BlueCross BlueShield of Texas

Individual Health Coverage

Administrative Guidelines for New Business

Administrative Guide

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Introduction

The information and guidelines contained in this Administrative Guide have been developed to assist you in the sales and enrollment of Blue Cross and Blue Shield of Texas individual products. It contains product information, business guidelines and useful information regarding membership and billing processes. While all of the guidelines have not been specifically addressed in this book, this guide provides a general overview. Please call your Producer Service Representative at (800) 531-4457 toll-free, for updates and clarifications.

Important Notice

This guide is not the insurance contract and is subject to change at any time. It contains a general overview of the Select Family of Products. The rules governing benefits and eligibility are contained in the contract which the applicant will receive if approved for coverage. You, as an agent, may not solicit applications for the Select Family of Products unless you hold a valid Group I license and have been appointed to do business with Blue Cross and Blue Shield of Texas. No agent can bind coverage, guarantee approval of any person for coverage, or change the eligibility requirements before a contract is issued.

Select Family of Products

Select Blue Advantage – Series V
A preferred provider health insurance plan that features a choice of eight deductibles and a $25 copay for network provider office visits[1]. Copays include same-day lab and X-ray, a prescription drug card program and individual and family coverage is available.

PPO Select Choice – Series V
A preferred provider health insurance plan that features a choice of eight deductibles and a $25 copay for network physician office visits[1]. A prescription drug card program and individual and family coverage is available.

PPO Select Saver – Series V
A preferred provider health insurance plan offering "back to the basics – cost effective" coverage. This option is designed to provide a selection of benefits, including a choice of seven deductibles that will fit your client's health care coverage needs and budget. PPO Select Saver includes a prescription drug card program and individual and family coverage is available.

BlueEdge Individual HSA
If your client likes to take charge of their health and be responsible for how they spend their health care dollars, then BlueEdge Individual Health Savings Account (HSA) may be the right choice. As a consumer-centered plan option, this health insurance plan allows your client to decide how, when and where their health care dollars are spent. BlueEdge Individual HSA gives your client the edge on health care!

SelecTEMP PPO
As the name implies, this preferred provider health benefit insurance temporary plan offers a choice of benefit periods ranging from one to eleven months. SelecTEMP PPO was designed for your clients who are between permanent health plans and is nonrenewable. Your client will have the option to apply for additional policies and have a choice of deductibles to tailor their premium rates and out-of-pocket expenses according to their health insurance needs.

Dental Indemnity USA
A dental insurance plan that provides benefits for diagnostic and preventive care along with specified specialty dental treatment. Your client must have Blue Cross and Blue Shield of Texas (BCBSTX) health coverage in order to elect dental coverage.

[1]*Copay does not apply to visits for preventive care services*

Select Blue Advantage – Series V

Plan Provisions

Options		Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII
Calendar Year Deductibles	Individual Network	$250	$500	$1,000	$1,500	$2,500	$3,500	$5,000	$10,000
	Individual Out-of-Network	$500	$1,000	$2,000	$3,000	$5,000	$7,000	$10,000	$20,000
	Family Network	$750	$1,500	$3,000	$4,500	$7,500	$10,500	$15,000	$30,000
	Family Out-of-Network	$1,500	$3,000	$6,000	$9,000	$15,000	$21,000	$30,000	$60,000
Copayment Amounts	Office Visit[2] (Network Provider)	$25	$25	$25	$25	$25	$25	$25	$25
	Emergency Care (Facility Only)[3]	$100	$100	$100	$100	$100	$100	$100	$100
Calendar Year Out-of-Pocket Maximum (Does not include deductible or copay)	Individual/Network	$3,000							
	Individual/Out-of-Network	$6,000							
	Family/Network	$6,000							
	Family/Out-of-Network	$12,000							
Coinsurance[4]	Network Plan Pays	85%							
	You Pay	15%							
	Out-of-network Plan Pays	75%							
	You Pay	25%							

2 *Copayment does not apply to office visits for preventive care services when in-network providers are used. Includes same day lab and X-ray.*

3 *$100 copayment applies to the emergency room/facility charge only. All other services are subject to deductible and coinsurance. Copayment waived if admitted to hospital immediately following emergency room visit.*

4 *Percentages apply to allowable amount for eligible expenses after calendar-year deductibles are met.*

Prescription Drug Card Program

Options		Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII
Copayment Amounts	Generic	$10	$10	$10	$10	$10	$10	$10
	Preferred	$30	$30	$30	$30	$30	$30	$30
	Non-Preferred	$45	$45	$45	$45	$45	$45	$45
Mail Order Prescription Drug Program	90-day supply for 2 copayments.							

