

HealthSelect of Texas

CONSUMER DIRECTED
HealthSelect SM

Answers to your questions about the HealthSelect transition

On September 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will become the new plan administrator for HealthSelectSM of Texas and Consumer Directed HealthSelectSM. BCBSTX will manage the provider network, process claims, oversee wellness and disease management programs, and provide customer service. ERS will still set the benefits and pay the claims.

How will this change affect me?

If you are enrolled in an HMO, HealthSelect Medicare Advantage or KelseyCare Advantage, this change will not affect you. If you are enrolled in HealthSelect of Texas, HealthSelect Out-of-State, HealthSelect Secondary or Consumer Directed HealthSelect, most of your current plan benefits and requirements will not change. But you may need to take some steps to get the most out of your health coverage.

What do I need to do?

Make sure your PCP and other providers are in the HealthSelect network.

More than 50,000 providers across the State of Texas will continue to be in the HealthSelect network. You will pay more—sometimes much more—if you see a provider who is not in the HealthSelect network. To find out if your primary care physician (PCP) and other providers will be in the HealthSelect network after September 1, go to www.bcbstx.com/hs and click on find a doctor or hospital in the Find a Provider box. Then click on the box that applies to your coverage. Or call a BCBSTX Personal Health Assistant at (800) 252-8039 (see box at right).

- If you're enrolled in HealthSelect of Texas, live and work in Texas, and are not enrolled in Medicare, you must have an in-network PCP. If your current PCP will no longer be in the BCBSTX HealthSelect network, call a BCBSTX Personal Health Assistant to designate a new PCP.
- If you need to schedule a doctor visit or medical procedure on or after September 1, 2017, make sure your PCP and other provider(s) will still be in the network.
- You can nominate a provider to be added to the HealthSelect network. Go to www.bcbstx.com/hs. Click on Publications and Forms, then go to Nominate a Provider.

Submit a Transition of Care form to BCBSTX

Are you receiving care for a chronic illness or an acute medical condition, or are you pregnant and in your second or third trimester? If so, you may be able to continue to receive in-network health care services from your current provider for a certain period after September 1, 2017, even if he or she will no longer be in the HealthSelect network. You need to fill out a Transition of Care form and submit it to BCBSTX. To download the form, go to www.bcbstx.com/hs and click on "Publications and Forms."

Here to help!

For information and answers to questions about the transition, visit BCBSTX online or call!

Go to www.bcbstx.com/hs for general information about the transition. Beginning September 1, you will be able to set up a new online account to get access to your personal information at www.healthselectoftexas.com.

Call (800) 252-8039 toll-free, Monday - Friday 7 a.m. - 7 p.m. CT or Saturday 7 a.m. - 3 p.m. CT. Either over the phone or by live chat, a Personal Health Assistant can support you by:

- helping you find a PCP, specialist or other provider in the BCBSTX network;
- finding out whether your provider or scheduled service requires a referral or prior authorization;
- checking the status of your referrals and prior authorizations;
- providing you with information about your plan's benefits and coverage;
- giving you cost estimates for health care services or procedures before you go to the doctor or hospital;
- scheduling appointments for you; or
- connecting you with a nurse to help you take care of your health when you have received a diagnosis or if you are managing a medical condition.

What if I need to go to the doctor or file a claim before September 1?

Through August 31, 2017, you should continue to use your UnitedHealthcare ID card when you see a doctor or other provider. For individual information about your coverage or claims, log on to your UnitedHealthcare online account or call UnitedHealthcare Customer Service at (866) 336-9371 (TTY: 711). BCBSTX will not have access to individual information until September 1, 2017.

Will this change affect my pharmacy benefits?

No. OptumRx will still be the plan administrator for prescription drug coverage for HealthSelect of Texas and Consumer Directed HealthSelect after September 1, 2017.

When will I get new ID cards?

In late August, BCBSTX and OptumRx will send you and your dependents separate ID cards for medical and prescription drug coverage to use starting September 1, 2017. You should continue to use your current combined health and prescription ID card through August 31, 2017.

What if I currently have a referral to see a specialist or prior authorization for care?

Referrals and prior authorizations issued by UnitedHealthcare before September 1, 2017, will be transferred to BCBSTX. If the provider is still in the HealthSelect network, referrals and prior authorizations will be honored through the original expiration date. For specialists who will no longer be in the network, referrals and prior authorizations will be honored for 90 days or the end date of the referral, whichever is sooner. After September 1, 2017, all new referrals and prior authorizations will need to be issued by BCBSTX.

What if I am currently enrolled in a care management program for diabetes or another health condition?

If you are currently enrolled in a care management program with UnitedHealthcare, you will automatically be enrolled in a BCBSTX care management program. You will receive a letter to tell you that you have been enrolled, but you can opt out of the program. You may receive a phone call from a BCBSTX nurse. The nurse will review your care plan with you and answer any questions you may have.

Will wellness programs like Real Appeal still be available?

Beginning September 1, you will have access to several wellness program options.

- If you are eligible, you and your covered dependents (18 or older) will be able to choose between two different online weight loss programs: Real Appeal or Naturally Slim. These programs were designed to help you feel better, have more energy and cut your risk for many health conditions.
- Wellness coaches will support you with information about nutrition, fitness, exercise and stress management.
- The Well onTarget wellness website will offer tools to help you set and reach your wellness goals.
- The HealthSelect Fitness Program will give you access to more than 9,000 fitness centers nationwide.
- With Blue PointsSM you will be able to earn points for participating in wellness activities. You will be able to redeem the points in an online shopping mall.



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2017 Summer Enrollment

ACTIVE EMPLOYEE GUIDE



2017 Summer Enrollment dates: June 26-July 28, 2017

Your agency or institution is in one of four phases during Summer Enrollment. Please make your benefit changes during your two-week phase, which is listed on your Personal Benefits Enrollment Statement.



Summer Enrollment is the only time of year you can make benefit changes unless you have a qualifying life event, like the birth of a child, marriage or divorce. For more information, visit www.ers.state.tx.us/Employees/Life-Events/.

The State of Texas offers a valuable benefits package to help protect your health and secure your future. As an active state agency or higher education institution employee, you have the chance to make changes to your benefits during Summer Enrollment.

Even if you don't think you want to make any changes, be sure to read this booklet and learn more about your options and any changes for Plan Year 2018. You are responsible for understanding how your benefits work and how your decisions may affect what you pay for health care and other benefits.

What can you do during Summer Enrollment?

- ☐ Switch your health insurance coverage. As an active employee, you can switch between HealthSelectSM of Texas and Consumer Directed HealthSelectSM. If you live or work in a county served by an HMO, you also have the option of switching between a HealthSelect plan and an HMO. For information about your health insurance options, see pages 4-6. A chart comparing coverage is on pages 8-9.
- ☐ Add or remove dependents from your coverage. If you have not already, you will need to verify that each dependent you add to your medical insurance is eligible for coverage. If you don't verify each dependent, he or she will be removed from all coverage (Medical, Dental, Vision and/or Dependent Life). For more information, see page 3.
- ☐ Add or drop vision and dental coverage for yourself and your dependents. For information about vision and dental options, see pages 10-12.
- ☐ Enroll in a TexFlex flexible spending account or change your contribution level. You have the option of enrolling in accounts for health care; dependent day care; parking and transit costs for your commute to work and, if you enroll in Consumer Directed HealthSelect, a limited flexible spending account to pay for eligible vision and/or dental expenses. Flexible spending accounts lower your taxable income to save you money. See page 13.
- ☐ Apply for, increase, decrease or drop life insurance coverage. If you want to enroll in or increase your coverage, you will need to provide evidence of insurability. See page 14.
- ☐ Apply for or drop a dependent term life insurance plan for your dependents. You will need to provide evidence of insurability for each new dependent. See page 14.
- ☐ Enroll in, increase or drop Voluntary Accidental Death & Dismemberment (AD&D) coverage. Evidence of insurability is not required. See page 14.
- ☐ Apply for or drop short-term or long-term disability coverage. To enroll, you will need to provide evidence of insurability. See page 15.
- ☐ If you're enrolling in health insurance for yourself or a dependent, certify tobacco use or non-use. This certification is required when you enroll in health insurance through ERS, and it's legally binding. If you have already certified tobacco-use status, you do not need to re-certify unless the status has changed for you or your dependents. You can change your status at any time during the plan year. For more information, including alternatives to the tobacco user premium, see page 6.



If you are a return-to-work retiree, you can switch between retiree and active benefits by contacting your agency's benefits coordinator or Human Resources office. If you work for the Health and Human Services Commission Enterprise please contact the HHS Employee Service Center before July 28.



What's new!

- Beginning September 1, 2017, Scott & White Health Plan will no longer be available as a health plan option if you live or work in the following counties: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Reagan, Runnels, Schleicher, Sterling, Sutton and Tom Green. If you live or work in one of these counties and are currently enrolled in Scott & White Health Plan, you will automatically be enrolled in HealthSelect of Texas unless you enroll in Consumer Directed HealthSelect during Summer Enrollment. You should have received a letter to notify you of this change.
- The IRS has increased the contribution limits for TexFlex health care and limited flexible spending accounts from \$2,550 to \$2,600. If you want to increase your annual contribution, you need to do so during Summer Enrollment.
- Beginning September 1, 2017, if you are in HealthSelect of Texas or HealthSelect Out-of-State, you will no longer have a copayment if you consult a network virtual visits doctor online. Learn more about convenient, money-saving virtual visits at www.bcbstx.com/hs under Value Added Benefits.

On September 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) will become the new plan administrator for HealthSelect of Texas and Consumer Directed HealthSelect. Most benefits and requirements for HealthSelect of Texas and Consumer Directed HealthSelect will not change. If you are enrolled in an HMO, HealthSelect Medicare Advantage or KelseyCare Advantage you will not be affected.

- The HealthSelect provider network includes more than 50,000 health professionals, hospitals and other facilities throughout Texas. Most doctors and other providers who are in the current HealthSelect network will still be in the network as of September 1, 2017. However, some will not. To find out which providers have signed on to be in the HealthSelect network as of September 1, 2017 go to Find a Provider at www.bcbstx.com/hs and click on Find a doctor or hospital. Then click on the box that applies to your health plan. You can also speak with a BCBSTX Personal Health Assistant by calling (800) 252-8039. To nominate a provider to be added to the HealthSelect network, go to www.bcbstx.com/hs and click on Publications and Forms.
- If your current primary care physician (PCP) will still be in the HealthSelect network, you do not need to take any action.
- If you are enrolled in Consumer Directed HealthSelect or HealthSelect Out-of-State you do not need to designate a PCP.
- If you are enrolled in HealthSelect of Texas and do not designate a PCP who is in the HealthSelect network, you could pay more – possibly much more – for your health care. Call a BCBSTX Personal Health Assistant at (800) 252-8039 to designate your PCP or for help finding one.
- BCBSTX will mail new medical ID cards to all HealthSelect of Texas and Consumer Directed HealthSelect participants in late August. You should continue to use your current health plan ID card until August 31, 2017.

For information or answers to general questions about HealthSelect benefits, network providers, referrals and prior authorizations, or other plan details, go to www.bcbstx.com/hs or call a BCBSTX Personal Health Assistant at (800) 252-8039, Monday – Friday, 7 a.m. - 7 p.m. CT or Saturday 7 a.m. - 3 p.m. CT.

No benefit changes?

If you do not want to make any changes to your benefits, you do not need to take any action. Your benefit elections, including your annual election amounts for TexFlex flexible spending accounts, will not change.

Need to make benefits changes?

You can make or request changes to your benefits in one of three ways:



Go to www.ers.state.tx.us and sign in to your online account. After you log in, be sure to confirm that your contact information is correct. Verify the Social Security number and date of birth for each of your dependents. Click on Benefits Enrollment to begin making your Summer Enrollment changes.



If you need to make benefit changes but do not have internet access, contact your agency's or institution's Human Resources office or benefits coordinator. If you are an HHS Enterprise employee, contact the HHS Employee Service Center at (888) 894-4747.



Call ERS toll-free at (866) 399-6908. Please be sure to call during your two-week enrollment phase, which is listed on your Personal Benefits Enrollment Statement.

Dependent eligibility and verification

When you select your online changes, you'll be asked to certify that each of your dependent children is eligible for Texas Employees Group Benefits Program (GBP) coverage unless you've already certified each dependent. You can't enroll new dependent children until you complete the online certification. If you enroll any new dependents, including a spouse, in health coverage, you'll be required to provide documentation, such as a marriage license or birth certificate, verifying that each dependent is eligible. To enroll a common law spouse, you must obtain a Declaration of Informal Marriage from the county courthouse with a registration date prior to the date of your spouse's enrollment in the GBP.

Aon Hewitt, a company that is working with ERS to conduct the dependent eligibility verification, will mail a letter that outlines the steps in the verification process, and lists the dependents who need to be verified, the documentation needed and the deadlines for submitting documentation. If you have questions about the dependent eligibility verification, contact Aon Hewitt Dependent Verification Center toll-free at (800) 987-6605.

Opt out of health insurance and prescription drug coverage

If you can certify that you already have other health insurance that is equal to or better than coverage offered through ERS, you can sign up for a monthly health insurance Opt-Out Credit of up to \$60 for full-time employees and \$30 for part-time employees.

You must be eligible for the state contribution toward your health insurance premium to qualify for the Opt-Out Credit.

This credit must be applied to your dental insurance and/or Voluntary Accidental Death & Dismemberment insurance premiums. It cannot be applied to premiums for the State of Texas Dental Discount Plan or State of Texas Vision.

The health insurance Opt-Out Credit is not available if:

- your other insurance is Medicare,
- you have health insurance coverage through ERS as a dependent, or
- you receive a state contribution for other insurance coverage.



IMPORTANT: If you waive or opt-out of your health plan, you give up your prescription coverage and will no longer have Basic Term Life Insurance coverage. If you lose your other health insurance coverage, it is a qualifying life event, and you may enroll in health coverage offered through ERS if you sign up within 31 days of losing your other health insurance coverage.

HealthSelect of Texas and Consumer Directed HealthSelect

No matter where you live or work, you can choose between HealthSelect of Texas and Consumer Directed HealthSelect medical plans for you and your eligible dependents. With both plans, you have access to a provider network of more than 50,000 providers in Texas. Both plans include a comprehensive prescription drug program administered by OptumRx.

On September 1, 2017, Blue Cross and Blue Shield of Texas will become the medical plan administrator for both plans. ERS sets the benefits and pays the claims, while BCBSTX manages the provider network, processes claims and provides customer service.

Health care can be expensive, but ERS works to keep costs as low as possible. You can help lower your costs by making sure your providers are in the HealthSelect network when you use your medical coverage.

Keep in mind that, even if a hospital is in the HealthSelect network, doctors and other providers who practice at that hospital may not be. Be sure to find out if all your providers are in the HealthSelect network before your treatment or procedure. To find out if a doctor, hospital or other provider is in the HealthSelect network, go to www.bcbstx.com/hs and click on “Find a doctor or hospital” in the “Find a Provider” box. and click on Find a Provider. If a provider is not in the HealthSelect network, notify your PCP and ask if a network provider is available.

HealthSelect of Texas

HealthSelect of Texas is a point-of-service health insurance plan.

- You do not have to meet a deductible amount before the plan begins to pay if your provider is in the HealthSelect network.

2018 Deductible	Individual Coverage	Family Coverage
In-network	\$0	\$0
Out-of-network	\$500	\$1,500

- You are responsible for copayments for doctor and hospital visits and other medical services, such as outpatient surgery and high-tech radiology.

- To save money with the plan, you need to designate a primary care physician (PCP).
- If you live or work in Texas, you need a referral from your PCP to an in-network specialist or facility to receive in-network benefits. If you do not get a referral from your PCP, you could pay more for your treatment, even if the provider is in the HealthSelect network.

You do not need a referral for:

- eye exams (both routine and diagnostic),
- OB/GYN visits,
- mental health counseling,
- chiropractic visits,
- occupational therapy, speech therapy and physical therapy, and
- virtual visits, urgent care centers and convenience care clinics.

It pays to stay in the network!

All health plans managed by ERS are network-based, which means you’ll pay less – sometimes a lot less – if you see a provider in the network.

Here’s an example of the difference in what you might pay for an in-network and out-of-network doctor visit for non-preventive care if you’re in HealthSelect of Texas. This is an example and not a true estimate of costs you would pay by going out-of-network if you have not met your deductible. For more information see the Health Plan Comparison Chart on pages 8-9.

HealthSelect of Texas	In-Network PCP	Out-of-Network Provider You must first meet a \$500/person or \$1,500/family deductible before the plan begins to pay.
Amount billed by doctor	\$150	\$160
Allowable amount For out-of-network service, the allowable amount – not the billed charge – is the amount applied toward your deductible, and the amount used to calculate what the plan will pay after you’ve met the deductible (example: 60% of allowable amount for a PCP visit).	\$100	\$65
HealthSelect of Texas pays	\$75	\$0
Member owes	\$25 copay	\$160 Because you have not met your out-of-network deductible, you owe the full amount billed by the doctor. Only \$65 of this amount will be applied to your deductible, because the plan does not cover the difference between the amount billed and the allowable amount.

Consumer Directed HealthSelect is a high-deductible health plan paired with a tax-free health savings account (HSA). The high deductible means you could have higher out-of-pocket costs before your health plan begins to pay for coverage. It's available to Texas Employees Group Benefits Program (GBP) participants who are not enrolled in Medicare.

- You do not need to designate a PCP or get a referral to see a specialist, but you generally will pay less for care – sometimes much less – if you see a provider who is in the HealthSelect network.
- The monthly dependent premium is lower than HealthSelect of Texas. But you pay the full cost of doctor visits, prescriptions, hospital stays and any other non-preventive health service or product until you have reached the annual deductible. (See deductible amounts below.)
- After you have met the deductible, you pay coinsurance (20% in-network, 40% out-of-network) for medical services and prescriptions rather than a copayment.
- Deductibles are based on the calendar year and reset January 1 of each year.

2018 Deductible (includes prescriptions)	Individual Coverage	Family Coverage
In-network	\$2,100	\$4,200
Out-of-network	\$4,200	\$8,400

Health savings account (HSA)

An HSA is like a tax-free nest egg for health care expenses. You can use money in your HSA to pay for eligible out-of-pocket health expenses.

- You can use your HSA funds for qualified medical expenses for yourself, your spouse and eligible dependents. The IRS defines qualified medical expenses. Visit www.hsacenter.com/what-is-an-hsa/qualified-medical-expenses/ for more information.
- To help cover your out-of-pocket health costs, the state makes a monthly contribution to the HSA of every member enrolled in Consumer Directed HealthSelect: \$45 for an individual (\$540 per year) or \$90 for a family (\$1,080 per year) in Plan Year 2018.
- You can make pre-tax contributions to your HSA through payroll deductions. The IRS sets the maximum contribution amount each year. The annual maximum contribution limit for 2018 is \$3,450 for individuals and \$6,900 for families. If you are age 50 or older, you can also make a \$1,000 "catch-up" contribution each year.
- All the money in your HSA carries over from one year to the next – there is no use-it-or-lose-it rule, and you can keep the funds if you change health plans or leave state employment.

