### Employee Retirement System Consumer Directed HealthSelectSM (CDHS) Plan Quick Reference Guide

#### Major Characteristics

<table>
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<tr>
<th>Benefits, Eligibility, Claims Status or Verification</th>
<th>Claim Reviews, All Correspondence</th>
<th>Prior authorization, Online Approval of Benefits for Select Outpatient Services and Inpatient Admissions</th>
<th>Laboratory Services</th>
<th>Behavioral Health Services (Mental Health and Chemical Dependency)</th>
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<tr>
<td>Employee Retirement System of Texas (ERS) offers a Consumer Directed HealthSelect (CDHS) Plan to its participants. The Consumer Directed HealthSelect (CDHS) Plan offers:</td>
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<tr>
<td>- Eligibility and benefit information may be obtained through availity.com or a web vendor of your choice or call HealthSelect of Texas Provider Customer Service at 800-451-0287</td>
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<tr>
<td>- Verification does not apply to Consumer Directed HealthSelect participants</td>
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<td>- The Review form with instructions is located on the BCBSTX website: bcbstx.com/provider click on the Education and Reference tab, then click on Forms.</td>
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<td>- Access the iExchange Web Application through the BCBSTX website at <a href="http://www.bcbstx.com/provider/tools/iexchange.html">http://www.bcbstx.com/provider/tools/iexchange.html</a></td>
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<td>- Current listings of providers and their NPI numbers are available online through the iExchange Web application or the HealthSelect Provider Finder.</td>
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<td>- For questions or problems, call the iExchange Support Desk 800-746-4614.</td>
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<td>- For case management or to contact the Medical Care Mgmt Dept., call 800-344-2354.</td>
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<td>- For referrals, approval of benefits for select outpatient prior authorizations and inpatient admissions, refer to the iExchange webpage at <a href="http://www.bcbstx.com/provider/tools/iexchange.html">http://www.bcbstx.com/provider/tools/iexchange.html</a></td>
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<td>- Any network service where prior authorization is not obtained by the provider before the service is rendered, the service will be denied by BCBSTX and the participant will be held harmless in all instances.</td>
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<td>- Refer to the Preauthorization/Notification/Referral Requirements List under Clinical Resources on bcbstx.com/provider to determine the services that require prior authorization or referrals or call the iExchange interactive Voice Response (IVR) at 855-896-2701.</td>
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<td>- For additional information, refer to the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual at bcbstx.com/provider. Refer to Section M - Employee Retirement System of Texas (ERS) Participants Benefit Plan using Blue Essentials Network for ERS information.</td>
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<td>- Laboratory Services</td>
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<td>- Magellan Behavioral Health Providers of Texas, Inc. (Magellan) coordinates all behavioral health (mental health and chemical dependency) services for Consumer Directed HealthSelect.</td>
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<tr>
<td>- To obtain prior authorization, check benefits, eligibility, claims status/problems or verification, call Magellan at 800-442-4093.</td>
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<td>- The physician, referring provider or behavioral health professional must contact Magellan to prior authorize all inpatient, partial hospitalization and outpatient behavioral health services.</td>
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<td>- Prior authorization must be obtained prior to delivery of care for behavioral health services.</td>
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<td>- The physician or professional provider is responsible for filing claims.</td>
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<tr>
<td>- Mail claims to: Magellan Behavioral Health Providers of Texas, Inc. Attn: Claims P.O. Box 1659 Maryland Heights, MO 63043</td>
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*To access eligibility and benefits, you must have full subscriber information, i.e., subscriber’s ID, patient date of birth, etc.*

### Behavioral

If subscriber elects, claims are paid by BCBSTX using Blue EssentialsSM providers for in-network benefits and also has out-of-network benefits.

- A high deductible – which is offset by the HSA.
- An HSA account established from which the first of any services incurred may be paid on a 100% basis.
- Preventive/Wellness services from in-network professional providers, facility, and ancillary providers paid at 100% of the allowable fee, separate from the HSA (services may include: physicals, diagnostic tests including lab, radiology and mammograms, and well child care and immunizations).

If HSA funds are depleted, the subscriber would be responsible out of pocket for any remaining deductible or coinsurance.

The Provider Claim Summary (PCS) will notify you of any patient responsibility. The subscriber may be billed for any deductible and coinsurance amount.

To receive network benefits, CDHS participants must receive medical care from a physician, professional provider, facility, or ancillary provider within their applicable network.

Network physicians, professional providers, facility and ancillary providers may only bill CDHS participants for deductibles, coinsurance and non-covered services.

### Network

If the participant has CDHS HSA (Health Savings Account), here are some important features:

- HSA can be funded from ERS, subscriber or both. Amounts for eligible POS expenses are applied to meeting the deductible.
- If subscriber elects, claims are paid by BCBSTX using available HSA account balance until the account is depleted.
- The subscriber may also access their available funds by use of a debit card issued by the HSA administrator.