Select Blue Advantage – Series V

Plan Provisions

	Network	Out-of-Network
Calendar-Year Deductible Options Per member (maximum of three per family)	$250 / $750 $500 / $1,500 $1,000 / $3,000 $1,500 / $4,500 $2,500 / $7,500 $3,500 / $10,500 $5,000 / $15,000 $10,000 / $30,000	$500 / $1,500 $1,000 / $3,000 $2,000 / $6,000 $3,000 / $9,000 $5,000 / $15,000 $7,000 / $21,000 $10,000 / $30,000 $20,000 / $60,000
Out-of-Pocket Maximum/Security Provision (Does not include deductible)	$3,000 individual / $6,000 family per calendar year	$6,000 individual / $12,000 family per calendar year
Coinsurance[5]	85% / 15%	75% / 25%
Pre-existing Condition Limitation (Conditions diagnosed or treated)	18 months prior can be considered pre-existing for **18 months** after effective date (This limitation does not apply to applicants under 19 years of age.)	
Preauthorization	• **Required** for each hospital admission, extended care services, home infusion therapy, and organ and tissue transplants • **Patient** is responsible for pre-authorization; network providers may pre-authorize care	
Preventive Care Services (Benefits covered as defined by national guidelines)	100% of allowable amount when in-network providers are used. Benefits are reduced to 75% when out-of-network providers are used.	
Emergency Care	• $100 copay (facility only), additional charges subject to deductible and coinsurance • Paid at network level until patient can be safely transferred to a network facility	
Benefit Level Guidelines	Patient will receive network level of benefits only if a BlueChoice provider and facility is used	
Application Fee	$30; non-refundable	

5 Percentages apply to allowable amount for eligible expenses after calendar-year deductibles are met.

PPO Select Choice – Series V

Options		Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII
Calendar Year Deductibles	Individual/Network	$250	$500	$1,000	$1,500	$2,500	$3,500	$5,000	$10,000
	Individual/Out-of-Network	$500	$1,000	$2,000	$3,000	$5,000	$7,000	$10,000	$20,000
	Family/Network	$750	$1,500	$3,000	$4,500	$7,500	$10,500	$15,000	$30,000
	Family/Out-of-Network	$1,500	$3,000	$6,000	$9,000	$15,000	$21,000	$30,000	$60,000
Copayment Amounts[9]	Network Provider Office Visit (Physician consultation only)[7]	$25	$25	$25	$25	$25	$25	$25	$25
	Emergency Care[8] Plan Pays	80%	80%	80%	80%	80%	80%	80%	80%
	You Pay	20%	20%	20%	20%	20%	20%	20%	20%
Calendar Year Out-of Pocket Maximum	Individual/Network	$3,000							
	Individual/Out-of-Network	$6,000							
	Family/Network	$6,000							
	Family/Out-of-Network	$12,000							
Coinsurance[9]	Network Plan Pays	80%							
	You Pay	20%							
	Out-of-Network Plan Pays	70%							
	You Pay	30%							

7 *Copayment does not apply to office visits for preventive care services when in-network providers are used.*
8 *Subject to deductible*
9 *Percentages apply to allowable amount for eligible expenses after calendar-year deductibles are met.*

Prescription Drug Card Program

Options		Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII
Copayment Amounts	Generic	$10	$10	$10	$10	$10	$10	$10	$10
	Preferred	$30	$30	$30	$30	$30	$30	$30	$30
	Non-Preferred	$45	$45	$45	$45	$45	$45	$45	$45
Separate Deductibles		$200	$200	$200	$200	$200	$200	$200	$200
Options		**Plan I**	**Plan II**	**Plan III**	**Plan IV**	**Plan V**	**Plan VI**	**Plan VII**	**Plan VIII**
Mail Order Prescription Drug Program	Generic	$30	$30	$30	$30	$30	$30	$30	$30
	Preferred	$60	$60	$60	$60	$60	$60	$60	$60
	Non-Preferred	$90	$90	$90	$90	$90	$90	$90	$90