HSA contributions and maximums* for 2018

Description	Individual Account	Family Account**
Annual maximum contribution January 1, 2018 - December 31, 2018	\$3,450	\$6,900
Annual state contribution	\$540 (\$45 monthly)	\$1,080 (\$90 monthly)
Annual maximum participant contribution	\$2,810	\$5,820

*HSA contributions and limits may change from year to year, or based on eligibility requirements and the participant's age. Maximums are set by the IRS and include both pre-tax and post-tax contributions to an HSA.

**Includes the member plus any number of dependents enrolled in Consumer Directed HealthSelect.



Thinking about enrolling in Consumer Directed HealthSelect?

The key benefits of Consumer Directed HealthSelect are:

- the ability to save money, tax free, in your HSA for health care costs now or far in the future, and
- the state's contribution to your HSA (if you're eligible): \$540 a year for an individual or \$1,080 for a family.

For some people, it could be a great way to save money and lower your taxable income. But you will be responsible for all of your non-preventive health care costs until you meet the annual deductible.

Optum Bank administers the HSA program. If you enroll in Consumer Directed HealthSelect, you need to open an Optum Bank HSA as soon as possible so that state contributions and other funds can be deposited into your account. You will get a debit card from Optum Bank to pay for health expenses. You will have access only to the amount of money that has accumulated in your HSA, and not funds that have been pledged to be deposited in the future. You should review IRS guidelines or consult a tax advisor to make sure you are eligible to participate in an HSA. For more information, visit www.ers.state.tx.us/Employees/Health/CDHS/HSA/



HMOs



If you live or work in an eligible county, you have the option of enrolling in an HMO. These regional plans have smaller networks than the HealthSelect plans. But they cover the same care and services as HealthSelect and generally have lower dependent premiums.

- You must use providers (such as doctors and hospitals) in the HMO network for your services to be covered, unless the health plan has authorized out-of-network treatment. Only emergency care services are covered outside the network.
- HMOs have their own prescription drug coverage. The annual drug deductible is \$50 per person per plan year, which resets on September 1.

HMO Plan	Service Area	Counties
Community First Health Plans	San Antonio area	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson
KelseyCare powered by Community Health Choice	Houston area	Brazoria, Fort Bend, Galveston, Harris and Montgomery
Scott & White Health Plan	Central Texas	Austin, Bastrop, Bell, Bosque, Brazos, Burleson, Burnet, Coryell, Falls, Freestone, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Travis, Walker, Waller, Washington, and Williamson

Out-of-pocket limits



To help protect you from catastrophic health costs, all five health plans have a network out-of-pocket maximum of \$6,650 for individuals and \$13,300 for families. This is the maximum amount you will pay in one year for network copays, coinsurance, prescriptions, deductibles and other qualified health care expenses. Once you reach this maximum, the plan pays 100% of covered health expenses for the rest of the year. Only Consumer Directed HealthSelect has an out-of-network out-of-pocket maximum (individual: \$13,100; family: \$26,200).



All participants enrolled in health insurance plans offered through ERS must certify their status as tobacco users or non-users. If you are a tobacco user, you may qualify for an alternative to the Tobacco User Premium, if it complies with your doctor’s recommendations. For more information, see the ERS Tobacco policy on ERS website at www.ers.state.tx.us/Employees/Health/Tobacco_Policy/ or contact ERS toll-free at (866) 399-6908.



Prescription drug coverage

Your health insurance plan includes coverage for prescription drugs. If you are enrolled in HealthSelect of Texas or Consumer Directed HealthSelect, you will receive separate ID cards for medical (Blue Cross and Blue Shield of Texas) and prescription drug (OptumRx) coverage in late August. Please use these separate ID cards beginning September 1, 2017.

Beginning August 1, HealthSelect Prescription Drug Program will have a new phone number. You can find this number on the new prescription ID card that OptumRx will mail you in August.


Prescription drugs are divided into three tiers, with different copays for each tier.

- Tier 1 are usually inexpensive medications, such as generic drugs.
- Tier 2 are usually lower-cost preferred brand-name drugs.
- Tier 3 are non-preferred brand-name drugs with a high cost.

	HealthSelect of Texas	Consumer Directed HealthSelect	HMOs
Deductible	\$50 for each covered individual (January 1 - December 31)	\$2,100 per individual and \$4,200 per family (in combined medical and pharmacy expenses) using in-network pharmacies (January 1 - December 31)	\$50 for each covered individual (September 1 - August 31)
Copays: In-network	Up to a 30-day supply of Non-maintenance medications: Tier 1: \$10, Tier 2: \$35, Tier 3: \$60 Maintenance medications*: Tier 1: \$10, Tier 2: \$45, Tier 3: \$75	20% coinsurance after the annual deductible is met	Up to a 30-day supply of Non-maintenance medications: Tier 1: \$10, Tier 2: \$35, Tier 3: \$60 Maintenance medications*: Tier 1: \$10, Tier 2: \$45, Tier 3: \$75
Copays: Out-of-network	Copay plus 40% coinsurance for all three tiers	40% coinsurance after the annual out-of-network deductible is met	Does not apply
Extended Days Supply (EDS)**	90-day supply: Tier 1: \$30, Tier 2: \$105, Tier 3: \$180	20% coinsurance after the annual deductible is met.	Does not apply
Mail order	Yes	Yes	Yes
Brand-name drug payment	If a generic drug is available and you choose the brand-name drug, you will pay the Tier 1 copay or coinsurance, as applicable, plus the difference in cost to the plan between the brand-name drug and the generic drug.		

*A retail maintenance fee is an additional charge for filling a 30-day supply or less of maintenance medications, which are prescriptions you take regularly.

**An Extended Days Supply (EDS) means a pharmacy can dispense up to a 90-day supply of maintenance prescription drugs at one time.



To find out which pharmacies you can use under each plan, visit the plan website.

HEALTH PLANS COMPARISON CHART

Effective September 1, 2017

Benefits	HealthSelect SM of Texas ¹				Consumer Directed HealthSelect SM 1		HMOs	
	In-Area		HealthSelect SM of Texas Out-of-State ²		Network	Non-Network	Community First, Scott & White	KelseyCare powered by Community Health Choice
	Network	Non-Network	Network	Non-Network				
Calendar year deductible	None	\$500 per person \$1,500 per family	None	\$500 per person \$1,500 per family	\$2,100 per person \$4,200 per family	\$4,200 per person \$8,400 per family	None	None
Out-of-pocket coinsurance maximum⁴	\$2,000 per person per calendar year	\$7,000 per person per calendar year	\$2,000 per person per calendar year	\$7,000 per person per calendar year	None	None	\$2,000 per person ³	\$2,000 per person ³
Total out-of-pocket maximum¹⁰ (including deductibles, coinsurance and copays) ¹¹	**\$6,550 per person \$13,100 per family	None	**\$6,550 per person \$13,100 per family	None	**\$6,550 per person \$13,100 per family	**\$13,100 per person \$26,200 per family	\$6,550 per person \$13,100 per family ³	\$6,550 per person \$13,100 per family ³
Primary care physician required	Yes	No	No	No	No	No	Community First - yes Scott & White - no	No
Primary care physicians' office visits	\$25	40%	\$25	40%	20%	40%	\$25	\$15
Mental health care								
a. Outpatient physician or mental health provider office visits	\$25 copay	40% coinsurance after you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance	\$25	\$25
b. Hospital Mental health inpatient stay (copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per calendar year.)	20% coinsurance after copay	40% coinsurance after copay and you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after copay and you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance	20% coinsurance (plus \$150 a day copay per admission)	20% coinsurance (plus \$150 a day copay per admission)
c. Outpatient facility care (partial hospitalization/ day treatment and extensive outpatient treatment)	20% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance	\$25 copay (prior authorization required)	\$25 copay
Physicals*	No charge	40%	No charge	40%	No charge	40%	No charge	No charge
Specialty physicians' office visits	\$40	40%	\$40	40%	20%	40%	\$40	\$25
Routine eye exam, one per year per participant*	\$40	40%	\$40	40%	20%	40%	\$40 ^{3,6}	\$25 ³
Routine preventive care*	No charge	40%	No charge	40%	No charge	40%	No charge	No charge
Diagnostic x-rays, lab tests, and mammography	20%	40%	20%	40%	20%	40%	20%	No charge* (physician office)
Office surgery and diagnostic procedures	20%	40%	20%	40%	20%	40%	20%	\$15 PCP or \$25 Specialist
High-tech radiology (CT scan, MRI, and nuclear medicine) ^{7,9,12}	\$100 copay plus 20%	\$100 copay plus 40%	\$100 copay plus 20%	\$100 copay plus 40%	20%	40%	\$100 copay plus 20% coinsurance	\$150 copay per scan type per day (Outpatient testing only)
Urgent care clinic	\$50 copay plus 20%	\$50 copay plus 40%	\$50 copay plus 20%	\$50 copay plus 40%	20%	40%	\$50 copay plus 20%	\$50 copay plus 20%

Benefits	HealthSelect SM of Texas ¹				Consumer Directed HealthSelect ^{SM1}		HMOs	
	In-Area		HealthSelect SM of Texas Out-of-State ²		Network	Non-Network	Community First, Scott & White	KelseyCare powered by Community Health Choice
	Network	Non-Network	Network	Non-Network				
Urgent care clinic	\$50 copay plus 20%	\$50 copay plus 40%	\$50 copay plus 20%	\$50 copay plus 40%	20%	40%	\$50 copay plus 20%	\$50 copay plus 20%
Maternity Care doctor charges only*; inpatient hospital copays will apply	No charge for routine prenatal appointments \$25 or \$40 for first post-natal visit ⁵	40%	No charge for routine prenatal appointments \$25 or \$40 for first post-natal visit ⁵	40%	No charge for routine prenatal appointments 20% for first post-natal visit	40%	No charge for routine prenatal appointments \$25 or \$40 for first post-natal visit ⁵	No charge
Chiropractic Care								
a. Coinsurance	20%; \$40 copay plus 20% with office visit	40%	20%; \$40 copay plus 20% with office visit	40%	20%	40%	CFHP: 20%; \$40 copay SWHP: 20%; \$40 copay plus 20% with office visit	\$25 copay
b. Maximum benefit per visit	\$75	\$75	\$75	\$75	\$75	\$75	CFHP: \$75/ SWHP - None	–
c. Maximum visits Each participant Per calendar year	30	30	30	30	30	30	CFHP: 30; SWHP: 35 (maximum manipulative therapy visits)	30
Inpatient hospital (semi-private room and day's board, and intensive care unit) ¹²	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 40% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 40% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	20%	40%	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per plan year per person ³)	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per plan year per person)
Emergency care	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	20%	20%	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 copay plus 20% (if admitted copay will apply to hospital copay)
Outpatient surgery other than in physician's office	\$100 copay plus 20%	\$100 copay plus 40%	\$100 copay plus 20%	\$100 copay plus 40%	20%	40%	\$100 copay plus 20%	\$150 copay plus 20%
Bariatric surgery ^{8, 8A, 11}	a. Deductible \$5,000 b. Coinsurance 20% c. Lifetime max \$13,000	Not covered	a. Deductible \$5,000 b. Coinsurance 20% c. Lifetime max \$13,000	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing aids	Plan pays up to \$1,000 per ear every three years (no deductible).				Plan pays up to \$1,000 per ear every three years (after deductible is met).		Plan pays up to \$1,000 per ear every three years (no deductible).	
Durable medical equipment ¹²	20%	40%	20%	40%	20%	40%	20%	20%
Ambulance services (non-emergency) ¹²	20%	20%	20%	20%	20%	20%	20%	20%

¹ Benefits are paid on allowable amounts; using providers who contract with Blue Cross Blue and Shield of Texas will protect you from liability for amounts over the allowable amount. ² HealthSelect Out-of-State applies to employees and retirees under age 65 and their eligible dependents who live or work outside of Texas. You cannot enroll in Out-of-State coverage unless your work or home address is outside of Texas. ³ Applies to plan year, September 1 - August 31. ⁴ Does not include copays. ⁵ Copay depends on whether treatment is given by PCP or specialist. ⁶ For treatment charges, one visit per plan year. ⁷ Outpatient testing only. Does not apply to inpatient services. ⁸ Active employees only; see health plan for additional requirements/limitations. ^{8A} The deductible and coinsurance paid for bariatric surgery does not apply to the total out-of-pocket maximum. ⁹ No copay if high-tech radiology is performed during ER visit or inpatient admission. ¹⁰ Out-of-pocket maximums are not mutually exclusive from other out-of-pocket limits. This means that a participant's total network out-of-pocket maximum could contain a combination of coinsurance and/or copayments. (For example, a participant could pay up to \$6,550 in copayments alone if there was no coinsurance paid throughout the year. If a participant met the \$2,000 coinsurance out-of-pocket maximum, he/she would pay \$4,550 in copayments, totaling \$6,550 in overall out-of-pocket expense.) ¹¹ Includes medical and prescription drug copays, coinsurance and deductibles. Excludes non-network and bariatric services. ¹² Preauthorization required. Mental Health Benefits follow those of medical and surgical benefits listed in this chart. This comparison chart offers a general overview of benefits and their associated out-of-pocket expenses under HealthSelect plans and the HMOs. Contact the plan's customer service department for specific questions. *Under the Affordable Care Act, certain preventive and women's health services are paid at 100% (at no cost to the participant) dependent upon physician billing and diagnosis. In some cases, the participant will still be responsible for payment on some services. **Effective calendar year

Dental Plans



Helpful tip: Find a list of providers for State of Texas Dental ChoiceSM or the HumanaDental DHMO at <https://our.humana.com/ers/> or by calling HumanaDental at (877) 377-0987, TTY: 711.

State of Texas Dental Choice

This is a preferred provider organization (PPO) dental insurance plan.

- You can see any provider, but you will pay less if you see one who is in the HumanaDental PPO.
- Benefits are available in the United States and Canada, and Mexico if you live in the United States.



HumanaDental Dental Health Maintenance Organization

This is a dental health maintenance organization (DHMO) dental insurance plan.

- Coverage applies only to dentists in the Texas service area. Before you enroll, make sure there is a DHMO network dentist in your area.
- You must select a primary care dentist (PCD) from a list of approved providers. You and your enrolled dependents can choose different primary care dentists.
- Services from participating specialty dentists cost 25% less than the dentist's usual charge.



State of Texas Dental Discount PlanSM

This is not a dental insurance plan.

- You receive discounted prices – 20% to 60% off – on usual charges for dental treatment and services at participating providers.
- There are no claim forms, copays, deductibles, annual maximums or limits on use.



Dental discount plan features

Plan Features	Dental Discount Plan	Dental Insurance
Claim forms and paperwork	—	✓
Copays	—	✓
Deductibles	—	✓
Annual maximums	—	✓
Limits on use	—	✓
Savings on cosmetic services	✓	—

Dental insurance plans comparison chart

	HumanaDental DHMO ¹	State of Texas Dental Choice Plan SM Preferred Provider Organization (PPO) Administered by HumanaDental Insurance Company	
Dentists	You must select a primary care dentist (PCD). NOTE: Not all participating dentists accept new patients. Dentists are not required to stay on the plan for the entire year.	In-network/ participating dentist	Out-of-network/ non-participating dentist ²
Deductibles	None	Preventive-Individual-\$0; Family-\$0 Combined Basic/Major -Individual-\$50; Family-\$150 Orthodontic services-no deductible	Preventive-Individual-\$50; Family-\$150 Combined Basic/Major -Individual-\$100; Family-\$300 Orthodontic services-no deductible
Copays/ coinsurance	Primary dentist - Copays vary according to service and are listed in the "Schedule of Dental Benefits" booklet. Specialty dentistry - You pay 75% of the dentist's usual and customary fee. DHMO pays nothing.	Preventive and Diagnostic Services - You pay nothing. Basic Services - You pay 10% coinsurance after meeting the Basic Services deductible. Major Services - You pay 50% coinsurance after meeting the Major Services deductible. You will not be charged for anything over the allowed amount. After you reach the Maximum Calendar Year Benefit, you pay 60% until January 1. ³	Preventive and Diagnostic Services - You pay 10% coinsurance after meeting the Preventive and Diagnostic deductible. Basic Services - You pay 30% coinsurance after meeting the Basic Services deductible. Major Services - You pay 60% coinsurance after meeting the Major Services deductible. You may be required to pay the difference between the allowed amount and billed charges. After you reach the Maximum Calendar Year Benefit, you pay 60% until January 1. ³
Maximum calendar year benefit	Unlimited	\$1,500 per covered individual (includes orthodontic extractions)	\$1,500 per covered individual (includes orthodontic extractions)
Maximum lifetime benefit	Unlimited	\$1,500 per covered individual for orthodontic services	\$1,500 per covered individual for orthodontic services
Average cost of cleaning / oral exams	Vary according to service and are listed in the "Schedule of Dental Benefits" booklet Up to two cleaning/oral exams per calendar year allowed	You pay nothing. Up to two cleaning/oral exams per calendar year allowed	10% of the allowed amount after deductible is met Up to two cleaning/oral exams per calendar year allowed
Orthodontic coverage	Orthodontic services performed by a general dentist listed in the directory with an "O" treatment code – child - \$1,800, adult - \$2,100 Orthodontic services performed by specialist – You pay 75% of his/her usual fee. DHMO pays nothing.	Orthodontic services are only available to dependents age 19 or younger. You pay 50% of the allowed amount.	Orthodontic services are only available to dependents age 19 or younger. You pay 50% of the allowed amount. You may be required to pay the difference between the allowed amount and billed charges.

NOTE: The comparison chart is a summary of the benefits offered by the two dental insurance plans. See plan booklet for actual coverage and limitations. Prior to starting treatment, discuss with your dentist the treatment plan and all charges.

¹ This comparison chart reflects participant responsibility for services received from participating primary care dentists only. Services from participating specialty dentists are 25% less than the dentist's usual charge.

² In the State of Texas Dental Choice Plan PPO, deductibles and annual maximums are per calendar year. Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO network dentist.

³ Services received after the maximum calendar year benefit is reached will be paid at 40% coinsurance by the plan.



Your health insurance plan covers some vision and eye health services, including an annual eye exam and treatment for diseases of the eye. But it does not cover the cost of eyeglasses or contact lenses.

You and your eligible dependents can enroll in State of Texas Vision for an additional monthly premium. For a set copay

amount, State of Texas Vision offers an eye exam, contact lens fitting, and other options (such single vision lenses or ultraviolet coating). State of Texas Vision offers an allowance on the cost of eyeglasses or contact lenses as well as discounts for LASIK. For a complete list of plan benefits and a list of providers, visit www.stateoftexasvision.com.