### Plan offers:

- Employee Retirement System of Texas Consumer Directed Health Select (CDHS) Plan offers:
  - Eligibility and benefit information may be obtained through availity.com or a web vendor of your choice or call HealthSelect of Texas Provider Customer Service at 800-451-0287
  - Verification does not apply to Consumer Directed HealthSelect participants
  - The Review form with instructions is located on the BCBSTX website: bcbstx.com/provider click on the Education and Reference tab, then click on Forms.
  - Access the iExchange Web Application through the BCBSTX website at http://www.bcbstx.com/provider/tools/iexchange.html
  - Current listings of providers and their NPI numbers are available online through the iExchange Web application or the HealthSelect Provider Finder.
  - For questions or problems, call the iExchange Support Desk 800-746-4614.
  - For case management or to contact the Medical Care Mgmt Dept., call 800-344-2354.
  - For referrals, approval of benefits for select outpatient prior authorizations and inpatient admissions, refer to the iExchange webpage at http://www.bcbstx.com/provider/tools/iexchange.html
  - Any network service where prior authorization is not obtained by the provider before the service is rendered, the service will be denied by BCBSTX and the participant will be held harmless in all instances.
  - Refer to the Preauthorization/Notification/Referral Requirements List under Clinical Resources on bcbstx.com/provider to determine the services that require prior authorization or referrals or call the iExchange interactive Voice Response (IVR) at 855-896-2701.
  - For additional information, refer to the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual at bcbstx.com/provider. Refer to Section M - Employee Retirement System of Texas (ERS) Participants Benefit Plan using Blue Essentials Network for ERS information.
- Laboratory Services
- Magellan Behavioral Health Providers of Texas, Inc. (Magellan) coordinates all behavioral health (mental health and chemical dependency) services for Consumer Directed HealthSelect.
- To obtain prior authorization, check benefits, eligibility, claims status/problems or verification, call Magellan at 800-442-4093.
- The physician, referring provider or behavioral health professional must contact Magellan to prior authorize all inpatient, partial hospitalization and outpatient behavioral health services.
- Prior authorization must be obtained prior to delivery of care for behavioral health services.
- The physician or professional provider is responsible for filing claims.
- Mail claims to: Magellan Behavioral Health Providers of Texas, Inc. Attn: Claims P.O. Box 1659 Maryland Heights, MO 63043

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This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual at bcbstx.com/provider.

Refer to Section M - Employee Retirement System of Texas (ERS) Participants Benefit Plan using Blue Essentials Network for ERS information.

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Claims Submission:
- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is 84980.
- For support relating to claims that are being sent to the Availity platform, submitters should contact Availity Client Services at 800-AVAILITY (282-4548).
- For support relating to claims and/or other transactions available on the Availity portal or other Availity platforms, submitters should contact Availity Client Services at 800-AVAILITY (282-4548).
- For information on electronic filing, access the Availity website at availity.com.
- Paper claims must be submitted on the Standard CMS-1500 (02/12) or UB-04 claim form.
- All claims must be filed with the insurer’s complete unique ID number including any letter or 3-digit alpha prefix.
- Duplicate claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.
- If services are rendered directly by the physician or professional provider, the services may be billed by the physician or professional provider. However, if the physician or professional provider does not directly perform the service and the service is rendered by another provider, only the rendering provider may bill for those services. Note: This does not apply to services provided by an employee of a physician or professional provider, e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing physician or professional provider.

ParPlan is a Blue Cross and Blue Shield of Texas (BCBSTX) payment plan under which healthcare professionals agree to:
- File all claims electronically for BCBSTX patients;
- Accept the BCBSTX allowable amount;
- Bill subscribers only for deductibles, cost-share (coinsurance) and medically necessary services which are limited or not covered; either at the time of service or after BCBSTX has reimbursed the provider;
- Not bill BCBSTX for experimental, investigative or otherwise unproven or excluded services; and
- Not bill either BCBSTX or subscribers for covered services which are not medically necessary.

BCBSTX encourages the provider’s office to:
- Ask for the subscriber’s ID card at the time of a visit;
- Copy both sides of the subscriber ID card and keep the copy with the patient’s file;
- Eligibility, benefits and/or verification requests, contact availity.com or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the subscriber’s ID card.
- Claim Status may be obtained through the Availity Claim Research tool or a web vendor of your choice.
- For Claim Adjustments, call Blue Cross and Blue Shield of Texas Provider Customer Service at 800-451-0287**.
- Utilize the Exchange Web application at http://www.bcbstx.com/provider/tools/exchange.html or call 855-896-2701 to obtain: approval of referrals, approval of benefits for select outpatient services and inpatient admissions, maternity notifications, or for notification within 48 hours of an emergency hospital admission. For case management, call the Medical Care Management Department at 800-344-2354.

Provider Record ID and Network Effective Dates:
- A minimum of 30 days advance notice is required when making changes affecting the provider’s BCBSTX status, especially in the following areas:
  (1) Physical address (primary, secondary, tertiary); (2) Billing address; (3) NPI and Provider Record ID changes; (4) Moving from Group to Solo practice; (5) Moving from Solo to Group practice; (6) Moving from Group to Group practice; and (7) Backup/covering providers.
- New Provider Record ID effective dates will be established as of the date the completed application is received in the BCBSTX corporate office. This applies to all additions, changes and cancellations.
- BCBSTX will not add, change or cancel information related to the Provider Record ID on a retroactive basis.
- Retroactive Provider Record ID effective dates will not be issued.
- Retroactive network participation will not be issued.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new Provider Record ID.
- If the provider files a claim electronically and their Provider Record ID changes, the provider must contact the Availity Health Information Network at 800-AVAILITY (282-4546) to obtain a new EDI Agreement.
- For Provider Record ID questions or to obtain a Provider Record ID application, please contact the Provider Services department at 972-996-9610, press 3.

BlueCard (Out-of-State Claims):
- To check benefits or eligibility, call 800-676-BLUE (2583)*;
- File all claims that include a 3-digit alpha prefix on the subscriber’s ID card to BCBSTX (Note: The subscriber’s unique ID number may contain alpha characters which may or may not directly follow the 3-digit alpha prefix);
- File all other claims directly to the Home Plan’s address as it appears on the back of the subscriber ID card;
- For status of claims filed to BCBSTX, contact availity.com Availity or a web vendor of your choice or call the toll-free Provider Customer Service number indicated on the subscriber’s ID card.

*Interactive Voice Response (IVR) system. To access, you must have full subscriber’s information, i.e. subscriber’s ID, patient date of birth, etc.)
**To adjust a claim, you must provide a Document Control Number (claim number)