PPO Select Choice – Series V

Plan Provisions

	Network	**Out-of-Network**
Calendar-Year Deductible Options Per Member (maximum of three per family)	$250 / $750 $500 / $1,500 $1,000 / $3,000 $1,500 / $4,500 $2,500 / $7,500 $3,500 / $10,500 $5,000 / $15,000 $10,000 / $30,000	$500 / $1,500 $1,000 / $3,000 $2,000 / $6,000 $3,000 / $9,000 $5,000 / $15,000 $7,000 / $21,000 $10,000 / $30,000 $20,000 / $60,000
Out-of-pocket Maximum (Does not include deductible)	$3,000 individual / $6,000 family per calendar year	$6,000 individual / $12,000 family per calendar year
Coinsurance[10]	80% / 20%	70% / 30%
Pre-existing Condition Limitation (Conditions diagnosed or treated)	12 months prior can be considered pre-existing for **12 months** after effective date (This limitation does not apply to applicants under 19 years of age.)	
Preauthorization	• **Required** for each hospital admission, extended care services, home infusion therapy, and organ and tissue transplants • **Patient** is responsible for pre-authorization; network providers may pre-authorize care	
Preventive Care Services (Benefits covered as defined by national guidelines)	100% of allowable amount when in-network providers are used. Benefits are reduced to 70% when out-of-network providers are used.	
Emergency Care	• Paid at network level until patient can be safely transferred to a network facility. • Subject to deductible and coinsurance	
Benefit Level Guidelines	Patient will receive network level benefits only if a BlueChoice provider and facility are used	
Application Fee	$30; non-refundable	

10 *Percentages apply to allowable amount for eligible expenses after calendar-year deductibles are met.*

PPO Select Saver – Series V

Options		Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII
Calendar Year Deductibles	Individual/Network	$500	$1,000	$1,500	$2,500	$3,500	$5,000	$10,000
	Individual/Out-of-Network	$1,000	$2,000	$3,000	$5,000	$7,000	$10,000	$20,000
	Family/Network	$1,500	$3,000	$4,500	$7,500	$10,500	$15,000	$30,000
	Family/Out-of-Network	$3,000	$6,000	$9,000	$15,000	$21,000	$30,000	$60,000
Calendar Year Out-of Pocket Maximum	Individual/Network	$3,000						
	Individual/Out-of-Network	$6,000						
	Family/Network	$9,000						
	Family/Out-of-Network	$18,000						
Coinsurance[12]	Network Plan Pays	75%						
	You Pay	25%						
	Out-of-Network Plan Pays	60%						
	You Pay	40%						

12 *Percentages apply to allowable amount for eligible expenses after calendar-year deductibles are met.*

Prescription Drug Card Program

Options		Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII
Copayment Amounts	Generic	$10	$10	$10	$10	$10	$10	$10
	Preferred	$40	$40	$40	$40	$40	$40	$40
	Non-Preferred	$55	$55	$55	$55	$55	$55	$55
Separate Deductibles		$200	$200	$200	$200	$200	$200	$200
Mail Order Prescription Drug Program		90-day supply for 2 copayments.						

PPO Select Saver – Series V

Plan Provisions

	Network	**Out-of-Network**
Calendar-Year Deductible Options Per Member (maximum of three per family)	$500 / $1,500 $1,000 / $3,000 $1,500 / $4,500 $2,500 / $7,500 $3,500 / $10,500 $5,000 / $15,000 $10,000 / $30,000	$1,000 / $3,000 $2,000 / $6,000 $3,000 / $9,000 $5,000 / $15,000 $7,000 / $21,000 $10,000 / $30,000 $20,000 / $60,000
Out-of-pocket Maximum/Security Provision (Does not include deductible)	$3,000 individual / $9,000 family per calendar year	$6,000 individual / $18,000 family per calendar year
Coinsurance[13]	75% / 25%	60% / 40%
Pre-existing Condition Limitation (Conditions diagnosed or treated)	12 months prior can be considered pre-existing for **12 months** after effective date (This limitation does not apply to applicants under 19 years of age.)	
Preauthorization	• **Required** for each hospital admission, extended care services, home infusion therapy, and organ and tissue transplants • **Patient** is responsible for preauthorization; network providers may pre-authorize care	
Preventive Care Services (Benefits covered as defined by national guidelines)	• 100% of allowable amount when in-network providers are used. Benefits are reduced to 60% when out-of-network providers are used.	
Emergency Care	• Paid at network level until patient can be safely transferred to a network facility. Subject to deductible and coinsurance	
Benefit Level Guidelines	Patient will receive network level benefits only if a BlueChoice provider and facility are used	
Application Fee	$30; non-refundable	