Vision coverage comparison chart

	State of Texas Vision	HealthSelect of Texas	Consumer Directed HealthSelect	Community First HMO	KelseyCare powered by Community HMO	Scott & White HMO
Routine eye exam	\$25 copay	\$40 copay ¹	20% coinsurance ²	\$40 copay ³	\$15 PCP/ \$25 Specialist	\$40 copay
Frames	\$150 retail allowance	Not covered	Not covered	\$125 retail allowance ⁴	Not covered	Not covered
Standard contact lens fitting	\$25 copay	Not covered	Not covered	\$125 allowance	Not covered	Not covered
Specialty contact lens fitting	\$35 copay	Not covered	Not covered	Not covered	Not covered	Not covered
Single-vision lenses	\$10 copay	Not covered	Not covered	100% covered	Not covered	Not covered
Bifocal Lenses	\$15 copay	Not covered	Not covered	100% covered	Not covered	Not covered
Trifocal lenses	\$20 copay	Not covered	Not covered	100% covered	Not covered	Not covered
Progressives	\$70 copay	Not covered	Not covered	Not covered	Not covered	Not covered
Polycarbonate	\$50 copay	Not covered	Not covered	Not covered	Not covered	Not covered
Scratch coat (factory, single sided)	\$10 copay	Not covered	Not covered	Not covered	Not covered	Not covered
Ultraviolet coating	\$10 copay	Not covered	Not covered	Not covered	Not covered	Not covered
Tint	\$10 copay	Not covered	Not covered	Not covered	Not covered	Not covered
Standard anti-reflective coating	\$40 copay	Not covered	Not covered	Not covered	Not covered	Not covered
Contact lenses⁵ (conventional or disposable)	\$150 allowance	Not covered	Not covered	\$125 Allowance	Not covered	Not covered

All benefits listed are available annually, unless indicated, using network providers.

¹ This is for network providers only in the HealthSelect of Texas In-Area plan. Benefits differ for non-network providers and the out-of-area plan. See your health plan materials for details.

² After the deductible is met, you will pay 20% coinsurance for network providers only (40% coinsurance for non-network providers).

³ Members can go to any Community First network doctor for their eye exam.

⁴ Cost savings when using OptiCare vision providers. Frame discounts are not available if the frame manufacturer prohibits the discount.

⁵ Contact lenses are in lieu of eyeglass lenses and frames benefit.

All costs and allowances are retail; you are responsible for any charges in excess of the retail allowances.

Note: Besides the eye exam, the additional offerings through the health plans are value added benefits. ERS does not guarantee the length of time that a specific value added product will be offered.

TEXFLEX

Financial planners and tax advisors encourage people to save money on taxes by lowering their taxable income. ERS offers you opportunities to follow this advice. By participating in one or more of the TexFlex flexible spending accounts, you can set aside money pre-tax from your paycheck, to cover eligible out-of-pocket health care, dependent care and commuting expenses. Each month, your defined TexFlex contribution is automatically withdrawn from your paycheck and deposited into your account.

Once your account is set up, you can make changes to your TexFlex contribution only during Summer Enrollment, unless you have a qualifying life event during the plan year. (This does not apply to the Commuter Spending Account. You can make changes to your Commuter Spending

Account elections at any time.) If you do not make a change during Summer Enrollment, your account elections will stay the same.

After you enroll in a TexFlex health care or TexFlex limited account account, you will receive a debit card in the mail. You can use it to pay for eligible expenses. There is no cost to you to use the debit card.

Because TexFlex accounts are tax-free, the Internal Revenue Service (IRS) requires all purchases with TexFlex funds to be validated. WageWorks, the new TexFlex plan administrator, may ask you to submit proof that you used your TexFlex funds to pay for eligible expenses. Please be sure to **SAVE YOUR RECEIPTS** — even if you use your debit card.

TexFlex offers four types of accounts, and active employees might be eligible to enroll in up to three of them at a given time. The following charts show how each type of account can be used, and the rules that apply.

Flexible spending accounts comparison chart

	Health Care Account	Limited Account	Dependent Care Account
Eligible expenses (for a complete list see plan website)	<ul style="list-style-type: none"> Your portion of medically necessary charges, including copays and coinsurance Prescription drug deductible 	Vision and dental expenses not covered by insurance	<ul style="list-style-type: none"> Day care, After-school care, and Summer day camp for dependent children under age 13 Adult day care for qualifying individuals
Maximum contribution	\$2,600 per participant, per fiscal year	\$2,600 per participant, per fiscal year	\$5,000 per household, per fiscal year
Funds availability	Full election available Sept. 1	Full election available Sept. 1	Funds available monthly as contributions are made
Debit card (no fee)	Yes	Yes	No
Carryover of funds or grace period	Carryover up to \$500 after Aug. 31	Carryover up to \$500 after Aug. 31	Grace period (extra time to incur expenses) from Sept. 1 to Nov. 15
Runout period*	Submit claims incurred between Sept. 1, 2016 and Aug. 31, 2017 by Dec. 31, 2017	Submit claims incurred between Sept. 1, 2016 and Aug. 31, 2017 by Dec. 31, 2017	Submit claims incurred between Sept. 1, 2016 and Nov. 15, 2017 by Dec. 31, 2017

*Extra time allowed to submit claims for PY17 account

Commuter spending account comparison chart

	Transit	Parking
Eligible expenses	Public transportation expenses used to commute to and from work (bus, train, subway and vanpool)	Parking expenses near your workplace or a place from which you commute by public transit to work
Maximum contribution	\$255 per month, per participant	\$255 per month, per participant
Funds availability	Monthly as contributions are made from your paycheck	
Debit card (no fee)	Yes	
Carryover of funds	Unused funds carry over month to month	
Runout period	No deadline to use funds as long as you are actively employed	



Optional Life and Voluntary AD&D Insurance



SECURIAN®

Financial security for you and your family

Your health coverage through ERS includes \$5,000 Basic Term Life Insurance, with \$5,000 of accidental death & dismemberment (AD&D) coverage at no cost.

Optional Term Life Insurance

During Summer Enrollment, you can apply for additional life insurance in increments based on your annual salary. See your Personal Benefits Enrollment Statement for details on your current coverage and monthly premiums. Securian's Insurance Needs Calculator at www.lifebenefits.com/plandesign/ers can help you decide how much life insurance coverage you might need. Premiums and coverage amounts will be based on the salary reported to ERS on September 1, 2017.

You can update your ERS beneficiaries any time of the year.



Evidence of insurability (EOI) is an application process during which you must provide information about you or your covered dependent's health. EOI is required for any life and/or disability insurance elections made after your first 31 days of employment. You or your dependent may be denied coverage based on information in your EOI application.

Dependent Term Life Insurance

For an additional monthly premium, you can apply to enroll your eligible dependents in term life insurance. If approved, this benefit includes \$5,000 term life with \$5,000 AD&D for each covered family member. The benefit will be paid to you upon the death of a covered dependent or in the event of certain accidental injuries. Your monthly premium covers all your eligible dependents, but you must list each dependent on your policy.

Voluntary AD&D Insurance

Voluntary AD&D Insurance can provide additional financial protection for you and your family in the event of certain accidental injuries or accidental death. You can choose insurance in increments of \$5,000, starting at \$10,000 up to \$200,000.

EOI is not required for AD&D coverage. You can sign up for coverage for yourself only, or for yourself and your eligible family members.

- If you die as the direct result of an accidental bodily injury, your beneficiaries receive the full coverage amount.
- If an eligible family member dies in an accident, you will receive part of the coverage amount.
- If you have an accident and suffer any of the covered injuries, such as loss of a hand, foot or sight of one eye, you will receive a benefit up to the full amount of coverage.
- If an eligible family member loses a hand, foot or sight of one or both eyes in an accident, you will receive a percentage of the benefit if you have coverage for that family member.



Texas Income Protection PlanSM disability insurance

Childbirth, accident, illness – when you can’t work, the Texas Income Protection Plan (TIPP) provides you money to help pay the bills. TIPP disability insurance coverage is administered by ReedGroup.

- Short-term disability insurance coverage provides a maximum benefit of 66% of your monthly salary (up to \$10,000) or \$6,600, whichever is less, for up to five months (a maximum of 150 days). For example, if your monthly salary is \$4,000, the highest amount you’ll get for short-term disability is \$2,640 per month.

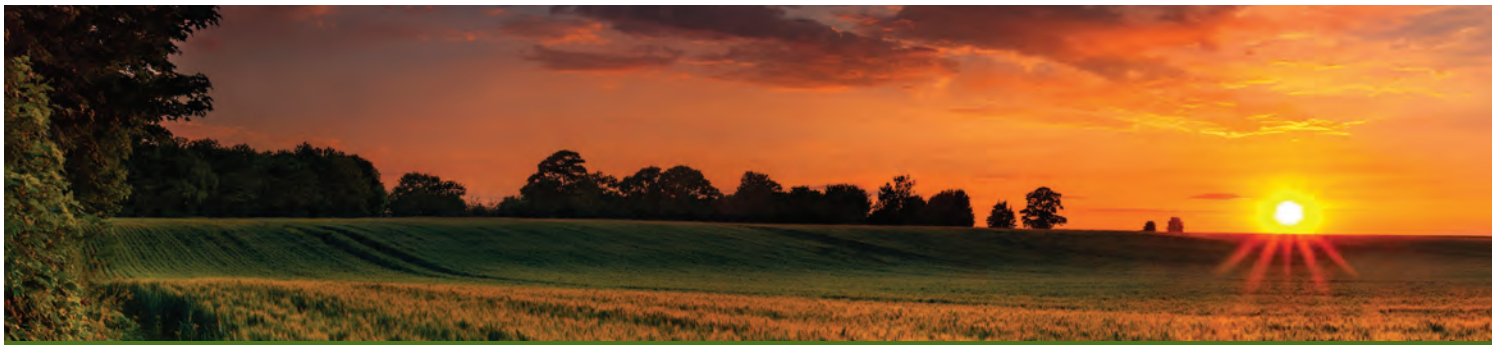
- Long-term disability insurance coverage provides a maximum benefit of 60% of your monthly salary (up to \$10,000) or \$6,000, whichever is less, for a period ranging from 12 months to normal Social Security retirement age, depending on your age at the time of disability. (Note: For some mental diseases and disorders, the maximum benefit period for disability is two years.)

Pre-existing conditions are subject to certain exclusions. You must use all of your sick leave (including extended sick leave, sick leave pool and donated sick leave) or complete a waiting period (30 days for short-term, 180 days for long-term), whichever option is longest, before disability benefits will be paid.

TIPP coverage is not available to family members.

TIPP coverage overview

Coverage Detail	Short-Term Disability Coverage	Long-Term Disability Coverage
Monthly benefit	66% of your monthly salary, up to \$10,000	60% of your monthly salary, up to \$10,000
When do benefits start?	After a waiting period of 30 consecutive days or after you’ve used all your sick leave (whichever is longer); sick leave can be used during the 30-day waiting period	After a waiting period of 180 consecutive days or after you’ve used all your sick leave (whichever is longer); sick leave can be used during the 180-day waiting period
How long are benefits paid?	Up to five months after the completion of your waiting period	Until you are able to return to work or until you reach your Maximum Benefit Period (based on the age you become disabled) or based on the condition causing your disability.
Integration of benefits	TIPP benefits are reduced if you get other disability payments. The minimum benefit is 10% of your monthly salary.	



Contact Information

HEALTH INSURANCE

HealthSelectSM of Texas **Consumer Directed HealthSelectSM**

Administered by UnitedHealthcare through August 31, 2017

Group number – 744260

Toll-free: (866) 336-9371, TDD: 711

myNurseLine: (866) 336-9371

<http://healthselectoftexas.welcometouhc.com/hs-of-texas.html>

*Administered by Blue Cross and Blue Shield of Texas
beginning September 1, 2017*

Group number – 238000

Toll-free: (800) 252-8039

www.bcbstx.com/hs

(Until August 31, 2017)

www.healthselectoftexas.com

(Beginning September 1, 2017)

Consumer Directed HealthSelectSM **Health savings account (HSA)**

Administered by Optum Bank

Toll-free: (800) 791-9361, TDD: 711

www.optumbank.com

HealthSelect Prescription Drug Program

(pharmacy benefits for HealthSelect of Texas
and Consumer Directed HealthSelect)

Administered by OptumRx

Toll-free: (866) 336-9371, TDD: 711

www.OptumRx.com/ERS

Community First Health Plans

An affiliate of the University Health System

Group number – 0010180000

Toll-free: (877) 698-7032, TDD: (210) 358-6080

Local: (210) 358-6262

NurseLink: (210) 358-6262

members.cfhp.com

KelseyCare powered by Community Health Choice

Group number – 15000

Toll-free: (844) 515-4877, TDD: 711

NurseLine: (713) 442-0000

www.erskelseycare.com/

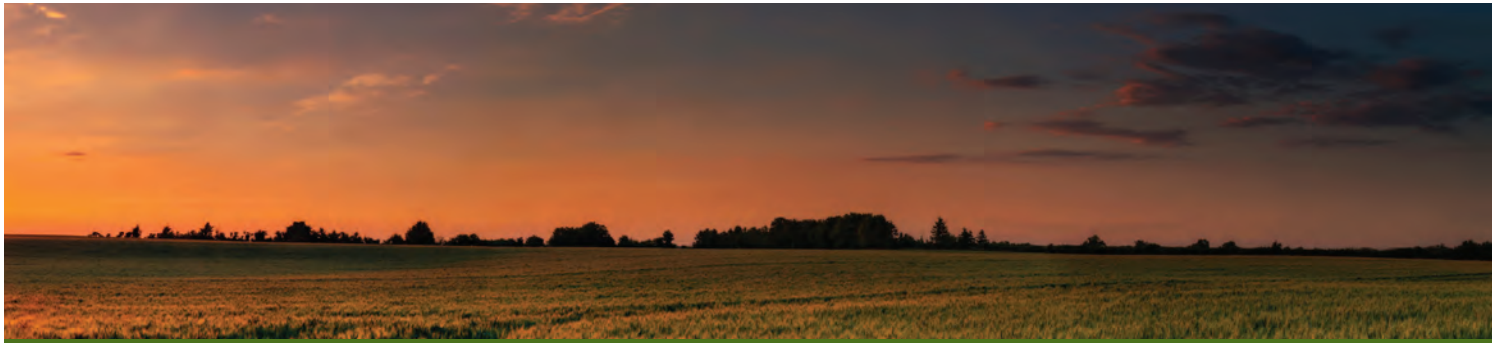
Scott & White Health Plan

Group number – 000058

Toll-free: (800) 321-7947, TDD: (800) 735-2989

VitalCare Nurse Advice: (877) 505-7947

ers.swhp.org



Contact Information

OPTIONAL BENEFITS

State of Texas Vision

Administered by Superior Vision Services, Inc.

Toll-free: (877) 396-4128

www.stateoftexasvision.com

State of Texas Dental ChoiceSM

Administered by HumanaDental

Insurance Company

Group number – 536957

Toll-free: (877) 377-0987, TDD: 711

humana.com/ers

HumanaDental DHMO

Insured by DentiCare, Inc.,

dba CompBenefits, a member

of the HumanaDental family

of companies

Group number – 538226

Toll-free: (877) 377-0987, TDD: 711

humana.com/ers

State of Texas Dental Discount PlanSM

Administered by Careington

International Corporation

Toll-free: (844) 377-3368, TDD: 711

www.txdentaldiscount.com

Life and Accidental Death & Dismemberment Insurance

Insured by Securian

Toll-free: (877) 494-1716, TDD: 711

www.lifebenefits.com/plandesign/ers

Texas Income Protection PlanSM (TIPP)

(short-term and long-term disability insurance)

Administered by ReedGroup

Toll-free: (855) 604-6230, TDD: 711

www.texasincomeprotectionplan.com

Disability evidence of insurability is administered by Securian. Contact information is listed above.

TexFlex

Administered by WageWorks

Toll-free: (844) 884-2364, TDD: 711

www.texflexers.com

TexaSaver 401(k) / 457 ProgramSM

Administered by Empower RetirementTM

Toll-free: (800) 634-5091, TDD: (800) 766-4952

www.texasaver.com

Discount Purchase Program

Administered by Beneplace

Toll-free: (800) 683-2886, TDD: (800) 683-2886

Local: (512) 346-3300

www.Beneplace.com/DiscountProgramERS

Summer Enrollment Event Schedule

ERS and its plan administrators travel around the state, hosting events to help you make informed decisions about your benefits. You may attend any fair or presentation, not just those at your agency or institution. You can also join one of our webinars. All events are free and open to all employees.

Summer Enrollment fairs start at 10 a.m. and end at 1 p.m., with presentations starting at 10:30 a.m., unless otherwise noted.

To sign up for a webinar, go to the events calendar on the ERS website at www.ers.state.tx.us and click on the webinar you want to attend.

Webinars

June 21
2 p.m.

June 23
11 a.m.

June 30
11 a.m.

June 30
2 p.m.

July 3
2 p.m.

July 5
11 a.m.

July 10
11 a.m.

July 12
2 p.m.

July 19
2 p.m.

July 20
11 a.m.

July 24
2 p.m.

Enrollment Fairs

June 20
Employees Retirement System
200 E. 18th St.
Austin, 78701

June 21
Health and Human Services Commission
Room K101
4601 S. 1st St.
Abilene, 79605

June 22
Texas Department of Transportation
Lubbock District Training Center
Mesquite Room
135 Slaton Rd.
Lubbock, 79404

June 22
Texas Department of Transportation
Auditorium
7600 Washington Ave.
Houston, TX 77007

June 23
Texas Tech University Health Science Center
School of Pharmacy Building - Foyer
1300 S. Coulter St.
Amarillo, 79106

June 26

Texas Department of Public Safety
Building A – Cafeteria
5805 N. Lamar Blvd.
Austin, 78752

June 27

University of Houston Victoria
University North Building –
Multi-purpose Room
3007 N Ben Wilson St.
Victoria, 77901

June 28

Houston Community College
Multi-purpose Room
5601 West Loop S.
Houston, 77081

June 28

Texas Parks and Wildlife
Headquarters - Lobby
4200 Smith School Rd.
Austin, 78744

June 29

Lone Star College
Community Building – Flag Room I & II
5000 Research Forest Dr.
The Woodlands, 77381

June 30

Texas Department of Criminal Justice
Texas Prison Museum
491 State Hwy 75 N.
Huntsville, 77320

July 5
1:30 – 4:30 p.m.,
presentation at 2 p.m.

**Texas Department
of Transportation**
Training Center – Building E
4502 Knickerbocker Rd.
San Angelo, 76904

July 6
Midland College
Marie Hall Building – Atrium
3600 N. Garfield St.
Midland, 79705

July 7
**Texas Department
of Transportation**
Building RS-200 –
Auditorium 1A.1
200 E. Riverside Dr.
Austin, 78704

July 7
El Paso Community College
Administrative Service Center
Building A
Auditorium Room 130
9050 Viscount Blvd.
El Paso, 79925

July 10
Texas State Technical College
Murray Watson Recreation Center
3801 Campus Dr.
Waco, 76705

July 11
Tarrant County College
South Energy Technology Center
(SETC Building)
2537 Joe B. Rushing Rd.
Fort Worth, 76119

July 11
**Texas Higher Education
Coordinating Board**
Room 1.100
1200 E. Anderson Lane
Austin, 78752

July 12
**Texas Department
of Transportation**
Dal Trans Building –
Yielding/Oliver Rooms
4625 U.S. 80 Frontage Rd.
Mesquite, 75150

July 13
**Texas Department
of Transportation**
District Training Center –
Room WFS2
1601 Southwest Pkwy
Wichita Falls, 76302

July 13
Austin Community College
Highland Business Center –
Lobby
5930 Middle Fiskville Rd.
Austin, 78752

July 14
**Texas Commission on
Environmental Quality**
Building A
12100 Park 35 Circle
Austin, 78753

July 14
Texas Woman's University
Multipurpose Classroom
Laboratory Building
304 Administration Dr.
Denton, 76201

July 17
Alamo Community College
McAllister Fine Arts Center –
Auditorium
1300 San Pedro Ave.
San Antonio, 78212

July 17
**Texas Department
of Transportation**
Building RS-200 –
Auditorium 1A.1
200 E. Riverside Dr.
Austin, 78704

July 18
Texas State University
JC Kellam Administration Building –
Room 1100
601 University Dr.
San Marcos, TX 78666

July 18
**Texas Department
of Transportation**
Room 2
4615 NW Loop 410
San Antonio, 78229

July 19
**Texas Department
of Transportation**
Building 2
1701 South Padre Island Dr.
Corpus Christi, 78416

July 20
South Texas College
Building H – Student Lounge
3201 Pecan Blvd.
McAllen, 78501

July 21
Texas State Technical College
Service Support Center –
Conference Room
1902 N. Loop 499
Harlingen, 78550

July 24
**Texas Department
of Insurance**
Metro Center Building –
Tippy Foster Room
Suite 100
7551 Metro Center Dr.
Austin, 78744

July 25
Employees Retirement System
200 E. 18th St.
Austin, 78701

July 26
Texas Education Agency
William B. Travis Building
1701 Congress Ave.
Austin, 78701

The Employees Retirement System of Texas (ERS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ERS provides free language aids and services, such as: written information in other formats (large print, audio, accessible electronic formats, other formats) qualified interpreters, and written information in other languages.

