A tracking mechanism in eSales Tools that allows producers and internal HCSC employees to view the enrollment status of small group accounts processed.

BlueWorldwide Expat®SM
A comprehensive system of global medical coverage for active employees and their dependents spending more than six months outside the United States.
Glossary of Terms

Cost Estimator
This online tool is available for PPO plans. It allows members to estimate costs for common medical procedures.

Electronic Data Interchange (EDI) (Availity)
EDI gives medical providers timely access to view, track and monitor claim status reports electronically.

eSales Tools
This application automates the quoting and request for proposal process for small and mid-market groups.

Health Assessment
An online wellness tool. Members complete a questionnaire and receive a report identifying their health risks and strengths, and providing suggestions for healthier living.

HMO Blue® Texas
A health maintenance organization product offered to employer groups of two or more throughout the state.

iEXCHANGE Web
This system allows BCBSTX BlueChoice and HMO Blue Texas participating physicians, professional providers and facilities to process referrals and inpatient certifications.

Provider Finder
This online tool allows members or prospective members to search for any network physician by name, health plan or provider type and find a list of physicians meeting that specific search criteria.

News from the Blues
An electronic communication for producers and employers to keep them up-to-date on the most current BCBSTX and industry topics.

ParPlan
ParPlan is a statewide group of non-network physicians and other practitioners who contract with BCBSTX to offer out-of-network care at a savings to BCBSTX members. Traditional ParPlan providers agree to accept the BCBSTX allowable amount for reimbursement, to file claims for patients, and not to balance bill members for amounts over the copayment, coinsurance and deductible for covered services.

RealMed
A health care technology firm, in partnership with BCBSTX, that offers a one-vendor revenue cycle solution for providers, which begins when a patient schedules an appointment and ends when the participating provider receives payment.
Comprehensive Contact List

**Behavioral Health Services**
*For preauthorization of behavioral health services*

Phone (non-HMO) ..................... 800-528-7264
Phone (HMO Only) ..................... 800-729-2422

**BlueCard**
Phone ............................. 800-810-BLUE (2583)
Online resource: ...................... bcbstx.com

**BlueLine**
Phone ............................. 800-971-8212

**Cobra Administration Services**
*Accounts contracted with HCSC COBRA Administration Services*

Phone ............................. 888-541-7107
Fax ................................. 618-998-2747
Monday-Friday 7:30 a.m. to 5 p.m. CT

**HCSC COBRA Administration Services**
*Correspondence Address:*
(No premium payments please)

**Health Care Service Corporation**
PO Box 1180, Marion, IL 62959-7680

**HCSC COBRA Administration Services**
*Premium Payment Address:*

**Health Care Service Corporation**
PO Box 21026, Tulsa, OK 74121

**VIA OVERNIGHT/CARRIER**

**Bank of Oklahoma**
HCSC COBRA
Lock Box 21026
6242 E. 41st Street, Tulsa, OK 74135

**Online resource:**
Email address for electronic submission of COBRA Enrollment forms or inquiries*
cobra@bcbstx.com

*Applies only to accounts with HCSC Administered COBRA Services*

**Consumer Markets – Individual Products**
Producer Sales and Service Center ........ 800-531-4457
Producer assistance/escalated issues

Producer Service fax line .................. 972-766-0570

**Hallmark Services Corporation Producer Services**

- Claims
- Benefits
- Underwriting
- Membership

Phone ............................. 888-697-0679
Applications ready for Underwriting Fax ........ 888-223-1988

**MAILING ADDRESS FOR COMPLETED APPLICATIONS AND UNDERWRITING CORRESPONDENCE:**

**Blue Cross and Blue Shield of Texas**
Hallmark Services Corporation
PO Box 3236, Naperville, IL 60566-7236

**Producer of Record Changes**
Health Care Service Corporation
Attn: Producer Administration
1020 West 31st Street, Downers Grove, IL 60515
OR Fax to: 918-549-3039

**Online resource:**
Blue Access for Producers ........ bcbstx.com/producer
Hallmark Services Corporation ........ hscil.com
Producer Email Inquiries: . CMproducerservices@bcbstx.com

**Dearborn National**
Group Customer Service ................. 800-778-2281
Group Commissions ...................... 800-352-3935
Group fax ................................ 312-540-3105

**Online resource:**
dearbornnational.com

**Dental Member Customer Service**
Phone ............................. 800-521-2227

**HSA Vendors**
BenefitWallet™ ......................... 866-712-4551
Member Customer Service ............... 877-635-5472

**Online resource:**
Email address for HSA employer support:
HSAEmployerSetup@mybenefitwallet.com

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For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Comprehensive Contact List

HSA Bank®
Phone ....................... 866-357-5232
Monday-Friday 7 a.m. to 9 p.m. CT

Online resource:
Email address for form submissions:
hcsc@hsabank.com

Medicare – Blue MedicareRx (Part D)
Producer Assistance
Phone ....................... 888-723-7423

MAILING ADDRESS:
Blue MedicareRx
PO Box 3897
Scranton, PA 18505-9947

Medicare Supplement Producer Assistance
Phone ....................... 800-366-4236

Member Customer Service (Health and Dental)
• Claim questions
• Benefit inquiries
Phone ....................... 800-521-2227
Monday-Friday 8 a.m. to 8 p.m. CT
Hearing impaired line ................ 800-735-2988
24/7