13 *Percentages apply to allowable amount for eligible expenses after calendar-year deductibles are met.*

Product Overviews

BlueEdge Individual HSA

Plan Provisions

	Network	Out-of-Network
Calendar-Year Deductible Options Per Member (maximum of two per family)	**Plans I-III** $1,250 $1,750 $2,500 **Plans IV-VI** $1,250 $1,750 $2,500 **Plans VII-VIII** $3,500 $5,000	**Plans I-III** $2,500 $3,500 $5,000 **Plans IV-VI** $2,500 $3,500 $5,000 **Plans VII-VIII** $7,000 $10,000
Out-of-pocket Maximum/Security Provision	**Plans I-VI** $3,000 individual / $6,000 family per calendar year **Plans VII** $3,500 individual / $7,000 family per calendar year **Plans VIII** $5,000 individual / $10,000 family per calendar year	**Plans I-VI** $6,000 individual / $12,000 family per calendar year **Plans VII** $7,000 individual /$14,000 family per calendar year **Plans VIII** $10,000 individual /$20,000 family per calendar year
Coinsurance[14]	**Plans I-III** 90% / 10% **Plans IV-VI** 75% / 25% **Plans VII-VIII** 100%/0%	**Plans I-III** 70%/30% **Plans IV-VI** 60%/40% **Plans VII-VIII** 100%/0%
Pre-existing Condition Limitation (Conditions diagnosed or treated)	12 months prior can be considered pre-existing for **12 months** after effective date (This limitation does not apply to applicants under 19 years of age.)	
Preauthorization	• **Required** for each hospital admission, extended care services, home infusion therapy, and organ and tissue transplants • **Patient** is responsible for pre-authorization; network providers may pre-authorize care	
Preventive Care Services (Benefits covered as defined by national guidelines)	100% of allowable amount when in-network providers are used. Benefits are reduced when out-of-network providers are used.	
Emergency Care	• Paid at network level until patient can be safely transferred to a network facility. • Subject to deductible and coinsurance	
Benefit Level Guidelines	Patient will receive network level benefits only if a BlueChoice provider and facility are used	
Application Fee	$30; non-refundable	

14 *Percentages apply to allowable amount for eligible expenses after calendar-year deductibles are met.*

Prescription Drug Card Program

Options		Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI	Plan VII	Plan VIII
Copayment Amounts	Generic	$10	$10	$10	$10	$10	$10	$0	$0
	Preferred	$50	$50	$50	$50	$50	$50	$0	$0
	Non-Preferred	$65	$65	$65	$65	$65	$65	$0	$0
Mail Order Prescription Drug Program		90-day supply for 2 copayments.							

After the calendar year deductible is met, the copayment amount will apply until the out-of-pocket maximum has been met.

Product Overviews

SelecTEMP PPO

This temporary PPO coverage is designed for your clients who are between permanent health plans. SelecTEMP PPO is a good fit for situations when your client has a need for temporary medical coverage due to:

- Waiting for employer group coverage to begin
- Between jobs
- Recent college graduate
- A dependent coming off the parent's plan

SelecTEMP PPO coverage offers:

- Freedom to choose doctors and hospitals
- Access to the BlueChoice® provider network
- Choice of five deductibles
- Three-tier prescription drug program with a separate drug deductible
- Mail order drug program - 90-day supply at 2 times the copayment amount
- Individual and spouse coverages
- No application fee

The SelecTEMP PPO plan is not designed to take the place of a permanent health insurance policy. A few health questions must be answered, but medical underwriting is not required. SelecTEMP PPO is **nonrenewable**.

Eligibility Requirements

Each person applying must be a:

- Texas resident at least 60 days of age, and under 65 years of age. A court-ordered dependent under 60 days of age may apply with their parent. A complete copy of the court order must be submitted with the application. Newborn children must be at least 60 days old and have had their first well-baby exam.
- U.S. citizen; or non-U.S. citizen living in the U.S. at least two years

Noneligible Persons

The following persons are not eligible for coverage:

- Pregnant females
- Expectant males (males with pregnant wife, girlfriend, etc.)
- Any member of a household who is pregnant, whether that person is applying for coverage or not, will make the entire household ineligible for family coverage until the pregnancy has ended. Children over 60 days of age may apply separately.