If you need these services, call: 1-877-275-4377, TDD: 711.

If you believe that ERS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax or email:

Mail: Section 1557 Coordinator
Employees Retirement System of Texas
P.O. Box 13207, Austin, Texas 78711.
Fax: 512-867-3480.
Email: 1557coordinator@ers.state.tx.us
For more information visit: <http://www.ers.state.tx.us>

You can also file a civil rights complaint with the U.S. Department of Health and Human Services online, by mail or by phone at:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>.
Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201.
Phone: 1-800-368-1019, 800-537-7697 (TDD).

ATTENTION: Language assistance services, free of charge, are available to you.	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ.

1-877-275-4377



HealthSelectSM
of Texas

CONSUMER DIRECTED

HealthSelectSM

(800) 252-8039 | www.bcbstx.com/hs

**2017 SUMMER
ENROLLMENT BROCHURE**

Active employees and retirees
not eligible for Medicare

September 1, 2017 - August 31, 2018

Toll-free at (800) 252-8039 Monday-Friday 7 a.m. - 7 p.m. central time (CT) and Saturday 7 a.m - 3 p.m. CT



WELCOME!

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WELCOME HEALTHSELECT MEMBERS

Your health is important. Your 2018 coverage features new programs to help you with your health care decisions, and we're here to help you every step of the way.

In this brochure, you'll find information about your health plan, including new options and programs to help you make the most of your benefits and get care where and when you need it.

Health care is more than just about knowing where to go when you're sick. It's also about knowing how to stay well. Your HealthSelect medical plan includes access to great care and resources to help your overall well-being.



Whether you have a medical problem and need care, or you're healthy and interested in staying well, your HealthSelect medical plan can help by offering:

- Personal Health Assistants that can help guide you at every step along the way – from helping you find a primary care physician (PCP), to connecting you with clinicians, to explaining what wellness programs are available
- One of the largest networks of physicians and facilities in Texas
- Resources to help with continuing care or answering your questions about the HealthSelect transition to Blue Cross and Blue Shield of Texas (BCBSTX)
- Experts to help you with chronic conditions
- Virtual visits with \$0 copay for HealthSelect In-Area and Out-of-State participants
- Discounts on health and wellness products and services from top retailers
- A Fitness Program which gives you access to discounted memberships at over 9,000 health clubs and gyms nationwide¹

¹ The Fitness Program is provided by Healthways, Inc., an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.

A photograph of a young boy with dark hair, wearing a green shirt, sitting at a table and eating broccoli. He is looking up and smiling as he takes a bite. The background is slightly blurred, showing a kitchen setting with a green cup and other items on the table.

PLAN OPTIONS

Understand your health plan options and select what works best for you and your family.

Beginning September 1, 2017, BCBSTX will be the third-party administrator for HealthSelectSM of Texas and Consumer Directed HealthSelectSM. The Employees Retirement System of Texas (ERS) sets the benefits and pays the claims, while BCBSTX manages the provider network, processes claims and provides customer service.

HealthSelect of Texas

HealthSelect of Texas is the state's insurance plan available to employees, retirees not enrolled in Medicare, spouses and dependents who are eligible to participate in a Texas Employees Group Benefits Program (GBP) health plan. If you are enrolled in HealthSelect, you need to choose a PCP. Your PCP is your personal physician, helping keep you healthy and referring you to specialists and other providers if needed. It is important for participants in this plan to check and make sure your current PCP will be in-network with BCBSTX beginning September 1, 2017. If you need help finding an in-network PCP with BCBSTX, go to **www.bcbstx.com/hs** or call toll-free at **(800) 252-8039** Monday-Friday 7 a.m. - 7 p.m. CT and Saturday 7 a.m - 3 p.m. CT to speak to a Personal Health Assistant.²

Living or working out of state?

- The HealthSelect Out-of-State plan is available only to active employees, retirees under 65, and their eligible dependents living or working outside the state of Texas.
- This plan no longer requires a deductible for in-network services and a copay will apply to certain services like PCP and specialist office visits, rather than coinsurance.
- You are not required to select a PCP and referrals for specialists are not required. However, having a PCP is important to managing your health and well-being.

Consumer Directed HealthSelect

Consumer Directed HealthSelectSM is a high-deductible health plan paired with a health savings account (HSA).³ The monthly premium for spousal and dependent coverage is lower, but the higher deductible means you could pay more upfront in out-of-pocket costs for health care services and prescriptions. The deductible is the amount you must pay for covered health services or prescriptions first before the plan begins to pay for anything (except preventive care services). With Consumer Directed HealthSelect, you have access to the same large provider network as HealthSelect of Texas, including tens of thousands of providers across Texas. You don't have to choose a primary care physician or get referrals to specialists under the Consumer Directed HealthSelect plan. Participants who are eligible for Medicare are not eligible for this plan.

² Member communications and information from Personal Health Assistants are not meant to replace the advice of health care professionals. Participants are encouraged to seek the advice of their doctors to discuss their health care needs. Decisions regarding course and place of treatment remain with the member and his or her health care providers.

³ Participants who are enrolled in any part of Medicare (Part A, B, C and/or D), receive benefits under TRICARE or TRICARE for Life, or have a health care flexible spending account (like a TexFlex health care account) in the same plan year are not eligible for an HSA.

Here's how Consumer Directed HealthSelect works:

- You have both an in-network and out-of-network annual deductible. Consumer Directed HealthSelect participants are responsible for paying an annual in-network deductible of \$2,100 for an individual or \$4,200 for a family for covered health services and prescriptions before the plan begins to pay for anything except for preventive services.⁴ There is an out-of-network deductible of \$4,200 for an individual or \$8,400 for a family, so your deductible is twice as much if you do not use network providers in this plan.
- You pay for health care services and prescription drugs out-of-pocket (except preventive services) until you meet your annual deductible.
- After you've met your deductible, your plan pays 80% (you pay 20%) of covered, in-network services and prescriptions. If you go out-of-network, your plan only pays 60% (you pay 40%) for covered services and prescriptions.
- Your preventive services are fully covered. Preventive health care services, like annual check-ups or vaccinations, are covered at 100% for in-network care.

Be prepared for out-of-pocket expenses with a health savings account (HSA)

You can use your HSA⁵ to pay for qualified medical expenses, including your deductible and coinsurance.

- One of the advantages of joining Consumer Directed HealthSelect is that the State of Texas will contribute pre-tax dollars to your HSA account every month. In FY18, the state will contribute \$45 per month (\$540 per year) for individual coverage and \$90 per month (\$1,080 per year) for family coverage to your HSA.
- You can also make tax-free contributions to your HSA through payroll deductions or independently.
- An HSA is a personal bank account to help you save and pay for health care while giving you real tax savings.
- HSAs are portable. You can use your HSA on qualified medical expenses, even if you change to a different health plan or change employers. The money in your HSA stays with you.
- Your unused HSA balance will carry over from one year to the next, so you won't lose money in your account at the end of the year.

Access programs and tools

Your health coverage includes comprehensive benefits and access to programs and tools that can help you and your family members improve health and well-being. We want you to get the most from your health plan.

Need help deciding?

Personal Health Assistants are ready and waiting to answer your questions. Connect with one today via:

- Click to Chat — Go to **www.bcbstx.com/hs** and click on the "Personal Health Assistants" box, then scroll down to the bottom of the page and click on "Chat now." Online chat is available Monday-Friday 8 a.m. - 5 p.m. CT.
- Call toll-free at **(800) 252-8039** Monday-Friday 7 a.m. - 7 p.m. CT and Saturday 7 a.m. - 3 p.m. CT.

⁴ Preventive care is covered at 100% when appropriately coded as preventive care per the Affordable Care Act guidelines.

⁵ Important Information about HSAs: HSA contributions and limits may change from year to year, or based on eligibility requirements and the participant's age. Maximums are set by the IRS and include both pre-tax and post-tax contributions to an HSA. HSAs have tax and legal ramifications. BCBSTX does not provide legal or tax advice. 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. You should seek advice based on your particular circumstances from an independent advisor regarding the tax consequences of specific health insurance plan or products.

IMPORTANCE OF A PCP



The importance of your PCP

The HealthSelect of Texas benefit plan requires that you choose a PCP to manage your health care needs so that you can receive the highest level of benefits and save the most money. Once you designate a PCP, he or she is responsible for coordinating your care and managing any referrals you may need to see specialists. Without a referral from your PCP, you will have to pay more out of pocket, even if you see a network specialist.

You do not need a referral for:

- Eye exams (both routine and diagnostic)
- OB/GYN visits
- Mental health counseling
- Chiropractic visits
- Occupational therapy and physical therapy
- Virtual visits, urgent care centers and convenience care clinics

To keep your health care costs as low as possible, make sure all of your health care providers are part of your BCBSTX network.

Why you need your own doctor

Even if you have Consumer Directed HealthSelect, having a PCP can be a boost to your health and help save you money. Having a PCP means you'll have someone in your corner helping you get the care you need. Your PCP:

- Will get to know you — your health history, your medications and your lifestyle
- Can treat many non-urgent health issues like ear infections, rashes, allergies, fevers, colds, flu and much more
- Will provide routine medical care, such as physicals and annual exams
- Is your health coach who can show you better ways to stay healthier
- Can decide if you need any tests or if you should see a specialist
- Can help you with specialized care for a chronic health issue, such as asthma, diabetes or a heart problem

If you want to select or change your PCP before September 1, 2017, speak to a Personal Health Assistant toll-free at **(800) 252-8039**, Monday - Friday 7 a.m. - 7 p.m. CT or Saturday 7 a.m. - 3 p.m. CT. After September 1, you will be able to select your PCP online.



HELP EVERY STEP OF THE WAY

Help is just a phone call away

We want to help you learn more about your benefit plan and how to make the most of it. It's easy to talk to a Personal Health Assistant every step of the way.

Our Personal Health Assistants are trained to help you and your covered family members plan for better health care and save money by:

- Helping you better understand your benefits and coverage
- Giving you cost estimates for health care services or procedures before you go to the doctor or hospital⁶
- Helping you with referrals and prior authorizations
- Scheduling appointments for you
- Connecting you with a nurse to help you learn more about a diagnosis or medical condition
- Sharing information about useful web and mobile tools, and helping you use them



How can I reach a Personal Health Assistant?

It's easy! Just call toll-free at **(800) 252-8039**. They are standing by and ready to assist you with your benefits questions, Monday-Friday 7 a.m. - 7 p.m. CT and Saturday 7 a.m. - 3 p.m. CT.

Or go to **www.bcbstx.com/hs** and use Click to Chat. Click on the **"Chat now"** link on the Personal Health Assistant page. Personal Health Assistants are available online Monday-Friday 8 a.m. - 5 p.m. CT.

⁶ Personal Health Assistants offer cost estimates for various providers, facilities and procedures. Lower pricing and cost savings are dependent on the provider or facility of your choosing. Cost estimates are just an estimate. In addition to your usual deductibles, copayments and/or coinsurance, the actual cost of the services may vary based on a number of factors including the date of service, the actual procedure performed and what services were billed by the provider and your particular benefit plan. Coverage is subject to the limitations, exclusions and terms of your plan.

QUESTIONS ABOUT CONTINUING CARE

Questions about continuing care or wondering how to make the transition to BCBSTX?

- How can I confirm that my doctors are in the BCBSTX network?
- How can I schedule appointments?
- How can I get help with referrals or prior authorizations?
- I'm managing a condition, how can I connect with a nurse?
- Can I continue seeing my doctor after September 1, 2017 if she/he is not in the network?
- Do I need a new referral or prior authorization if I already have one?

A Personal Health Assistant can help answer those questions and more. To speak to a Personal Health Assistant call toll-free at **(800) 252-8039**, Monday - Friday 7 a.m. - 7 p.m. CT or Saturday 7 a.m. - 3 p.m. CT. To check online to see if your doctors are in the BCBSTX network go to **www.bcbstx.com/hs**. Go to the "Find a Provider" box on the home page and then click "Find a doctor or hospital." Select your enrolled plan, then search for your plan's specific network. If you do not find your provider in the directory, call a Personal Health Assistant toll-free at **(800) 252-8039** to see if you can continue to see that provider for a limited time.

Continuing care

Most likely the doctors you have been seeing are in your BCBSTX network. Even if your doctors stay the same, make sure you let them know that your insurance plan has changed once the plan year begins on September 1. You can expect to receive new ID cards from BCBSTX in late August. Make sure your providers have the information from your new ID card.

If you are currently receiving treatment from a doctor who will not be in the BCBSTX HealthSelect network after September 1, 2017, you may apply to continue treatment with that doctor temporarily. To continue with your care, certain eligibility guidelines need to be met. You will need to fill out and submit a transition of care form. You can fill out the form online or download it by going to **www.bcbstx.com/hs** and clicking on "Publications and Forms."

Medical conditions that may meet the eligibility guidelines include:

- Pregnancy in the second or third trimester
- Patients who continue to be hospitalized after August 31, 2017
- Terminal illness where life expectancy is less than six months
- Long term treatment of cancer, heart disease, transplants

Examples of medical conditions that do not meet the guidelines:

- Routine care (immunizations, physicals)
- Chronic conditions which are stabilized (asthma, diabetes)
- Minor illness (flu, sore throat, sprains)
- Elective surgery



**WE'RE HERE
TO HELP**

Support for Your Wellness Journey

Whether it's learning how to take care of yourself through healthy eating and exercise, getting help for an emotional problem or dealing with a more difficult health challenge, we're here to help. The HealthSelect health improvement program is centered on you. A multi-disciplinary team, led by a clinician, is in your corner to work with you and guide you on your unique path.

Here are some examples of what we can help you with:

- Are you trying to lose weight?
- Do you need counseling for an ongoing situation?
- Are you dealing with a chronic or serious illness such as heart disease or diabetes?
- Do you have back pain?
- Are you trying to control asthma or live with chronic obstructive pulmonary disease (COPD)?
- Do you want to quit smoking?

If you, or a covered dependent, have a chronic condition and have been enrolled in a program to help you manage your condition call toll-free at **(800) 252-8039** Monday-Friday 7 a.m. - 7 p.m. CT or Saturday 7 a.m - 3 p.m. CT to speak with a Personal Health Assistant. The Personal Health Assistant can connect you with one of our nurses who is a licensed clinician with special training to help you manage a health condition. Our nurses are available to you and your covered family members at no additional cost.



WHAT TO EXPECT

Take advantage of your benefits

After September 1, 2017, you'll have access to new resources and tools to help you make the most of your HealthSelect plan. You can get information about your health benefits, anytime, anywhere. There are many ways to connect. Our website, Blue Access for MembersSM, is a great place to start. You can register online through the HealthSelect website beginning September 1, 2017, using the information on your medical ID card. You can also register using the BCBSTX mobile app. Text **BCBSTXAPP** to **33633** to get the BCBSTX app that lets you use Blue Access for Members while you're on the go.⁷ Or you can download from an app store for your iPhone® or Android™ smartphone.

Keep your benefits at your finger tips. With the app you can:

- Stay informed on the go and better manage your health, wellness and benefits
- Find an in-network doctor, hospital or urgent care facility
- Check the cost and quality of doctors and services covered under your plan
- Check the status or history of a claim
- Request a new ID card or save a digital copy to your phone
- View Explanation of Benefits (EOB) statements
- Confirm prior authorization and referral requirements
- Connect with a Personal Health Assistant by phone or chat
- Tell us how you want us to communicate with you and set up requests for text alerts

HealthSelectSM of Texas Plan Prescription Drugs

Your current plan administrator for prescription drug coverage for HealthSelect of Texas and Consumer Directed HealthSelect will remain the same after September 1, 2017. Your prescription plan administrator will send you a new ID card for prescription drug coverage before September 1.

⁷ Message and data rates may apply. Read terms, conditions and privacy policy at bcbstx.com/mobile/text-messaging.

Make the most of your medical plan

The HealthSelect of Texas and Consumer Directed HealthSelect medical plans offer you and your eligible dependents value added programs and services which will be available beginning September 1.

Don't have time to visit the doctor?

The virtual visits program provides you and your covered dependents access to care for non-emergency medical needs. You will be able to choose either Doctor on Demand or MDLIVE® to access a board-certified doctor 24 hours a day/seven days a week.⁸

Weight Management Programs with Long-Lasting Results

HealthSelect weight management programs are offered at no additional cost to you. Eligible HealthSelect participants and their eligible dependents will be able to choose either the Naturally Slim® or Real Appeal® online weight management program. Covered dependents (age 18 and older) are also able to sign up.⁹

Get answers day or night with 24/7 Nurseline

If you're not sure where to go for care, or you just have a question, calling the 24/7 Nurseline may be your answer. With the 24/7 Nurseline, you and your covered family members have access to caring registered nurses at any time, any day of the year.¹⁰

Looking for a New Way to Experience Wellness?

The Well onTarget® online portal offers personalized tools and resources to help you — no matter where you may be on the path to health and wellness.

Earn rewards

Blue Points can help motivate you to maintain a healthy lifestyle. Earn points for participating in wellness activities. You can redeem points in the online shopping mall.¹¹

Take Advantage of Discounts

With Blue365®, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or pre-authorizations.¹²

Additional information about these and other programs will be available on the HealthSelect website after September 1, 2017.

⁸ In the event of an emergency, this service should not take the place of an emergency room or urgent care center. Virtual visits doctors do not take the place of your primary care doctor. Proper diagnosis should come from your doctor, and medical advice is always between you and your doctor. Virtual visits are currently not available in Arkansas. Service availability depends on member's location. MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE and Doctor on Demand are independent companies who provide virtual visit services for Blue Cross and Blue Shield of Texas. MDLIVE and Doctor on Demand are solely responsible for their operations and that of their contracted providers. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission.

⁹ The relationship between Blue Cross and Blue Shield of Texas, Naturally Slim and Real Appeal is that of independent contractors.

¹⁰ For medical emergencies, call 911. 24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

¹¹ Blue Points Program Rules are subject to change without prior notice. Redemption of points for items is limited to \$99 per participant per calendar year.