MAILING ADDRESS FOR MEDICAL CLAIMS AND CORRESPONDENCE:
Blue Cross and Blue Shield of Texas
PO Box 660044
Dallas, TX 75266-0044

Online resource:
Email address for electronic submission of enrollment applications/change forms or inquiries:
marshall_membership_inquiries@bcbstx.com
Blue Access for Members® ........... bcbstx.com

Membership/Eligibility/Group Service Department
Reporting and enrollment service
• Membership additions, changes or cancellations
• Premium billing questions
Phone ....................... 800-445-2227
Monday-Friday 8 a.m. to 6 p.m. CT
Fax ....................... 903-934-6050
903-934-6051
903-923-0340

MAILING ADDRESS FOR ENROLLMENT APPLICATIONS/CHANGE FORMS:
Blue Cross and Blue Shield of Texas
Membership/Eligibility/Group Service Department
PO Box 655730
Dallas, TX 75265-5730

Online resource:
Blue Access for Employers (BAE) ........ bcbstx.com/employer
Blue Access for Producers (BAP) .... bcbstx.com/producer

BAE and BAP Online Technical Services Help Desk
Phone ....................... 888-706-0583
Monday-Friday 7 a.m. to 10 p.m. CT
Saturday 7 a.m. to 3:30 p.m. CT

Preauthorization
Phone ....................... 800-441-9188
Monday-Friday 6 a.m. to 6 p.m. CT
972-783-4475

Premium Billing Questions
Phone ....................... 800-445-2227

PREMIUM PAYMENT MAILING ADDRESS:
Health Care Service Corporation
PO Box 731428
Dallas, TX 75373-1428

PREMIUM PAYMENT OVERNIGHT ADDRESS:
JPMorgan Chase (TX1-0029)
Attn: Health Care Service Corporation
14800 Frye Road, 2nd Floor
Fort Worth, TX 76155

Online resource:
Online payment services available through BAE
bcbstx.com/employer

Prescription Drug Program
(Prime Therapeutics)
Member Customer Service ................ 800-521-2227
Prime Therapeutics ................ 888-282-7545

Prime Therapeutics
MyPrime.com

Producer Service Center
• Producer appointments
• Contracting status
• Commissions
Phone ....................... 855-782-4272
918-549-3039

Producer Email Inquiries: producer_service_center@hcsc.net

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Comprehensive Contact List

Small Business Service Center (SBSC)
Call for:
• Quotes
• New case submission
• Existing group renewals
• Existing group benefit changes
Phone ........................................... 800-399-5831
Fax ................................................. 866-802-7498

MAILING ADDRESS FOR NEW GROUP AND RENEWAL CHANGE SUBMISSIONS:
Blue Cross and Blue Shield of Texas
Small Business Service Center
1001 E. Lookout Drive
Building B, 12th Floor
Richardson, TX 75082

Online resource:
Blue Access for Producers ............ bcbstx.com/producer
Run and track quotes through eSales Tools:
bcbstx.com/producer
Email requests for quotes: sbscquotes@bcbstx.com
Email requests for account information changes:
sbsc_changes@bcbstx.com
Email requests for amendments: sbscamend@bcbstx.com
Email requests for BCBSTX forms and supplies:
sbscsupply@bcbstx.com

Support for Accounts with Employer-Administered COBRA and State Continuation
Membership/Eligibility/Group Service Department
Phone ........................................... 800-445-2227

MAILING ADDRESS FOR GROUP BILLING-COBRA PREMIUM PAYMENTS:
Blue Cross and Blue Shield of Texas
PO Box 660049
Dallas, TX 75266-0049

Online resource:
Email address for electronic submission of COBRA enrollment forms or inquiries:
marshall_membership_inquiries@bcbstx.com

CONTACT LIST FOR LOCAL SALES OFFICES

Midwest Texas Sales
AUSTIN
Phone ........................................... 800-336-5696
Fax ................................................. 512-349-4884
9442 Capital of Texas Highway, North
Suite 500, Arboretum Plaza II
Austin, TX 78759

CORPUS CHRISTI
Phone ........................................... 800-442-1685
Fax ................................................. 361-878-1600
4444 Corona Drive, Suite 120
Corpus Christi, TX 78411

SAN ANTONIO
Phone ........................................... 210-558-5100
Fax ................................................. 210-558-5177
17806 IH 10 West, Building 2, Suite 200
San Antonio, TX 78256

North Texas Sales
AMARILLO
Phone ........................................... 806-371-3052
7901 Wallace Boulevard
Amarillo, TX 79124

DALLAS
Phone ........................................... 800-399-5831
1001 E. Lookout Drive
Building B, 14th Floor
Richardson, TX 75082

LUBBOCK
Phone ........................................... 800-399-5831
5225 South Loop 289, Suite 207
Lubbock, TX 79424

TYLER
Phone ........................................... 800-259-3668
Fax ................................................. 903-535-0398
3800 Paluxy Drive, Suite 540
Tyler, TX 75703

For the most current agent/producer information and materials, log in to our secured portal at bcbstx.com/producer.
Comprehensive Contact List

Southeast Texas Sales

BEAUMONT

Phone .......................... 409-896-0100
Fax ............................... 409-896-0111

2615 Calder Street, Suite 700
Beaumont, TX 77702

HOUSTON

Phone .......................... 800-235-0796
Fax ............................... 713-663-1184

1800 West Loop South, Suite 600
Houston, TX 77027