SelecTEMP PPO

Plan Provisions

Contract Period	From 1 to 11 months; may apply for additional nonrenewable SelecTEMP PPO coverage as many times as needed. Medical conditions which develop during any prior SelecTEMP PPO contract period will be considered pre-existing during the subsequent SelecTEMP PPO contract periods.
Deductible Options	$500, $1,000, $1,500, $2,000, $2,500
Out-of-Pocket Maximum (Does not include deductible)	$1,000 per member
Coinsurance[15]	80% / 20%
Lifetime Maximum Benefits	$2,000,000 per member
Effective Date	The later of the following: requested effective date or the day after U.S. postmark. Please note – if the envelope containing the application is not postmarked by the U.S. Post Office or if the postmark is not legible, the effective date will be the later of the following: (a) the requested effective date (if in the future) or (b) the date received by Blue Cross and Blue Shield of Texas.
Pre-authorization	Required for each hospital admission, extended care services, and home infusion therapy. Patient is responsible for pre-authorization.
Payment Options	• 1 month's coverage – payment required with application • 2-11 month's coverage – must submit total premium for entire coverage period elected or a single payment may be submitted for first month and monthly bank draft for remaining coverage period.
Change	Not allowed
When applying for permanent coverage with one of the Select Products	• A new application is required • Medical underwriting is required • Member must submit a request to cancel their SelecTEMP PPO coverage. (This is important in order to coordinate the new policy effective date and premium payments.)

15 *Percentages apply to allowable amount for eligible expenses after calendar-year deductibles are met.*

Product Overviews

Dental Indemnity USA — Individual Traditional Coverage

Dental Indemnity USA is an indemnity dental product, underwritten and distributed by Blue Cross and Blue Shield of Texas and administered by Dental Network of America.

Your clients listed and approved for health coverage are eligible for dental coverage if the appropriate dental box on the application is checked indicating a request to be covered by Dental Indemnity USA.

If membership changes occur to an existing health contract, the same changes will occur on dental. If the health coverage for a member cancels, the dental coverage will also cancel at the same time.

Your client may have health coverage without the dental coverage, but they cannot have dental coverage without BCBSTX health coverage.

Benefits

The plan provides benefits for diagnostic and preventive care, as well as almost every form of specialty dental treatment. Upon enrolling in the plan, members will receive a information packet which includes dental procedures covered by the plan. The fee schedule of benefits included in the packet will identify the maximum allowable benefit members can receive when a procedure is performed. The dollar amount assigned to each procedure is the maximum any member can receive, not to exceed actual charges. The dentist will file a standard claim form and payment is made either directly to the dentist, if authorized on the claim form, or to the member.

Network Overviews

Provider Access and Networks

The Select Family of Products provides your clients and their families with easy and affordable access to doctors and hospitals.

bcbstx.com

Log on to bcbstx.com and select Provider Finder to search for contracting network doctors, hospitals and other providers by location or specialty.

Provider Network Descriptions

BlueChoice

Select Blue Advantage, PPO Select Choice, PPO Select Saver, BlueEdge Individual HSA, and other PPO Select products feature the individual BlueChoice network of contracting physicians, specialists, hospitals and other health care providers. BlueChoice network providers have agreed to reduce their fees for PPO members. The BlueChoice network is one of the largest provider networks in Texas. Advantages of using a BlueChoice provider network include:

- Highest benefit levels
- No claim forms to file
- Providers pre-authorize care
- No balance billing for charges above the allowable amount

BlueCard Network

Freedom to Choose

With the BlueCard PPO Program, your client has the freedom to choose their provider. However, when utilizing BlueCard PPO network Providers, they will receive network benefits for many services.

Available Care Coast-to-Coast

Whether your client is at home or traveling, information they need about the BlueCard PPO Program is only a telephone call away. They may obtain information regarding BCBS PPO network providers and hospitals by calling the Customer Service telephone number on the back of their ID card or the BlueCard access telephone number at (800) 810-BLUE (2583) toll-free when medical services are warranted outside of their local plan service area (Texas).