¹² Blue365 is a discount program only for BCBSTX members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your Master Benefit Plan Document or call BCBSTX toll-free at (800) 252-8039, 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.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

KEY 2017 BENEFITS

HealthSelectSM of Texas¹

Consumer Directed HealthSelectSM 1

Benefits	HealthSelect SM of Texas ¹				Consumer Directed HealthSelect SM 1	
	In-Area		HealthSelect SM of Texas Out-of-State ²		Network	Non-Network
	Network	Non-Network	Network	Non-Network		
Calendar year deductible	None	\$500 per person \$1,500 per family	None	\$500 per person \$1,500 per family	\$2,100 per person \$4,200 per family	\$4,200 per person \$8,400 per family
Out-of-pocket coinsurance maximum⁴	\$2,000 per person per calendar year	\$7,000 per person per calendar year	\$2,000 per person per calendar year	\$7,000 per person per calendar year	None	None
Total out-of-pocket maximum¹⁰ (including deductibles, coinsurance and copays) ¹¹	**\$6,550 per person \$13,100 per family	None	**\$6,550 per person \$13,100 per family	None	**\$6,550 per person \$13,100 per family	**\$13,100 per person \$26,200 per family
Primary care physician required	Yes	No	No	No	No	No
Primary care physicians' office visits	\$25	40%	\$25	40%	20%	40%
Mental health care						
a. Outpatient physician or mental health provider office visits	\$25 copay	40% coinsurance after you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance
b. Hospital Mental health inpatient stay (copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per calendar year.)	20% coinsurance after copay	40% coinsurance after copay and you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after copay and you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance
c. Outpatient facility care (partial hospitalization/ day treatment and extensive outpatient treatment)	20% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance
Physicals[*]	No charge	40%	No charge	40%	No charge	40%
Specialty physicians' office visits	\$40	40%	\$40	40%	20%	40%
Routine eye exam, one per year per participant[*]	\$40	40%	\$40	40%	20%	40%
Routine preventive care[*]	No charge	40%	No charge	40%	No charge	40%
Diagnostic x-rays, lab tests, and mammography	20%	40%	20%	40%	20%	40%
Office surgery and diagnostic procedures	20%	40%	20%	40%	20%	40%
High-tech radiology (CT scan, MRI, and nuclear medicine) ^{7,9,12}	\$100 copay plus 20%	\$100 copay plus 40%	\$100 copay plus 20%	\$100 copay plus 40%	20%	40%
Urgent care clinic	\$50 copay plus 20%	\$50 copay plus 40%	\$50 copay plus 20%	\$50 copay plus 40%	20%	40%

Benefits	HealthSelect SM of Texas ¹				Consumer Directed HealthSelect ^{SM1}	
	In-Area		HealthSelect SM of Texas Out-of-State ²		Network	Non-Network
	Network	Non-Network	Network	Non-Network		
Urgent care clinic	\$50 copay plus 20%	\$50 copay plus 40%	\$50 copay plus 20%	\$50 copay plus 40%	20%	40%
Maternity Care doctor charges only*; inpatient hospital copays will apply	No charge for routine prenatal appointments \$25 or \$40 for first post-natal visit ⁵	40%	No charge for routine prenatal appointments \$25 or \$40 for first post-natal visit ⁵	40%	No charge for routine prenatal appointments 20% for first post-natal visit	40%
Chiropractic Care						
a. Coinsurance	20%; \$40 copay plus 20% with office visit	40%	20%; \$40 copay plus 20% with office visit	40%	20%	40%
b. Maximum benefit per visit	\$75	\$75	\$75	\$75	\$75	\$75
c. Maximum visits Each participant Per calendar year	30	30	30	30	30	30
Inpatient hospital (semi-private room and day's board, and intensive care unit) ¹²	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 40% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 40% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	20%	40%
Emergency care	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	20%	20%
Outpatient surgery other than in physician's office	\$100 copay plus 20%	\$100 copay plus 40%	\$100 copay plus 20%	\$100 copay plus 40%	20%	40%
Bariatric surgery ^{8, 9A, 11}	a. Deductible: \$5,000 b. Coinsurance 20% c. Lifetime max \$13,000	Not covered	a. Deductible \$5,000 b. Coinsurance 20% c. Lifetime max \$13,000	Not covered	Not covered	Not covered
Hearing aids	Plan pays up to \$1,000 per ear every three years (no deductible).				Plan pays up to \$1,000 per ear every three years (after deductible is met).	
Durable medical equipment ¹²	20%	40%	20%	40%	20%	40%
Ambulance services (non-emergency) ¹²	20%	20%	20%	20%	20%	20%

¹ Benefits are paid on allowable amounts; using providers who contract with Blue Cross and Blue Shield of Texas will protect you from liability for amounts over the allowable amount. ² HealthSelect Out-of-State applies to employees and retirees under age 65 and their eligible dependents who live or work outside of Texas. You cannot enroll in Out-of-State coverage unless your work or home address is outside of Texas. ³ Applies to plan year, September 1 - August 31.

⁴ Does not include copays. ⁵ Copay depends on whether treatment is given by PCP or specialist. ⁶ For treatment charges, one visit per plan year. ⁷ Outpatient testing only. Does not apply to inpatient services. ⁸ Active employees only; see health plan for additional requirements/limitations. ^{9A} The deductible and coinsurance paid for bariatric surgery does not apply to the total out-of-pocket maximum. ⁹ No copay if high-tech radiology is performed during ER visit or inpatient admission. ¹⁰ Out-of-pocket maximums are not mutually exclusive from other out-of-pocket limits. This means that a participant's total network out-of-pocket maximum could contain a combination of coinsurance and/or copayments. (For example, a participant could pay up to \$6,550 in copayments alone if there was no coinsurance paid throughout the year. If a participant met the \$2,000 coinsurance out-of-pocket maximum, he/she would pay \$4,550 in copayments, totaling \$6,550 in overall out-of-pocket expense.) ¹¹ Includes medical and prescription drug copays, coinsurance and deductibles. Excludes non-network and bariatric services.

¹² Preauthorization required. Mental Health Benefits follow those of medical and surgical benefits listed in this chart. This comparison chart offers a general overview of benefits and their associated out-of-pocket expenses under HealthSelect plans. Contact the plan's customer service department for specific questions. *Under the Affordable Care Act, certain preventive and women's health services are paid at 100% (at no cost to the participant) dependent upon physician billing and diagnosis. In some cases, the participant will still be responsible for payment on some services. **Effective calendar year



Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984

العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلتدرك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય અથવા કોઈ બાજુ વ્યક્તિને અસુબા અમ કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したり することができます。料金はかかりません。通訳とお話される場合、855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍອຳການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອສົມກັບນາຍແປພາສາ, ໃຫ້ໃຫ້ຫາບິ 855-710-6984.
Diné Navajo	T'áá nǫ́, éí doodago la'da biká anánílwo'ígíí, na'idilkidgo, ts'ídá bee ná ahóótí'í t'áá níí'k'e níká a'doolwoł dóó bina'idilkidígíí bee níí hodoonih. Ata'dahalne'ígíí bich'í' hodiílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-710-6984.



BlueCross BlueShield
of Texas

HealthSelectSM
of Texas

CONSUMER DIRECTED

HealthSelectSM

CONTACT INFORMATION

www.bcbstx.com/hs

Blue Cross and Blue Shield of Texas

Customer Service toll-free at **(800) 252-8039** Monday-Friday
7 a.m. - 7 p.m. CT and Saturday 7 a.m. - 3 p.m. CT

Personal Health
Assistant
(800) 252-8039

Beginning September 1, 2017, Blue Cross and Blue Shield of Texas (BCBSTX) is the third-party administrator for the HealthSelect of Texas and Consumer Directed HealthSelect plans.

Blue Cross and Blue Shield 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

GET CARE ANYTIME WITH VIRTUAL VISITS



Consult a doctor anytime online or by phone

Not the right time to visit the doctor?

Getting sick never comes at a good time. When you don't feel well or your child is sick, you may not want to leave home. With virtual visits, you and your covered dependents can talk to a doctor without leaving your home or office. A virtual visit is an option for you when you can't get to your doctor, when you get sick while traveling, or as an alternative to the emergency room or an urgent care facility.¹

Here's how virtual visits works:

- With virtual visits, you can speak to a doctor right away or make an appointment to see a doctor in the future based on what works best for you.
- A doctor can see you 24/7 any time, any day of the week.
- You can choose between MDLIVE[®] or Doctor on Demand.²
- You can have real-time consultations with a board-certified doctor from your computer, phone or mobile device.³
- Virtual visit doctors can diagnose and treat a wide range of medical conditions. See the back page for examples of conditions that the virtual visits doctor can treat.
- Most virtual visits take 10 to 15 minutes.
- If needed, prescriptions can be sent electronically to the pharmacy of your choice.
- There is no copay if you are enrolled in HealthSelect of Texas.⁴

How to take advantage of virtual visits

Sign-up for virtual visits will be available through MDLIVE or Doctor on Demand starting September 1, 2017, if you enroll in HealthSelect of Texas or Consumer Directed HealthSelect. If you already participate, your service continues until the new enrollment date. Then, you must re-enroll to continue access to virtual visits. Spouses and covered dependents are also able to sign up.





Connect

Access using a mobile app, through online video or by telephone anywhere a connection is available



Consult

Real-time interaction with a board-certified doctor



Diagnose

After the doctor provides a diagnosis, prescriptions can be electronically sent to the pharmacy of your choice (when appropriate)

With virtual visits, doctors can provide general health treatment and pediatric care for the following conditions and more:

- Allergies
- Asthma
- Bladder and urinary tract infections
- Bronchitis
- Cold and flu
- Ear problems
- Headaches
- Nausea
- Pinkeye
- Sore throat
- Rash

See your primary care physician for complex or chronic conditions, injuries requiring bandaging or sprains and broken bones or anything requiring an exam or test.

Get connected on September 1!

Registration is easy. You will be able to register by going online to the HealthSelect website. All you'll need to provide is your first and last name, date of birth and HealthSelect member ID.

¹ In the event of an emergency, this service should not take the place of an emergency room or urgent care center. MDLIVE and Doctor on Demand doctors do not take the place of your primary care doctor.

² MDLIVE and Doctor On Demand are independent companies that provide virtual visit services for Blue Cross and Blue Shield of Texas. MDLIVE and Doctor On Demand operate and administer the virtual visit program and are solely responsible for their operations and that of their contracted providers. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. The telemedicine services made available through Doctor On Demand are provided by licensed physicians practicing within a group of independently owned professional practices collectively known as "Doctor On Demand Professionals". These professional practices provide services via the Doctor On Demand telehealth platform. Doctor On Demand, Inc. does not itself provide any physician, mental health or other healthcare provider services. MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE and Doctor on Demand do not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services.

³ Internet/Wi-Fi connection is needed for computer access. Data charges may apply when using your tablet or smartphone. Check your phone carrier's plan for details. Service is limited to interactive-audio consultations (phone only), along with the ability to prescribe, when clinically appropriate, in Texas. Service is limited to interactive-audio/video (video only), along with the ability to prescribe, when clinically appropriate, in Idaho, Montana, New Mexico and Oklahoma. Virtual visits are currently not available in Arkansas. Service availability depends on member's location.

⁴ Your copay for virtual visits services may be as low as \$0. HealthSelectSM of Texas (In-Area) and HealthSelect of Texas (Out-of-State) members: \$0 copay. Consumer Directed HealthSelectSM In-network deductible and then 20% coinsurance. HealthSelect Secondary- In-network deductible and then 30% coinsurance.

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Blue Cross[®], Blue Shield[®] and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

TAKE STEPS TO WELL-BEING



A Fitness Program Designed to Work for You

Fitness can be easy, fun and low cost with the HealthSelect Fitness Program

Being active – it's vital to healthy living and fitness.

The HealthSelect Fitness Program helps you to make your fitness goals a reality. With access to more than 10,000 fitness centers nationwide, you can choose a gym that's right for you. You can visit gyms whether you're taking time off or working out of town.

Other program perks:

- No annual program or gym contract: Participation is month to month. Fees are \$25 per month per person to use any gym in the fitness program. There is a one-time sign-up fee of \$25 per person.*
- Alternative medicine discounts: Save money with health and well-being providers, such as massage therapists, trainers and nutrition coaches.
- Web help: Beginning September 1, 2017, you may go online to the HealthSelect website to find gyms and track your visits.
- Easy to pay: After you enroll, it's easy to set up an automatic credit card or bank account withdrawal to pay your monthly fee.

Get ready to get fit

Once enrolled in HealthSelect of Texas or Consumer Directed HealthSelect you may sign up for the HealthSelect Fitness Program beginning September 1, 2017. You may enroll by calling toll-free at **(888)-762-BLUE (2583)** Monday through Friday, 8 a.m. – 9 p.m., in any continental U.S. time zone. Covered dependents (age 18 and older) are eligible.

*The one-time enrollment fee and monthly membership fee for the Fitness Program are both subject to applicable taxes. The Fitness Program is provided by Tivity Health, an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.

The HealthSelect Fitness Program is provided to HealthSelect participants in addition to your health plan. This is NOT insurance. Use of the HealthSelect Fitness Program does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Fitness center access is provided only by vendors that take part in this program.





Looking for a new “weigh” of life?

Weight Management Programs with Long-Lasting Results

You choose what works best for you

We know losing weight can help us feel better. Losing weight may also reduce your risk for diabetes, heart disease and stroke. HealthSelect weight management programs help you set weight loss goals that may help you reach long-lasting results. Each of these programs feature weekly online sessions and other support. They are offered at no additional cost to eligible HealthSelect participants and their covered dependents.

Clinically-proven results through Naturally Slim®

Tired of counting calories or points? The Naturally Slim online program teaches skills you can use for the rest of your life. You can participate in the program when and where it works for you. Naturally Slim starts with 10 weeks of skill building focused on behavior change, called mindful eating. You will also have support and coaching for one full year to help you achieve lasting results. When you sign up you will get a welcome kit. Your welcome kit will include: useful information to get you started; a tape measure to help you monitor your progress; and food items you will use during the first Naturally Slim lesson. You'll get encouraging weekly email reminders to log your weight and watch the week's video. And you can use a mobile app that lets you get to lessons and practice skills on the go.

A fresh approach with Real Appeal®

Real Appeal is an online weight loss program that helps you form healthy habits that can lead to long-lasting results by developing healthy habits like eating well and exercising regularly. Motivating coaching videos and other resources, including weekly emails, help you use what you've learned. When you sign up, you'll get the Real Appeal success kit mailed right to your door. The kit contains guides, DVDs, a blender, cooking tools, resistance bands, a pedometer and a scale. A Real Appeal Transformation Coach will fine-tune the program to your needs, your goals, and your life for a full 52 weeks.

Take the first step to a healthier weight

If you are enrolled in HealthSelect of Texas or Consumer Directed HealthSelect, you may choose one of these weight management programs if you meet eligibility guidelines. You can only enroll in one program at a time. Covered dependents (age 18 and older) are also eligible. To learn more about these programs, speak to a Personal Health Assistant toll-free at **(800) 252-8039** Monday-Friday 7 a.m. – 7 p.m. CT and Saturday 7 a.m – 3 p.m. CT.



Confused About Where to Go for Care?

Smart health care choices may save you money.

Sometimes it's easy to know when you should go to an emergency room (ER). At other times, it's less clear. Where do you go when you have a cold, fever, sore throat, or you are generally not feeling well? The emergency room can be an expensive option. The chart below can help you figure out when to use each type of care.

When you use in-network providers for health care, you usually pay less for care. Search for in-network providers in your area at www.bcbstx.com/hs or by calling a Personal Health Assistant at **800-252-8039**.



Virtual Visits

- You can speak to a board-certified doctor online or via telephone for treatment of urgent care situations. If necessary, a doctor can prescribe medication for you and send it to your preferred pharmacy.
- Access to care for non-emergency medical issues whether you're at home or traveling.
- Average wait time is less than 10 minutes.
- Available 24 hours a day, seven days a week.

\$0 to \$¹



Doctor's Office

- Your doctor knows you and your medical history best and can treat you or refer you to a specialist if necessary.
- Generally the best place to go for non-emergency care.
- Average wait time is 24 minutes.²
- Office hours vary.

\$



Retail Health Clinic

- Often located in stores and pharmacies to provide convenient, low-cost treatment for minor medical problems.
- Usually lower out-of-pocket cost to you than urgent care.
- Wait times vary.
- Open during retail store hours.

\$



Urgent Care Provider

- Often used when your doctor's office is closed, and there is no true emergency.
- Many have online and/or telephone check-in.
- Average wait time is 11-20 minutes.³
- Generally open evenings, weekends and holidays.

\$\$\$



Hospital ER

- Best option for a life- or limb threatening condition, such as chest pain lasting more than two minutes, shortness of breath, stroke symptoms, uncontrolled bleeding, or fainting and seizures.
- Multiple bills for services such as the hospital facility and laboratory fees and each doctor you see, such as emergency room doctors, radiologists, pathologists, anesthesiologists, etc.
- Average wait time is 4 hours, 7 minutes.⁴
- Open 24 hours a day, seven days a week.

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Freestanding ER

- Most freestanding ERs and the doctors who treat patients at freestanding ERs are out-of-network. If you receive care from an out-of-network provider, you may have to pay much more. Providers outside the network may "balance bill" you, which means they may charge you more than your health plan's fee schedule.⁵ See back page for more facts about freestanding ERs.
- You could be transferred to a hospital ER based on medical situation.
- Freestanding ERs charge a facility fee that urgent care centers do not. You may also be billed for laboratory fees and each doctor you see.⁵
- Open 24 hours a day, seven days a week.

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If you need emergency care, call 911 or seek help from any doctor or hospital immediately.

¹ Your copay for virtual visits services may be as low as \$0. HealthSelect of Texas (In-Area) and HealthSelect of Texas (Out-of-State) members: \$0 copay. Consumer Directed HealthSelect In-network deductible and then 20% coinsurance. HealthSelect Secondary- In-network deductible and then 30% coinsurance.

² Medical Practice Pulse Report 2009, Press Ganey Associates

³ Urgent Care Benchmarking Study Results. Journal of Urgent Care Medicine, January 2012.

⁴ Emergency Department Pulse Report 2010 Patient Perspectives on American Health Care. Press Ganey Associates.







⁵ Texas Association of Health Plans, www.tahp.org

Note: The relative costs described here are for independently contracted network providers. Your costs for out-of-network providers may be significantly higher. Wait times described are just estimates.

The information provided in this guide is not intended as medical advice, nor meant to be a substitute for the individual medical judgment of a doctor or other health care professional. Please check with your doctor for individualized advice on the information provided. Coverage may vary depending on your specific benefit plan and use of network providers. This information is intended solely as a general guide to what services may be available. The actual availability of services may vary greatly from location to location. If you have questions about any health concern, you should discuss them with your health care provider. For questions, please call a Personal Health Assistant at 800-252-8039.

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Deciding Where to Go?