Easy Access to BlueCard PPO Network Providers

By linking individual Blue Cross and Blue Shield (BCBS) PPO networks, the BlueCard PPO Program provides your client with access to the largest health care network in America. As a member using BCBS PPO network providers, your client will receive the network benefits available through their health plan even while traveling outside their local plan service area. Although network providers outside of Texas may pre-authorize those services that require pre-authorization, it is ultimately your client's responsibility to obtain pre-authorization by calling the appropriate number on the back of their ID card. BlueCard PPO network providers have agreed to accept BCBS's allowable amount and not balance bill your client, the member.

BlueCard is Recognized Across the United States

The BCBS ID card, "The BlueCard," gives your client access to BCBS network providers throughout the U.S. The PPO-in-a-suitcase logo PPO tells providers that your client is part of the BlueCard PPO Program. The three-letter alpha prefix that precedes their subscriber number on the ID card identifies Blue Cross and Blue Shield of Texas as their home plan.

No Paperwork or Claims to File

When physicians agree to participate in their local PPO network, they accept responsibility to eliminate many of the hassles associated with other health care plans. BlueCard PPO network providers have also agreed to file your client's claims. When using the network providers, all they need to do is show their ID card. The member will be responsible for any applicable copayment or deductible, and coinsurance amounts, in addition to any services that are not covered or approved by Blue Cross and Blue Shield of Texas. The physicians will then file the claim to the local BCBS plan with whom they are a contracting PPO provider. When the provider submits the claim, it is important that the alpha prefix from the ID card is included. This prefix is the key to timely and accurate claims processing.

Choosing a BlueCard PPO Provider

To get the most out of the BlueCard PPO benefits, your client should always use a PPO Network Provider. They can simply call Customer Service or the BlueCard PPO Access Line at (800) 810-BLUE (2583), and representatives will help them locate a provider near them or they can log on to bluecares.com. If they have a provider in mind, they can also verify that the provider participates in the local BCBS Plan PPO Program.

ParPlan

While ParPlan is not a provider network, it is available for members who choose to use providers outside of the network. Members will be responsible for deductible, coinsurance and copays, but ParPlan providers have contracted with Blue Cross and Blue Shield of Texas and have agreed not to bill members for charges over the "allowable amount." Generally they will pre-authorize care and file claims for members.

Non ParPlan

Members are responsible for pre-authorizing care, submitting claims, and paying charges that exceed the allowable amount, which can be considerable, when using providers that have no contract with Blue Cross and Blue Shield of Texas.

General Provisions

Eligibility Information

Your clients applying for coverage must meet certain eligibility requirements.
The eligibility requirements for the Select Family of Products include:

Products	Eligibility Requirements
Select Blue Advantage – Series V PPO Select Choice – Series V PPO Select Saver – Series V BlueEdge Individual HSA	• Texas Resident • Non U.S. citizens are eligible to apply, but must be able to furnish medical records from a U.S. physician for up to two years prior, upon request • Current Health Records: If your client has not seen a physician in the past two years or is unable to supply medical records from a licensed U.S. physician, including, but not limited to a health evaluation conducted within the past two years, they may be required to have a physical exam (at their own expense) and provide medical records of such exam prior to being considered for coverage by underwriting[16].
SelecTEMP PPO	• Texas resident • U.S. citizen; or non-U.S. citizen living in the U.S. at least two years • Social security numbers are required for all applicants over age one • Must be at least 60 days of age and had well baby exam and under 65 years of age.

Applications will not be accepted on pregnant females, expectant fathers or any other member of a household who is pregnant, whether that person is applying for coverage or not. (This limitation does not apply to participants under 19 years of age.) Eligibility for coverage will be considered following the mother's postpartum examination and release from her physician. ***A newborn child must be at least 60 days of age and must have had their well-child exam to be considered for coverage.*** Applications may be considered for minor dependent children of expectant parents.

Eligible Dependents

- A spouse
- Dependents to age 26
- Natural, newborn children of the applicant are eligible for coverage on their date of birth for the first 31 days. To ensure continuous coverage beyond the first 31 days an application for coverage must be received within 31 days from birth. The application for coverage should be mailed to Hallmark Services Corporation — refer to back inside cover page for mailing address.
- Grandchildren added to an existing policy are subject to underwriting approval

16 *If the health evaluation has not been conducted prior to the submission, the application will be withdrawn. The applicant may reapply upon completion of the health evaluation.*

General Provisions

Health Premium Rate

Individual health premiums are determined by:

- Product type
- Deductible selection
- Geographic location of permanent, physical residence
- Age
- Sex
- Number and relationship of family members
- Underwriting risk status of all persons applying
- Use or non-use of tobacco products of all persons applying (not applicable to SelecTEMP PPO)

Rating Levels

Because Blue Cross and Blue Shield of Texas believes the cost of delivering health care services to members with minimal health care needs should not be offset by delivering health care services to members predicted to incur higher expenses, we developed the Preferred and Standard rating levels. These two rating levels will help to ensure that a balance of risk is maintained.

Preferred rates — Available for individuals and family members with medical conditions of minimal risk and who meet the preferred height/weight guidelines.

Standard rates — Will be assigned for individuals and families with medical conditions of moderate risk, or who fall within the standard height/weight guideline. All tobacco users will be assigned Standard rates.

Definition of a "Child"

- The natural child of the Subscriber or;
- A legally adopted child of the Subscriber (including a child for whom the Subscriber is a party in a suit in which the adoption of the child is being sought); or
- A stepchild; or
- A child for whom the Subscriber has received a court order or an order requiring that Participant have financial responsibility for providing health insurance; or
- A grandchild of the Subscriber who is dependent upon the Subscriber for Federal income tax purposes at the time application for coverage is made.

Health Rate Guarantee

Initial rates are guaranteed for six months except for premium adjustments required by:

- Applicant/dependent changing age bracket
- Adding or deleting dependents
- Applicant moving to a different geographic area of Texas.
- Benefit changes

Rates are trended on a semi-annual basis. If you are quoting a client within four weeks of the new rate period, you should quote the next period's rate.

How to Obtain Rating Information

Rating information can be located at HSCIL.com.

General Provisions

Reconsideration of Standard Rate due to Tobacco Use

Members may request a preferred (non-tobacco) rate on an existing policy if both of the following have occurred:

- The member must not have used any form of tobacco, cessation aid, or nicotine substitution product within the last 12 months; and
- The member must have had a complete medical examination by a physician within the previous 12 months.

Members must submit a fully completed, signed and dated 'Prior Tobacco Use Questionnaire', which must be completed by the member's physician. All requests are subject to underwriting approval of the member's BCBSTX claim history and the questionnaire.

Please note that the member will not be eligible for the preferred rate if there is an existing medical condition which would warrant a standard rate.

Reconsideration of Standard Rate due to Height and Weight

Members may submit an application for current consideration at the preferred rate if both of the following have occurred:

- The member must have maintained a weight within the preferred range for at least 12- consecutive months prior to the request; and
- The member must have the results of a complete medical examination by a physician within the previous 12 months available for review upon request.

All requests for reconsideration are subject to underwriting approval of the member's medical history, including BCBSTX claim history.

Please note that the member will not be eligible for the preferred rate if there is tobacco use or another existing medical condition which would warrant a standard rate.

General Provisions

General Information on Height / Weight:

- If the applicant has lost weight within the past year (through diet, exercise or medication use), one-half of the weight lost will be added to the current weight for underwriting purposes. Once the weight loss has been maintained for at least one year, the current weight will be used.

  Example – applicant is female, 5 feet 7 inches and 180 pounds. She has lost 40 pounds during the last 12 months. Add 20 pounds to the current weight of 180 equaling 200 pounds – this adjusted amount requires the Standard rate.

- Certain medical conditions can be impacted by excess weight, and may result in declination at weights lower than the maximum listed in the chart. This list covers some of the most common conditions, but is not all inclusive.

  High blood pressure
  Diabetes (diet controlled)
  Arthritis or gout in weight-bearing joint(s)
  Joint replacement (due to trauma) or artificial spinal disc implant
  Sleep apnea

Evidence of Insurability

Satisfactory Evidence of Insurability is required for all persons applying for health coverage. Coverage is not in effect until approved by BCBSTX and all requirements received. Requirements include, but are not limited to, premium and/or a signed and dated Amendatory Endorsement. No insurance is in force unless a contract/policy of insurance has been issued during the member's lifetime and the member remains insurable until the effective date of coverage or the date BCBSTX approves the application, whichever is later.