	Virtual Visits 	Doctor's Office 	Retail Health Clinic 	Urgent Care Center 	Hospital ER 	Freestanding ER 
Sprains, strains		■	■	■	<ul style="list-style-type: none"> Any life-threatening or disabling conditions Sudden or unexplained loss of consciousness Major injuries, including trauma Chest pain; numbness in the face, arm or leg; difficulty speaking Severe shortness of breath High fever with stiff neck, mental confusion or difficulty breathing Coughing up or vomiting blood Cut or wound that won't stop bleeding Possible broken bones 	<ul style="list-style-type: none"> Most major injuries except for trauma May also provide imaging and lab services but do not offer trauma or cardiac services requiring catheterization¹ Do not always accept ambulances
Animal bites		■	■	■		
X-rays		■		■		
Stitches				■		
Mild asthma	■	■	■	■		
Minor headaches	■	■	■	■		
Back pain		■	■	■		
Nausea, vomiting, diarrhea	■	■	■	■		
Minor allergic reactions	■	■	■	■		
Coughs, sore throat	■	■	■	■		
Bumps, cuts, scrapes	■	■	■	■		
Rashes, minor burns	■	■	■	■		
Minor fevers, colds	■	■	■	■		
Ear or sinus pain	■	■	■	■		
Burning with urination	■	■	■	■		
Eye swelling, irritation, redness or pain	■	■	■	■		
Vaccinations		■	■	■		

Start with a Personal Health Assistant²

A Personal Health Assistant can:

- Help you find an in-network provider or facility
- Help compare costs at different providers near you³
- Help you schedule your appointment
- Help with prior authorization
- Tell you about online educational tools

To speak to a Personal Health Assistant, just call **800-252-8039**.

24/7 Nurseline⁴

The 24/7 Nurseline can help you decide where to go for care when you or a family member have a health problem or concern. Nurses are available, 24 hours a day, seven days a week, to answer your health questions.

Urgent Care Center or Freestanding ER Knowing the Difference Can Save You Money

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs often look a lot like urgent care centers, but costs are much higher. Freestanding ERs are often out of network and may charge significantly more for services. Here are some ways to know if you are at a freestanding ER.

Freestanding ERs:

- Look like urgent care centers, but include EMERGENCY in facility names.
- Are open 24 hours a day, seven days a week.
- Are physically separate from a hospital.
- Are subject to the same copay as hospital ER and are staffed by ER physicians.

¹ "Freestanding ED 101: What you need to know" July 2016, The Advisory Board Company

² Personal Health Assistants offer cost estimates for various providers, facilities and procedures. Lower pricing and cost savings are dependent on the provider or facility of your choosing.

³ Member communications and information from Personal Health Assistants are not meant to replace the advice of health care professionals. Members are encouraged to seek the advice of their doctors to discuss their health care needs. Decisions regarding course and place of treatment remain with the member and his or her health care providers. Cost estimates are just an estimate. In addition to your usual deductibles, copayments and/or coinsurance, the actual cost of the services may vary based on a number of factors including the date of service, the actual procedure performed and what services were billed by the provider and your particular benefit plan. Coverage is subject to the limitations, exclusions and terms of your plan.

⁴ 24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium¹) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-252-8039 or visit www.bcbstx.com/hs. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-252-8039 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> \$0 Individual / \$0 Family <u>Non-Network</u> \$500 Individual / \$1,500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive services</u> and in <u>network</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$50 for prescription drug expenses per person, \$5,000 for bariatric surgery for active employees, and \$200 per service for certain non-prior authorized services.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : \$6,550 Individual / \$13,100 Family <u>Non-Network</u> : No Limit <u>Coinsurance Limit</u> : \$2,000 <u>Network</u> / \$7,000 <u>Non-Network</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Contributions ¹ , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, and bariatric surgery benefits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbstx.com/hs or call 1-800-252-8039 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes. A valid written referral from your primary care physician is required to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

¹ Under this plan, payment for your health plan coverage is called a contribution rather than a premium.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	A valid referral to see a network specialist is required to access network benefits excluding OB/Gynecologists, chiropractors, and eye exams by ophthalmologists and optometrists.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit plus 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Non-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.healthselectrx.com	Generic drugs (Tier 1)	\$10 copay (non-maintenance), \$10 copay (maintenance); \$30 copay (mail order or extended day supply)	\$10 copay plus 40% coinsurance (non-maintenance) \$10 copay plus 40% coinsurance (maintenance); \$30 copay plus 40% coinsurance (mail order or extended day supply)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred or non-preferred brand drug, you will pay the generic copay plus the cost difference between the preferred or non-preferred brand drug and the generic drug.
	Preferred brand drugs (Tier 2)	\$35 copay (non-maintenance), \$45 copay (maintenance); \$105 copay (mail order or extended day supply)	\$35 copay plus 40% coinsurance (non-maintenance) \$45 copay plus 40% coinsurance (maintenance); \$105 copay plus 40% coinsurance (mail order or extended day supply)	
	Non-preferred brand drugs (Tier 3)	\$60 copay (non-maintenance), \$75 copay (maintenance); \$180 copay (mail order or extended day supply)	\$60 copay plus 40% coinsurance (non-maintenance) \$75 copay plus 40% coinsurance (maintenance); \$180 copay plus 40% coinsurance (mail order or extended day supply)	
	<u>Specialty drugs</u>	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred or non-preferred brand drug, you will pay the generic copay plus the cost difference between the preferred or non-preferred brand drug and the generic drug.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Non-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /visit plus 20% <u>coinsurance</u>	\$100 <u>copay</u> /visit plus 40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit plus 20% <u>coinsurance</u>	\$150 <u>copay</u> /visit plus 20% <u>coinsurance</u> <u>Non-network deductible</u> does not apply	\$300 <u>copay</u> /visit plus 20% <u>coinsurance</u> applies to any <u>non-network</u> freestanding <u>emergency room</u> not affiliated with a hospital. <u>Non-network deductible</u> does not apply. <u>Emergency room copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> <u>Non-network deductible</u> does not apply	None
	<u>Urgent care</u>	\$50 <u>copay</u> / visit plus 20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150/day <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$150/day <u>copay</u> per admission plus 40% <u>coinsurance</u>	\$750 <u>copay</u> max per admission. \$2,250 <u>copay</u> max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> for office visits and 20% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	Certain services must be prior authorized; refer to Master Benefit Plan Document for details.
	Inpatient services	\$150/day <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$150/day <u>copay</u> per admission plus 40% <u>coinsurance</u>	\$750 <u>copay</u> max per admission. \$2,250 <u>copay</u> max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Non-Network Provider</u> (You will pay the most)	
If you are pregnant	Office visits	No Charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Charge	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$150/day <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$150/day <u>copay</u> per admission plus 40% <u>coinsurance</u>	\$750 copay max per admission. \$2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Max of 100 <u>non-network</u> visits per calendar year per person. <u>Non-network</u> home infusion therapy is not covered.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Replacement limit of one every 3 years per person unless change in condition or physical status. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	Limit of one routine exam per calendar year per person. No referral is required for eye exams.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Educational services, excluding Diabetes Self-Management Training Programs
- Glasses
- Infertility treatment
- Long-term care
- Personal comfort items
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery for active employees
- Chiropractic care
- Hearing aids (limited to \$1,000 per ear per 36-month period)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (limited to 96 hours per year for Non-network)
- Routine eye care (Adult)
- Weight loss programs (Limited to certain programs. See Master Benefit Plan Document for details on covered programs)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the HealthSelect of Texas plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-252-8039 or visit www.bcbstx.com/hs, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-252-8039.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-252-8039.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-252-8039.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-252-8039.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayments</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	20%
■ Hospital (facility) <u>copayments</u>	\$150
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/delivery professional services
 Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,300

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayments</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayments</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Hospital (ER) <u>copayments</u>	\$150
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,000
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

The plan would be responsible for the other costs of these EXAMPLE covered services.



BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
ລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍການຊ່ວຍເຫຼືອແລະຂໍມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໃບຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໃບຫາເບີ 855-710-6984.
Diné Navajo	T'áá ní, éí doodago la'da biká anánílwo'ígíí, na'idílkidgo, ts'ídá bee ná ahóótí'i' t'áá nílk'e níká a'doolwol. Ata' halne'í bich'i' hadeesdzih nínízingo éí kwe'é da'iníishgi áká anídaalwo'ígíí bich'i' hodiílnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'écégoó éí doodago bee nééhózinigíí ádingo kojí' hodiílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالاتی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium¹) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-252-8039 or visit www.bcbstx.com/hs. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-252-8039 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> \$2,100 Individual / \$4,200 Family <u>Non-Network</u> \$4,200 Individual / \$8,400 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive services</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$200 per service for certain non-prior authorized services.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : \$6,550 Individual / \$13,100 Family <u>Non-Network</u> : \$13,100 Individual / \$26,200 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	Contributions ¹ , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com/hs or call 1-800-252-8039 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No, <u>referrals</u> are not required to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .

¹ Under this plan, payment for your health plan coverage is called a contribution rather than a premium.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Non-Network Provider</u> (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.healthselectrx.com	Generic drugs (Tier 1)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred or non-preferred brand drug, you will pay the generic <u>coinsurance</u> plus the cost difference between the preferred or non-preferred brand drug and the generic drug.
	Preferred brand drugs (Tier 2)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Non-preferred brand drugs (Tier 3)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred or non-preferred brand drug, you will pay the generic <u>coinsurance</u> plus the cost difference between the preferred or non-preferred brand drug and the generic drug.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Non-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certain services must be prior authorized; refer to Master Benefit Plan Document for details.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you are pregnant	Office visits	No Charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Charge	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Non-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Max of 100 <u>non-network</u> visits per calendar year per person. <u>Non-network</u> home infusion therapy is not covered.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Replacement limit of one every 3 years per person unless change in condition or physical status. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limit of one routine exam per calendar year per person.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-----------------------|--|--------------------------|
| • Acupuncture | • Educational services, excluding Diabetes Self-Management Training Programs | • Long-term care |
| • Cosmetic surgery | • Glasses | • Personal comfort items |
| • Dental care (Adult) | • Infertility treatment | • Routine foot care |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|---|---|
| • Bariatric surgery for active employees | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
| • Chiropractic care | • Private-duty nursing (limited to 96 hours per year for <u>Non-network</u>) | • Weight loss programs (Limited to certain programs. See Master Benefit <u>Plan</u> Document for details on covered programs) |
| • Hearing aids (limited to \$1,000 per ear per 36-month period) | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the HealthSelect of Texas plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-252-8039 or visit www.bcbstx.com/hs, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/hs.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-252-8039.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-252-8039.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-252-8039.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-252-8039.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,100
■ <u>Specialist</u> <u>copayments</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/delivery professional services
 Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,100
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$4,200

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,100
■ <u>Specialist</u> <u>copayments</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,100
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$3,200

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,100
■ <u>Specialist</u> <u>copayments</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,000
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

The plan would be responsible for the other costs of these EXAMPLE covered services.



BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
ລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍການຊ່ວຍເຫຼືອແລະຂໍມູນເປັນພາສາຂອງທ່ານໄດ້ໃດໆບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໃບຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໃບຫາເບີ 855-710-6984.
Diné Navajo	T'áá ní, éí doodago la'da biká anánílwo'ígíí, na'ídlíkidgo, ts'ídá bee ná ahóótí'i' t'áá nílk'e níká a'doolwol. Ata' halne'í bich'i' hadeesdzih nínízingo éí kwe'é da'iníishgi áká anídaalwo'ígíí bich'i' hodiílnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'écégoó éí doodago bee nééhózinigíí ádingo kojí' hodiílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالاتی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

HEALTH PLANS COMPARISON CHART

Effective September 1, 2017

Benefits	HealthSelect SM of Texas ¹				Consumer Directed HealthSelect SM 1		HMOs	
	In-Area		HealthSelect SM of Texas Out-of-State ²		Network	Non-Network	Community First, Scott & White	KelseyCare powered by Community Health Choice
	Network	Non-Network	Network	Non-Network				
Calendar year deductible	None	\$500 per person \$1,500 per family	None	\$500 per person \$1,500 per family	\$2,100 per person \$4,200 per family	\$4,200 per person \$8,400 per family	None	None
Out-of-pocket coinsurance maximum⁴	\$2,000 per person per calendar year	\$7,000 per person per calendar year	\$2,000 per person per calendar year	\$7,000 per person per calendar year	None	None	\$2,000 per person ³	\$2,000 per person ³
Total out-of-pocket maximum¹⁰ (including deductibles, coinsurance and copays) ¹¹	**\$6,550 per person \$13,100 per family	None	**\$6,550 per person \$13,100 per family	None	**\$6,550 per person \$13,100 per family	**\$13,100 per person \$26,200 per family	\$6,550 per person \$13,100 per family ³	\$6,550 per person \$13,100 per family ³
Primary care physician required	Yes	No	No	No	No	No	Community First - yes Scott & White - no	No
Primary care physicians' office visits	\$25	40%	\$25	40%	20%	40%	\$25	\$15
Mental health care								
a. Outpatient physician or mental health provider office visits	\$25 copay	40% coinsurance after you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance	\$25	\$25
b. Hospital Mental health inpatient stay (copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per calendar year.)	20% coinsurance after copay	40% coinsurance after copay and you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after copay and you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance	20% coinsurance (plus \$150 a day copay per admission)	20% coinsurance (plus \$150 a day copay per admission)
c. Outpatient facility care (partial hospitalization/ day treatment and extensive outpatient treatment)	20% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	30% coinsurance	40% coinsurance after you meet the annual Non-Network Deductible	20% coinsurance	40% coinsurance	\$25 copay (prior authorization required)	\$25 copay
Physicals*	No charge	40%	No charge	40%	No charge	40%	No charge	No charge
Specialty physicians' office visits	\$40	40%	\$40	40%	20%	40%	\$40	\$25
Routine eye exam, one per year per participant*	\$40	40%	\$40	40%	20%	40%	\$40 ^{3,6}	\$25 ³
Routine preventive care*	No charge	40%	No charge	40%	No charge	40%	No charge	No charge
Diagnostic x-rays, lab tests, and mammography	20%	40%	20%	40%	20%	40%	20%	No charge* (physician office)
Office surgery and diagnostic procedures	20%	40%	20%	40%	20%	40%	20%	\$15 PCP or \$25 Specialist
High-tech radiology (CT scan, MRI, and nuclear medicine) ^{7,9,12}	\$100 copay plus 20%	\$100 copay plus 40%	\$100 copay plus 20%	\$100 copay plus 40%	20%	40%	\$100 copay plus 20% coinsurance	\$150 copay per scan type per day (Outpatient testing only)
Urgent care clinic	\$50 copay plus 20%	\$50 copay plus 40%	\$50 copay plus 20%	\$50 copay plus 40%	20%	40%	\$50 copay plus 20%	\$50 copay plus 20%

Benefits	HealthSelect SM of Texas ¹				Consumer Directed HealthSelect ^{SM1}		HMOs	
	In-Area		HealthSelect SM of Texas Out-of-State ²		Network	Non-Network	Community First, Scott & White	KelseyCare powered by Community Health Choice
	Network	Non-Network	Network	Non-Network				
Urgent care clinic	\$50 copay plus 20%	\$50 copay plus 40%	\$50 copay plus 20%	\$50 copay plus 40%	20%	40%	\$50 copay plus 20%	\$50 copay plus 20%
Maternity Care doctor charges only*; inpatient hospital copays will apply	No charge for routine prenatal appointments \$25 or \$40 for first post-natal visit ⁵	40%	No charge for routine prenatal appointments \$25 or \$40 for first post-natal visit ⁵	40%	No charge for routine prenatal appointments 20% for first post-natal visit	40%	No charge for routine prenatal appointments \$25 or \$40 for first post-natal visit ⁵	No charge
Chiropractic Care								
a. Coinsurance	20%; \$40 copay plus 20% with office visit	40%	20%; \$40 copay plus 20% with office visit	40%	20%	40%	CFHP: 20%; \$40 copay SWHP: 20%; \$40 copay plus 20% with office visit	\$25 copay
b. Maximum benefit per visit	\$75	\$75	\$75	\$75	\$75	\$75	CFHP: \$75/ SWHP - None	–
c. Maximum visits Each participant Per calendar year	30	30	30	30	30	30	CFHP: 30; SWHP: 35 (maximum manipulative therapy visits)	30
Inpatient hospital (semi-private room and day's board, and intensive care unit) ¹²	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 40% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	\$150/day copay plus 40% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per calendar year per person)	20%	40%	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per plan year per person ³)	\$150/day copay plus 20% (\$750 copay max-up to 5 days per hospital stay, \$2,250 copay max per plan year per person)
Emergency care	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 plus 20% (if admitted copay will apply to hospital copay)	20%	20%	\$150 plus 20% (if admitted copay will apply to hospital copay)	\$150 copay plus 20% (if admitted copay will apply to hospital copay)
Outpatient surgery other than in physician's office	\$100 copay plus 20%	\$100 copay plus 40%	\$100 copay plus 20%	\$100 copay plus 40%	20%	40%	\$100 copay plus 20%	\$150 copay plus 20%
Bariatric surgery ^{8, 8A, 11}	a. Deductible \$5,000 b. Coinsurance 20% c. Lifetime max \$13,000	Not covered	a. Deductible \$5,000 b. Coinsurance 20% c. Lifetime max \$13,000	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing aids	Plan pays up to \$1,000 per ear every three years (no deductible).				Plan pays up to \$1,000 per ear every three years (after deductible is met).		Plan pays up to \$1,000 per ear every three years (no deductible).	
Durable medical equipment ¹²	20%	40%	20%	40%	20%	40%	20%	20%
Ambulance services (non-emergency) ¹²	20%	20%	20%	20%	20%	20%	20%	20%

¹ Benefits are paid on allowable amounts; using providers who contract with Blue Cross Blue and Shield of Texas will protect you from liability for amounts over the allowable amount. ² HealthSelect Out-of-State applies to employees and retirees under age 65 and their eligible dependents who live or work outside of Texas. You cannot enroll in Out-of-State coverage unless your work or home address is outside of Texas. ³ Applies to plan year, September 1 - August 31. ⁴ Does not include copays. ⁵ Copay depends on whether treatment is given by PCP or specialist. ⁶ For treatment charges, one visit per plan year. ⁷ Outpatient testing only. Does not apply to inpatient services. ⁸ Active employees only; see health plan for additional requirements/limitations. ^{8A} The deductible and coinsurance paid for bariatric surgery does not apply to the total out-of-pocket maximum. ⁹ No copay if high-tech radiology is performed during ER visit or inpatient admission. ¹⁰ Out-of-pocket maximums are not mutually exclusive from other out-of-pocket limits. This means that a participant's total network out-of-pocket maximum could contain a combination of coinsurance and/or copayments. (For example, a participant could pay up to \$6,550 in copayments alone if there was no coinsurance paid throughout the year. If a participant met the \$2,000 coinsurance out-of-pocket maximum, he/she would pay \$4,550 in copayments, totaling \$6,550 in overall out-of-pocket expense.) ¹¹ Includes medical and prescription drug copays, coinsurance and deductibles. Excludes non-network and bariatric services. ¹² Preauthorization required. Mental Health Benefits follow those of medical and surgical benefits listed in this chart. This comparison chart offers a general overview of benefits and their associated out-of-pocket expenses under HealthSelect plans and the HMOs. Contact the plan's customer service department for specific questions. *Under the Affordable Care Act, certain preventive and women's health services are paid at 100% (at no cost to the participant) dependent upon physician billing and diagnosis. In some cases, the participant will still be responsible for payment on some services. **Effective calendar year

Dental Plans



Helpful tip: Find a list of providers for State of Texas Dental ChoiceSM or the HumanaDental DHMO at <https://our.humana.com/ers/> or by calling HumanaDental at (877) 377-0987, TTY: 711.

State of Texas Dental Choice

This is a preferred provider organization (PPO) dental insurance plan.



- You can see any provider, but you will pay less if you see one who is in the HumanaDental PPO.
- Benefits are available in the United States and Canada, and Mexico if you live in the United States.

HumanaDental Dental Health Maintenance Organization

This is a dental health maintenance organization (DHMO) dental insurance plan.



- Coverage applies only to dentists in the Texas service area. Before you enroll, make sure there is a DHMO network dentist in your area.
- You must select a primary care dentist (PCD) from a list of approved providers. You and your enrolled dependents can choose different primary care dentists.
- Services from participating specialty dentists cost 25% less than the dentist's usual charge.

State of Texas Dental Discount PlanSM

This is not a dental insurance plan.



- You receive discounted prices – 20% to 60% off – on usual charges for dental treatment and services at participating providers.
- There are no claim forms, copays, deductibles, annual maximums or limits on use.

Dental discount plan features

Plan Features	Dental Discount Plan	Dental Insurance
Claim forms and paperwork	—	✓
Copays	—	✓
Deductibles	—	✓
Annual maximums	—	✓
Limits on use	—	✓
Savings on cosmetic services	✓	—

Dental insurance plans comparison chart

	HumanaDental DHMO ¹	State of Texas Dental Choice Plan SM Preferred Provider Organization (PPO) Administered by HumanaDental Insurance Company	
Dentists	You must select a primary care dentist (PCD). NOTE: Not all participating dentists accept new patients. Dentists are not required to stay on the plan for the entire year.	In-network/ participating dentist	Out-of-network/ non-participating dentist ²
Deductibles	None	Preventive-Individual-\$0; Family-\$0 Combined Basic/Major -Individual-\$50; Family-\$150 Orthodontic services-no deductible	Preventive-Individual-\$50; Family-\$150 Combined Basic/Major -Individual-\$100; Family-\$300 Orthodontic services-no deductible
Copays/ coinsurance	Primary dentist - Copays vary according to service and are listed in the "Schedule of Dental Benefits" booklet. Specialty dentistry - You pay 75% of the dentist's usual and customary fee. DHMO pays nothing.	Preventive and Diagnostic Services - You pay nothing. Basic Services - You pay 10% coinsurance after meeting the Basic Services deductible. Major Services - You pay 50% coinsurance after meeting the Major Services deductible. You will not be charged for anything over the allowed amount. After you reach the Maximum Calendar Year Benefit, you pay 60% until January 1. ³	Preventive and Diagnostic Services - You pay 10% coinsurance after meeting the Preventive and Diagnostic deductible. Basic Services - You pay 30% coinsurance after meeting the Basic Services deductible. Major Services - You pay 60% coinsurance after meeting the Major Services deductible. You may be required to pay the difference between the allowed amount and billed charges. After you reach the Maximum Calendar Year Benefit, you pay 60% until January 1. ³
Maximum calendar year benefit	Unlimited	\$1,500 per covered individual (includes orthodontic extractions)	\$1,500 per covered individual (includes orthodontic extractions)
Maximum lifetime benefit	Unlimited	\$1,500 per covered individual for orthodontic services	\$1,500 per covered individual for orthodontic services
Average cost of cleaning / oral exams	Vary according to service and are listed in the "Schedule of Dental Benefits" booklet Up to two cleaning/oral exams per calendar year allowed	You pay nothing. Up to two cleaning/oral exams per calendar year allowed	10% of the allowed amount after deductible is met Up to two cleaning/oral exams per calendar year allowed
Orthodontic coverage	Orthodontic services performed by a general dentist listed in the directory with an "O" treatment code – child - \$1,800, adult - \$2,100 Orthodontic services performed by specialist – You pay 75% of his/her usual fee. DHMO pays nothing.	Orthodontic services are only available to dependents age 19 or younger. You pay 50% of the allowed amount.	Orthodontic services are only available to dependents age 19 or younger. You pay 50% of the allowed amount. You may be required to pay the difference between the allowed amount and billed charges.

NOTE: The comparison chart is a summary of the benefits offered by the two dental insurance plans. See plan booklet for actual coverage and limitations. Prior to starting treatment, discuss with your dentist the treatment plan and all charges.

¹ This comparison chart reflects participant responsibility for services received from participating primary care dentists only. Services from participating specialty dentists are 25% less than the dentist's usual charge.

² In the State of Texas Dental Choice Plan PPO, deductibles and annual maximums are per calendar year. Non-participating dentists can bill you for charges above the amount covered by your HumanaDental plan. To ensure you do not receive additional charges, visit a participating PPO network dentist.

³ Services received after the maximum calendar year benefit is reached will be paid at 40% coinsurance by the plan.

PLAN YEAR 2018 RATES

EMPLOYEES, RETIREES NOT ELIGIBLE FOR MEDICARE, SURVIVING DEPENDENTS AND COBRA

September 1, 2017 - August 31, 2018

NOTE: Health insurance rates are dependent on final approval of the state budget by the Governor. However, the final rates for Plan Year 2018 will not be higher than those listed below. ERS will notify you as soon as possible if any rates change.

Rates for HealthSelectSM Medicare Advantage and KelseyCare Advantage HMO also may change, but any rate changes for those plans would be effective January 1, 2018. Information on possible rate changes for those plans will be available in the fall.

Full-time Employees and Retirees Not Eligible for Medicare

	Premium*	State Pays	You Pay
HealthSelectSM of Texas			
You Only	\$ 621.90	\$ 621.90	\$ 0.00
You + Spouse	1,334.54	978.22	356.32
You + Children	1,099.06	860.48	238.58
You + Family	1,811.70	1,216.80	594.90
Consumer Directed HealthSelect^{SM**}			
You Only	\$ 621.90	\$ 621.90	\$ 0.00
You + Spouse	1,298.90	978.22	320.68
You + Children	1,075.20	860.48	214.72
You + Family	1,752.20	1,216.80	535.40
Community First Health Plans			
You Only	\$ 511.50	\$ 511.50	\$ 0.00
You + Spouse	1,097.18	804.34	292.84
You + Children	903.66	707.58	196.08
You + Family	1,489.34	1,000.42	488.92
KelseyCare powered by Community Health Choice			
You Only	\$ 483.98	\$ 483.98	\$ 0.00
You + Spouse	1,038.02	761.00	277.02
You + Children	854.94	669.46	185.48
You + Family	1,408.98	946.48	462.50
Scott & White Health Plan			
You Only	\$ 610.18	\$ 610.18	\$ 0.00
You + Spouse	1,309.34	959.76	349.58
You + Children	1,078.30	844.24	234.06
You + Family	1,777.46	1,193.82	583.64

*Includes premium for Basic Term Life Insurance

**The "State Pays" amount includes a monthly contribution to the member's Optum Bank health savings account (HSA). Please see the Consumer Directed HealthSelect HSA Contribution table on the next page.

Part-time Employees, Graduate Students/Teaching Assistants, Post-doctoral and Adjunct Faculty†

	Premium*	State Pays	You Pay
HealthSelectSM of Texas			
You Only	\$ 621.90	\$ 310.95	\$ 310.95
You + Spouse	1,334.54	489.11	845.43
You + Children	1,099.06	430.24	668.82
You + Family	1,811.70	608.40	1,203.30
Consumer Directed HealthSelect^{SM**}			
You Only	\$ 621.90	\$ 310.95	\$ 310.95
You + Spouse	1,298.90	489.11	809.79
You + Children	1,075.20	430.24	644.96
You + Family	1,752.20	608.40	1,143.80
Community First Health Plans			
You Only	\$ 511.50	\$ 255.75	\$ 255.75
You + Spouse	1,097.18	402.17	695.01
You + Children	903.66	353.79	549.87
You + Family	1,489.34	500.21	989.13
KelseyCare powered by Community Health Choice			
You Only	\$ 483.98	\$ 241.99	\$ 241.99
You + Spouse	1,038.02	380.50	657.52
You + Children	854.94	334.73	520.21
You + Family	1,408.98	473.24	935.74
Scott & White Health Plan			
You Only	\$ 610.18	\$ 305.09	\$ 305.09
You + Spouse	1,309.34	479.88	829.46
You + Children	1,078.30	422.12	656.18
You + Family	1,777.46	596.91	1,180.55

*Includes premium for Basic Term Life Insurance

**The "State Pays" amount includes a monthly contribution to the member's Optum Bank health savings account (HSA). Please see the Consumer Directed HealthSelect HSA Contribution table on the next page.

†The state does not contribute to the cost of health insurance for adjunct faculty.

Consumer Directed HealthSelect Health Savings Account (HSA) Contribution

	State Pays	An HSA is a tax-free savings account for qualified health expenses. You can receive the "State Pays" HSA contribution if you are: <ul style="list-style-type: none"> • enrolled in Consumer Directed HealthSelect, • eligible for a portion of your health premium to be paid by the state and • not enrolled in Medicare.
You Only	\$ 45 monthly (\$540 annually)	
You + Spouse	90 monthly (\$1,080 annually)	
You + Children	90 monthly (\$1,080 annually)	
You + Family	90 monthly (\$1,080 annually)	

Medicare-eligible Dependents of Full-time Retirees Not Eligible for Medicare

	Premium	State Pays	You Pay
Through December 31, 2017			
HealthSelectSM Medicare Advantage			
Spouse Only	\$ 510.76	\$ 353.68	\$ 157.08
Children Only	393.88	236.80	157.08
Spouse + Children	904.64	590.48	314.16
KelseyCare Advantage			
Spouse Only	\$ 263.68	\$ 131.84	\$ 131.84
Children Only	263.68	131.84	131.84
Spouse + Children	527.36	263.68	263.68

Medicare-eligible Dependents of Part-time Retirees Not Eligible for Medicare

	Premium	State Pays	You Pay
Through December 31, 2017			
HealthSelectSM Medicare Advantage			
Spouse Only	\$ 412.46	\$ 176.84	\$ 235.62
Children Only	354.02	118.40	235.62
Spouse + Children	766.48	295.24	471.24
KelseyCare Advantage			
Spouse Only	\$ 263.68	\$ 65.92	\$ 197.76
Children Only	263.68	65.92	197.76
Spouse + Children	527.36	131.84	395.52

Surviving Dependents

	HealthSelect SM of Texas	Consumer Directed HealthSelect SM	Community First Health Plans	KelseyCare powered by Community Health Choice	Scott & White Health Plan
Spouse Only	\$ 712.64	\$ 677.00	\$ 585.68	\$ 554.04	\$ 699.16
Children Only	477.16	453.30	392.16	370.96	468.12
Spouse + Children	1,189.80	1,130.30	977.84	925.00	1,167.28

COBRA

	HealthSelect SM of Texas	Consumer Directed HealthSelect SM	Community First Health Plans	KelseyCare powered by Community Health Choice	Scott & White Health Plan
You Only	\$ 632.07	\$ 586.17	\$ 519.47	\$ 491.40	\$ 620.12
You + Spouse	1,358.97	1,230.81	1,116.86	1,056.52	1,333.26
You + Children	1,118.78	1,002.64	919.47	869.77	1,097.60
You + Family	1,845.67	1,693.18	1,516.86	1,434.90	1,810.74

COBRA Disability

	HealthSelect SM of Texas	Consumer Directed HealthSelect SM	Community First Health Plans	KelseyCare powered by Community Health Choice	Scott & White Health Plan
You Only	\$ 929.52	\$ 862.02	\$ 763.92	\$ 722.64	\$ 911.94
You + Spouse	1,998.48	1,810.02	1,642.44	1,553.70	1,960.68
You + Children	1,645.26	1,474.47	1,352.16	1,279.08	1,614.12
You + Family	2,714.22	2,489.97	2,230.68	2,110.14	2,662.86

Dental Insurance

HumanaDental DHMO	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
You Only	\$ 9.59	\$ 9.78	\$ 14.39	Spouse Only	\$ 9.59
You + Spouse	19.17	19.55	28.76	Spouse + Children	23.01
You + Children	23.01	23.47	34.52	Children Only	13.42
You + Family	32.59	33.24	48.89		

State of Texas Dental Choice Plan SM	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
You Only	\$ 27.41	\$ 27.96	\$ 41.12	Spouse Only	\$ 27.41
You + Spouse	54.82	55.92	82.23	Spouse + Children	65.78
You + Children	65.78	67.10	98.67	Children Only	38.37
You + Family	93.19	95.05	139.79		

State of Texas Dental Discount PlanSM (no change from PY17)

Membership Level	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
You Only	\$ 2.25	\$ 2.30	\$ 3.38	Spouse Only	\$ 2.25
You + Spouse	4.50	4.59	6.75	Spouse + Children	5.40
You + Children	5.40	5.51	8.10	Children Only	3.15
You + Family	7.65	7.80	11.48		

State of Texas Vision

Membership Level	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
You Only	\$ 6.69	\$ 6.82	\$ 10.04	Spouse Only	\$ 6.69
You + Spouse	13.38	13.65	20.07	Spouse + Children	14.38
You + Children	14.38	14.67	21.57	Children Only	7.69
You + Family	21.07	21.49	31.61		

Tobacco-user Premium

If you and/or a family member enrolled in medical insurance is certified as a tobacco-user or has not certified as a non-user, you will pay an additional tobacco-user premium of \$30, \$60 or \$90 each month, depending on how many tobacco-users or non-certified family members you cover.

Tobacco-users of Any Age and Adults Who Fail to Certify	Monthly Tobacco-user Premium
Member <u>or</u> Spouse <u>or</u> Children* Only	\$30
Member + Spouse <u>or</u> Member + Children* <u>or</u> Spouse + Children*	\$60
Family (Member + Spouse + Children*)	\$90

*The charge for a child is the same regardless of how many children in the household use tobacco or how many covered children 18 or over are not certified.

If you are a tobacco-user, you may be able to participate in an alternative to the tobacco-user premium, if it is right for your health status and complies with your doctor's recommendations.

Please visit www.ers.state.tx.us/Employees/Health/Tobacco_Policy for more information.

The plans on this page are not available to surviving dependents, or those enrolled through COBRA and COBRA Disability.

Optional Term Life Insurance (no change from PY17)

Optional Term Life Insurance					
<p>After the first 31 days of employment, Elections 1 and 2 require approval through evidence of insurability (EOI).</p> <p>Elections 3 and 4 always require EOI approval.</p> <p>Beginning at age 70, Optional Term Life coverage is reduced to a percentage of your annual salary as follows:</p> <p>Age 70-74 65%</p> <p>Age 75-79 40%</p> <p>Age 80-84 25%</p> <p>Age 85-89 15%</p> <p>Age 90+ 10%</p>	Monthly Rate per \$1,000 of Annual Salary				
	Age	Election 1 Annual Salary x 1	Election 2 Annual Salary x 2	Election 3* Annual Salary x 3	Election 4*† Annual Salary x 4
	Under 25	\$ 0.05	\$ 0.10	\$ 0.15	\$ 0.20
	25 - 29	0.05	0.10	0.15	0.20
	30 - 34	0.06	0.12	0.18	0.24
	35 - 39	0.06	0.12	0.18	0.24
	40 - 44	0.08	0.16	0.24	0.32
	45 - 49	0.12	0.24	0.36	0.48
	50 - 54	0.19	0.38	0.57	0.76
	55 - 59	0.33	0.66	0.99	1.32
	60 - 64	0.57	1.14	1.71	2.28
	65 - 69	0.93	1.86	2.79	3.72
	70 - 74	1.48	2.96	4.44	5.92
	75 - 79	2.41	4.82	7.23	9.64
	80 - 84	3.92	7.84	11.76	15.68
	85 - 89	6.79	13.58	20.37	27.16
	90+	10.57	21.14	31.71	42.28
Retiree Fixed Optional Life Insurance (\$10,000 policy)					
\$23.40 per month for \$10,000					
Dependent Term Life Insurance					
Employee: \$1.38 per month for \$5,000 (includes \$5,000 AD&D coverage)			Retiree: \$3.05 per month for \$2,500		

Voluntary Accidental Death and Dismemberment Insurance (AD&D)* (no change from PY17)

You may enroll in AD&D coverage according to the following table:				
Age	Minimum Coverage	Maximum Coverage	Minimum Increments	
Under 70	\$ 10,000	\$ 200,000	\$ 5,000	You Only \$0.02 per \$1,000 of coverage
70-74	6,500	130,000	3,250	
75-79	4,000	80,000	2,000	You + Family \$0.04 per \$1,000 of coverage
80-84	2,500	50,000	1,250	
85-89	1,500	30,000	750	
90+	1,000	20,000	500	

Texas Income Protection PlanSM (TIPP)*

(lower premium for short-term disability, no change for long-term disability)

Short-term disability	\$0.26 per \$100 of monthly salary
Long-term disability	\$0.63 per \$100 of monthly salary

*Optional Term Life Insurance at Elections 3 and 4, AD&D, and short-term and long-term disability insurance are not available to retirees.

†Optional Term Life Insurance is limited to a maximum of \$400,000 or four times your annual salary, whichever is less.

SUMMER ENROLLMENT FORM

Information provided to the Employees Retirement System of Texas (ERS) is maintained for managing your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

Return the completed form to your agency benefits coordinator.

SECTION A: EMPLOYEE DATA *(For assistance, contact your benefits coordinator.)*

Last 4 digits of Social Security Number (SSN)	Agency Name	Dept ID/Agency Number	Effective Date
xxx-xx-			September 1, 2017
Employee Name: First, MI, Last		Phone Number	Email Address
		<input type="checkbox"/> Home <input type="checkbox"/> Cell ()	
Mailing Address	<input type="checkbox"/> Check if New	City	State
			ZIP Code
			Eligibility County

Important: Summer Enrollment allows you to make changes or apply for benefits and TexFlex for the new plan year. During the plan year, a qualifying life event (QLE) must occur before you can make changes to certain benefits. Changes due to QLEs must be requested within 31 days of the event.

SECTION B: BENEFITS OPTIONS *(Mark appropriate choices.)*

Health Coverage	Optional Benefits <i>(May be elected without being enrolled in health coverage.)</i>					
Health	Dental	Vision	Optional Term Life Insurance*	Voluntary AD&D	Dependent Term Life Insurance*	Short-term Disability*
<input type="checkbox"/> Waive <input type="checkbox"/> HealthSelect SM of Texas <input type="checkbox"/> Consumer Directed HealthSelect SM <input type="checkbox"/> HMO Name _____ <input type="checkbox"/> Enroll/Add/Drop Dependent <i>(See Section C)</i> <input type="checkbox"/> Waive + Opt-Out Credit <i>(By checking Waive + Opt Out Credit, you also certify that you have comparable coverage. See back of form for important information.)</i>	<input type="checkbox"/> Waive <input type="checkbox"/> State of Texas Dental Choice Plan SM <input type="checkbox"/> State of Texas Dental Discount Plan SM <input type="checkbox"/> HumanaDental DHMO <input type="checkbox"/> Enroll/Add/Drop Dependent <i>(See Section C)</i>	<input type="checkbox"/> Waive <input type="checkbox"/> State of Texas Vision <input type="checkbox"/> Enroll/Add/Drop Dependent <i>(See Section C)</i>	<input type="checkbox"/> Waive <input type="checkbox"/> Enroll Elect coverage level <input type="checkbox"/> OL1 Election 1 <input type="checkbox"/> OL2 Election 2 <input type="checkbox"/> OL3 Election 3 <input type="checkbox"/> OL4 Election 4 Decrease Level to <input type="checkbox"/> OL1 Election 1 <input type="checkbox"/> OL2 Election 2 <input type="checkbox"/> OL3 Election 3	<input type="checkbox"/> Waive <input type="checkbox"/> You Only <input type="checkbox"/> You + Family \$ _____ Amount up to \$200,000 in increments of \$5,000	<input type="checkbox"/> Waive <input type="checkbox"/> Enroll/Add/Drop Dependent <i>(See Section C)</i> <div>Long-term Disability*</div> <input type="checkbox"/> Waive <input type="checkbox"/> Enroll	
*To add or increase this coverage will require evidence of insurability (EOI). Initiate the EOI process by signing into your online account at www.ers.state.tx.us , or contact your benefits coordinator/HHS Employee Service Center.						

Employee Tobacco-user Certification: If you are enrolled or enrolling in a Texas Employees Group Benefits Program (GBP) health plan, have you used any type of tobacco product five or more times in the last three months? This includes but is not limited to cigarettes, pipes, cigars, cigarillos, snuff or chewing tobacco products. ☐ Yes ☐ No

SECTION C: DEPENDENT PERSONAL DATA *(and benefits choices.)*

Dependent Tobacco-user Certification: If your dependents are enrolled in a GBP health plan, you must certify below if your dependent used any type of tobacco product five or more times in the last three months. This includes but is not limited to cigarettes, pipes, cigars, cigarillos, snuff or chewing tobacco products.

Dependent Relationship*	Dependent's Name (First, MI, Last)	Gender	Date of Birth (mm-dd-yyyy)	Dependent SSN (Required for 12 months or older)	Health	Dental	Vision	Dep. Life	Tobacco User
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Relationship Code: Sp – Spouse D or S - Natural or adopted daughter or son O – Other than natural or adopted child. Includes stepchild, foster child, or ward. If you are adding a child, you must complete a **Dependent Child Certification** form (ERS GI 1.081) available at www.ers.state.tx.us or by calling ERS. For dependents newly enrolled in health coverage, you may be required to provide documentation to Aon Hewitt to verify your dependents' eligibility.

Continue to next page to complete form.

NOTE: You may enter your changes using your online account at www.ers.state.tx.us, contact your benefits coordinator/HHS Employee Service Center or contact ERS.

Last 4 digits of Employee SSN xxx-xx-_____ Employee Name: First, MI, Last _____

SECTION D: TEXFLEX ACCOUNT ENROLLMENT

Sign up for TexFlex for PY18 (September 1, 2017 - August 31, 2018). There will be an “administrative fee holiday” again this plan year. You will receive a TexFlex debit card when you enroll in the TexFlex health care account or TexFlex limited FSA if you were not enrolled last plan year. There is no annual fee for the debit card. The TexFlex debit card cannot be used for the TexFlex dependent care account.

<input type="checkbox"/> TexFlex health care account beginning September 1, 2017 (Minimum \$180/maximum \$2,600 per plan year)	\$ _____ .00 Annual Contribution	If you had a TexFlex account in Plan Year 2017, you will be automatically re-enrolled for the same annual amount up to the current maximum amount unless you change your selection during Summer Enrollment. If you have elected Consumer Directed HealthSelect SM you are not eligible to enroll in the health care account.
<input type="checkbox"/> TexFlex dependent care account beginning September 1, 2017 (Minimum \$180/maximum \$5,000 per plan year)	\$ _____ .00 Annual Contribution	
<input type="checkbox"/> TexFlex limited flexible spending account beginning September 1, 2017 (Minimum \$180/maximum \$2,600 per plan year)	\$ _____ .00 Annual Contribution	Only applicable with enrollment in the Consumer Directed HealthSelect SM plan.
<input type="checkbox"/> My annual salary is paid in less than 12 months. (If checked, you will have a 9 month election. If not checked, your selection will default to 12 months.)		
<input type="checkbox"/> I want to stop my enrollment in the TexFlex health care account for Plan Year 2018.		
<input type="checkbox"/> I want to stop my enrollment in the TexFlex dependent care account for Plan Year 2018.		
<input type="checkbox"/> I want to stop my enrollment in the TexFlex limited flexible spending account for Plan Year 2018.		

SECTION E: AUTHORIZATION (Carefully read the statements below before you sign and date.)

I authorize payroll deductions for the elections indicated on this Summer Enrollment Form. My insurance coverage may be cancelled if I do not pay the required amount due, either by payroll deduction or personal payment. I authorize any provider to release any information on persons covered when needed to verify eligibility or to process an insurance claim or complaint. My Texas Employees Group Benefits Program (GBP) coverage will remain in effect for the plan year unless I have a qualifying life event (QLE).

I have reviewed and understand the TexFlex account enrollment rules as explained on the ERS website. I understand I must have a QLE in order to increase or decrease my TexFlex account amount during the plan year. I understand my TexFlex dependent care account election is irrevocable for the plan year, and I must have a QLE in order to change my TexFlex dependent care account election or amount. I certify that all information provided on this form is valid and true to the best of my knowledge. I understand I will be asked to show documentation to support my selection and/or to prove eligibility for any newly added dependents and that all documentation must be dated prior to the enrollment date. False information could lead to expulsion from the GBP and/or criminal prosecution.

Notice about Insurance: Funding for health and other insurance benefits for participants in the GBP is subject to change based on available state funding. The Texas Legislature determines the level of funding for such benefits and has no continuing obligation to provide funding for those benefits beyond each fiscal year.

Tobacco-use Certification: I certify my understanding and agreement to the following: “Tobacco Products” are cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip or any other products that contain tobacco, and a “Tobacco User” is a person who has used any Tobacco Products five or more times within the past three consecutive months. If I (or any of my covered dependents): 1) have used Tobacco Products as a Tobacco User; or 2) start using Tobacco Products without notifying ERS, I will be subject to monetary penalties and may be terminated from participation in the GBP. Also, failure to notify ERS will constitute fraud. Under the penalties of perjury, the above information is true and correct. Providing or entering false information may disqualify me from continued coverage in the GBP. If I intentionally misrepresent material facts or engage in fraud, my coverage may be rescinded retroactively to the date of the misrepresentation or fraudulent act. In that event, I will receive thirty days notice before my coverage is rescinded. Further, if I or any of my covered dependents start using Tobacco Products without notifying ERS, I will be subject to monetary penalties and such failure to notify ERS will constitute fraud.

If you certified yourself or any of your dependents as a tobacco user, you may be able to participate in Choose to Quit, an alternative to the tobacco-user premium, if it is right for your health status and complies with your doctor’s recommendations. For more information about this program, visit, www.ers.state.tx.us/Employees/Health/Tobacco_Policy.

If you previously certified yourself or any of your dependents as a tobacco user, and you or they have stopped using tobacco for three consecutive months, you must complete the Tobacco User Certification Form (ERS 2.933) available at http://www.ers.state.tx.us/Insurance/Tobacco/Tobacco_User_Certification_Form/, or change the certification using your online account at www.ers.state.tx.us.

If you selected “Waive + Opt-Out Credit”:

I certify that I do not want the health plan coverage offered to me as an eligible participant. I am waiving my health plan coverage and certify that I have other health plan coverage with substantially equivalent coverage to the basic health plan. I understand waiving my state health insurance will cancel my prescription drug coverage and \$5,000 Basic Term Life policy. I will receive a credit of up to \$60 (or \$30 for part-time participants) that will be applied only toward the cost of eligible optional coverage in which I am enrolled (dental and/or Voluntary Accidental Death and Dismemberment (AD&D). Excludes the State of Texas Dental Discount Plan and State of Texas Vision). The credit is in place of the state contribution for basic health coverage. Due to federal legislation Medicare members cannot receive the Opt-Out Credit. I am able to view the Health Insurance Opt-Out Credit applied toward my eligible optional coverage premium by signing into my online account at www.ers.state.tx.us.

I understand that if I am currently in a waived status, I must have a QLE or wait until Summer Enrollment to enroll in medical or optional coverage offered to eligible participants.

Signature: _____ Date Signed (mm-dd-yyyy) : _____

To make your Summer Enrollment benefit changes online, go to www.ers.state.tx.us.

More information available at:
Employees Retirement System of Texas
(866) 399-6908 toll-free
www.ers.state.tx.us

Information provided to ERS is maintained for managing your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

You may complete your benefits election either by:

- Using your online account at www.ers.state.tx.us, or
- Sending this completed form to your benefits coordinator or HHS Employee Service Center for employees at HHS Enterprise agencies

Only for participants with active employee benefits.

SECTION A: EMPLOYEE DATA		
Employee Name:	SSN	ERS Employee ID
Type of employee: <input type="checkbox"/> 9-month (higher education institutions) <input type="checkbox"/> 12-month		

SECTION B: ACTION AND REASON CODE (Check only one box.)	
FSC <input type="checkbox"/> Family Status Change HIR <input type="checkbox"/> New Hire REH <input type="checkbox"/> Rehire PHC <input type="checkbox"/> Post Hire Change LOA <input type="checkbox"/> Leave of Absence RED <input type="checkbox"/> Reduction while on LOA RFL <input type="checkbox"/> Return from Leave	
Enter a reason code and event date if you checked the FSC box above. See the Family Status Change (FSC) Reference Chart on page 3 before completing.	
Reason Code:	Event Date: (mm-dd-yyyy)

SECTION C: TEXTFLEX HEALTH CARE ACCOUNT (Fill out only one of the three options in this section, if applicable.)	
<input type="checkbox"/> TexFlex health care account – for eligible medical, vision and dental out-of-pocket costs excluding insurance premiums. Program has a minimum annual pledge of \$180 and a maximum annual pledge of \$2,600 per tax year. Enrollment/change must be made within 31 days of your employment or qualifying life event. You will receive a TexFlex debit card, at no cost, to pay for eligible expenses. There is no annual administrative fee for the TexFlex health care account. Note: If you do not check this box, you will not be enrolled in this account.	
OPTION 1: NEW ENROLLMENT (Complete only if New Hire/Rehire or Family Status Change.)	
I want my monthly deduction to be (not to exceed \$216 per month):	\$.00
Number of months left in the plan year (September 1 – August 31):	x
Annual pledge:	\$.00
OPTION 2: INCREASE PLEDGE AMOUNT (Complete only if increasing pledge amount due to a Family Status Change.)	
Current annual pledge amount:	\$.00
Increase my annual pledge amount to:	\$.00
OPTION 3: REDUCTION (Complete only if reducing pledge amount due to a Family Status Change.)	
Current annual pledge amount:	\$.00
Reduce my annual pledge amount to:	\$.00

SECTION D: TEXTFLEX DEPENDENT CARE ACCOUNT (Fill out only one of the three options in this section, if applicable.)	
<input type="checkbox"/> TexFlex Dependent Care Account – for eligible child or adult dependent care expenses. Program has a minimum annual pledge of \$180 and a maximum annual pledge of \$5,000 or the lesser of your spouse's or your annual income that is below \$5,000. Enrollment/change must be made within 31 days of your employment or qualifying life event. The TexFlex debit card is not available to pay for dependent care expenses. There is no annual administrative fee for the TexFlex dependent care account. Note: If you do not check this box, you will not be enrolled in this account.	
OPTION 1: NEW ENROLLMENT (Complete only if New Hire/Rehire or Family Status Change.)	
I want my monthly deduction to be (not to exceed \$416 per month):	\$.00
Number of months left in the plan year (September 1 – August 31):	x
Annual pledge:	\$.00
OPTION 2: INCREASE PLEDGE AMOUNT (Complete only if increasing pledge amount due to a Family Status Change.)	
Current annual pledge amount:	\$.00
Increase my annual pledge amount to:	\$.00
OPTION 3: REDUCTION (Complete only if reducing pledge amount due to a Family Status Change.)	
Current annual pledge amount:	\$.00
Reduce my annual pledge amount to:	\$.00

SECTION E: TEXFLEX LIMITED FLEXIBLE SPENDING ACCOUNT (Fill out only one of the three options in this section, if applicable.)

Enrollment in the TexFlex limited flexible spending account (LFSA) is only applicable if you are enrolled in Consumer Directed HealthSelectSM

☐ **TexFlex LFSA** – for eligible dental and vision out-of-pocket costs excluding healthcare costs. Program has a minimum annual pledge of \$180 and a maximum annual pledge of \$2,600 per tax year. You must enroll or make any changes within 31 days of your employment or qualifying life event. You will receive a TexFlex debit card, at no cost, to pay for dental and vision expenses. There is no annual administrative fee for the TexFlex LFSA. Note: If you do not check this box, you will not be enrolled in this account.

OPTION 1: NEW ENROLLMENT (Complete only if New Hire/Rehire or Family Status Change.)

I want my monthly deduction to be (not to exceed \$216 per month):	\$.00
Number of months left in the plan year (September 1 – August 31):	x	
Annual pledge:	\$.00

OPTION 2: INCREASE PLEDGE AMOUNT (Complete only if increasing pledge amount due to a Family Status Change.)

Current annual pledge amount:	\$.00
Increase my annual pledge amount to:	\$.00

OPTION 3: REDUCTION (Complete only if reducing pledge amount due to a Family Status Change.)

Current annual pledge amount:	\$.00
Reduce my annual pledge amount to:	\$.00

Authorization:

I understand my TexFlex health care, dependent care, and/or limited flexible spending account enrollment is irrevocable for the plan year, unless I have a qualifying life event, terminate employment or retire. I authorize payroll deductions for the amount listed on this form.

I understand I have until August 31 to incur health care expenses for the plan year and can carry over a minimum of \$25, up to \$500 of my TexFlex health care account balance to the next plan year. Any amount over \$500 will be forfeited.

I understand I have until August 31 to incur eligible dental or vision expenses for the plan year and can carry over a minimum of \$25, up to \$500 of my TexFlex limited flexible spending account balance to the next plan year. Any amount over \$500 will be forfeited.

I understand I have until November 15 to incur dependent care expenses for the plan year. The carryover is not allowed for the TexFlex dependent care account.

I must file all eligible claims for reimbursement by December 31 of the associated plan year.

I understand that TexFlex account eligibility, enrollment and benefits information is available from my employer and at **www.ers.state.tx.us**. I certify that I have read and agree to all of the conditions and participation rules for this program.

Sign: _____ Date: _____

Family Status Change (FSC) Reference Chart

A qualifying life event (QLE) is an eligible event that allows you to change your enrollment elections within 31 days of that event. The following are QLEs that correspond with a particular change in your employment or family status. Remember, rules will determine if you can enroll in or make your requested changes.

Event	Qualifying Life Event (QLE) Example	Reason
Employee Marital Status Change	Participant gets married	MAR
	Participant gets a divorce or an annulment	DIV
	Death of a spouse	DOD
Dependent Status Change	Birth of a newborn child	BIR
	Participant adopts, fosters, or gets court-appointed guardianship of child	ADP
	Participant gains or loses dependents through death	DOD
	Dependent becomes eligible or loses eligibility for insurance coverage (Example: Participant's spouse is covering their child. The child lost eligibility for the spouse's insurance because the child does not attend school.)	DEP
	Dependent is related by blood or marriage, and was previously claimed on the participant's income tax return, but is no longer eligible to be claimed on participants income tax return	XMO
	Child gets married	DGM
Employment Status Change	Participant/Dependent employment status change	ESC
	Dependent becomes eligible for insurance after a waiting period	DWP
Address Change that Changes Dependent Eligibility	Dependent moves out of health or dental plan service area	DMV
Medicare/Medicaid/CHIP Eligibility Change	Participant/Dependent gains Medicare/Medicaid/CHIP eligibility	MDG
	Participant/Dependent loses Medicare/Medicaid/CHIP eligibility	MDL
Significant Change in Cost/ Coverage Imposed by Third Party	Significant change in cost by dependent care provider	SCC
	Significant change in cost/coverage of dependent's health or dental plan (excluding GBP)	SCC
	HIPP approval or loss of eligibility	SCC
Office of the Attorney General (OAG) - Ordered Coverage Change	Participant gains requirement to provide coverage for child through a National Medical Support Notice (NMSN) issued by the Office of the Attorney General (OAG) (Example: employee receives an NMSN to provide health coverage for his child.)	MSO
(Eligibility rules apply for these dependents)	Expiration of an NMSN, which is issued by the OAG and requires a participant to provide coverage for a child. (Example: employee's NMSN to provide health coverage for his child expires and the employee is no longer required to continue coverage for the child.)	MSD*
*Employees must contact their benefits coordinator (HHS Enterprise employees contact HHS Employee Service Center) to drop dependents added with a NMSN.		
Benefit changes must be consistent with the QLE. Dependent eligibility and enrollment rules apply.		

Employee Assistance Program (EAP)

**1-800-566-0088
903-266-2211 (Tyler)**

How can I benefit from the Employee Assistance Program?

The Employee Assistance Program (EAP) is a company program that is offered to you as an employee benefit. It provides confidential counseling and other related services that can help you and your family resolve personal problems ... problems that affect your health, family and/or job. In addition to assessment and referral services, your EAP provides information, education and consultation, both independently and in concert, with other professional resources

Why Should I Use the EAP?

Everyone needs a little help occasionally in dealing with a personal crisis or confronting a challenge at work. The EAP offers you an opportunity to solve those problems, improve the quality of your life and enhance and/or maintain a productive job performance. The EAP is also available to your family members who may need some help with personal problems.

What Kinds of Problems Do Employees Call the EAP About?

The EAP's confidential, professional services address a variety of personal concerns and organizational needs. Among the issues addressed are:

- Family Concerns
- Marital Problems
- Alcohol/Drug Abuse
- Codependency
- Domestic Violence
- Grief
- Family Communications
- Workplace Violence
- Depression/Anxiety

What Does the EAP Cost?

These important services of the EAP are paid for by your organization. It's FREE to you, you pay nothing. Your company values you as an employee and appreciates the work you do. However, if a referral outside the EAP is necessary, those fees will be your responsibility and may be covered by your health benefits.

OK ... Maybe something's bothering me ... Who do I call?

If personal or work problems are worrying you, call the EAP. Simply call the EAP's toll-free number at 1-800-566-0088 or in the Tyler area at 903-266-2211. An EAP counselor will cheerfully and confidentially guide you through the initial process and, when appropriate, provide the name of a conveniently located licensed counselor who is trained to help you with your concerns.

Will Anyone Know?

You can trust the EAP to be completely confidential. The EAP abides by all state and federal laws governing patient confidentiality. Information shared with an EAP counselor will not be disclosed to anyone without your written consent. The only exceptions are: 1) when a person presents a serious threat to him/herself or others, which requires the EAP counselor to report such danger to appropriate individuals or parties; and: 2) when your employer has presented you with a formal EAP referral. Management may require confirmation that you are participating in the program as agreed upon in that formal request.

Where do I see a counselor?

Whenever possible, you are referred to local counselors. The EAP understands your need for privacy and can give you several counselor options.

Can I call the EAP now?

Yes. Call the EAP now and get on the road to a healthier and happier life! Call 1-800-566-0088 or 903-266-2211 (Tyler) and tell the person who answers the phone you want to talk to someone about the EAP. Your EAP counselor will take it from there.

----No Problem is too Serious or too Simple. ----

Employee Assistance Program offers counseling to team members

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