Effective Date of Coverage

- The earliest effective date for new policies issued is two weeks (14 additional calendar days) from the date of receipt of the application, subject to underwriting approval. The exception is we cannot provide coverage effective dates of the 29th, 30th or 31st of the month. If the application is not approved within the two-week period following receipt of the application, the effective date will be the date of underwriting approval (with the exception of the 29th, 30th and 31st).
- Effective dates for SelecTEMP PPO product: The later of the following: requested effective date or the day after U.S. Postmark. Please note - if the envelope containing the application is not postmarked by the U.S. Post Office or if the postmark is not legible, the effective date will be the later of the following: (a) the requested effective date (if in the future) or (b) the date received by Blue Cross and Blue Shield of Texas. It is imperative that the SelecTEMP PPO application reach Blue Cross and Blue Shield of Texas within 30 days of the signature date or if you want to guarantee the receipt date, send your application by overnight guaranteed mail.
- At no time can the effective date be prior to the date the application is signed.
- No retroactive effective dates will be issued.
- SelecTEMP PPO should be offered to prevent gaps in coverage only.

General Provisions

Pre-existing Conditions

Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within 18 months (for Select Blue Advantage) or 12 months (for PPO Select Choice, PPO Select Saver, and BlueEdge Individual HSA) immediately preceding the effective date of the member's coverage under the contract, or a condition for which medical advice or treatment was recommended or received from a physician or professional provider within the two-year period immediately preceding the effective date of the member's coverage under the contract. Participants under age 19 are not subject to pre-existing condition exclusions. Medical conditions which develop between the date of application and the effective date of coverage are considered pre-existing conditions.

If your client is accepted for coverage, the contract will not pay benefits for any medical expenses incurred during the first 18 months after a member's effective date for treatment of a pre-existing condition on Select Blue Advantage. On PPO Select Choice, PPO Select Saver, and BlueEdge Individual HSA, no benefits will be paid for the first 12 months after a member's effective date for treatment of a pre-existing condition. **Participants under age 19 are not subject to pre-existing condition exclusions.**

Creditable Coverage — for Pre-Existing Conditions

Under Federal law, a person moving from a group, government or church health plan to an individual policy may not be subject to a new pre-existing condition limitation period if he or she has 18 months of prior coverage with no more than a 63-day lapse in coverage. A member moving from a group, government or church plan to an individual policy with less than 12-months coverage will receive credit for any time covered during the preceding 12 months on PPO Select Choice, PPO Select Saver, and BlueEdge Individual HSA. Select Blue Advantage continues to be 18 months.

If a member is eligible to receive credit toward his or her pre-existing condition waiting period, the following types of coverage will be considered in the determination:

- Self-funded or self-insured employee welfare benefit plan that provides health benefits
- Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization
- Medical-care program of the Indian Health Service or of a tribal organization
- State health benefits risk pool
- Health plan offered under Chapter 89 of Title 5, United States Code
- Public health plans defined by federal regulations
- Health plan under Section 5(e) of the Peace Corps Act
- Medicare or Medicaid
- State Children's Health Insurance Program

Please attach a written copy of any prior creditable coverage to the application to ensure credit is applied toward any pre-existing condition waiting period, and complete in full the creditable coverage section on the application.

Note — An individual must still be medically underwritten and approved for coverage by BCBSTX. The placement of temporary and permanent condition/exclusion riders is allowed, and will apply even though the covered member may have sufficient credit to satisfy the appropriate pre-existing waiting period. Participants under age 19 are not subject to pre-existing condition exclusions.

General Provisions

Receipt of Application

Applications for a permanent or temporary individual plan that are not received by BCBSTX within 30 days of the date of signature will be returned, and a new application must be submitted.

Ten-Day Right to Examine Contract

Within 10 days after its delivery to the insured, the contract/policy may be surrendered by delivering or mailing it to BCBSTX home office, branch office, or the agent through whom it was purchased. The recipient of the returned policy must notify Hallmark Service Corporation of the applicant's intent to surrender the policy. Upon notice of intent, or surrender and return of the identification cards/policy, the file will be closed and any premium paid will be refunded. The $30 health application fee is non-refundable.

No coverage is in effect until BCBSTX has approved the application and the first full premium amount, the application fee and all requirements including an Amendatory Endorsement, if applicable, have been received. There is no application fee for SelecTEMP PPO coverage. *Please instruct your clients not to cancel any current health coverage prior to receiving Blue Cross and Blue Shield of Texas written notice of approval.* Blue Cross and Blue Shield of Texas will not be liable for any health claims until all requirements have been received and coverage is activated.

Maternity Care — not covered

Maternity Care is not covered for applicants whose initial enrollment for any Select Products occurred after 08-01-97. Services and supplies incurred by a member for the delivery of a child will be considered maternity care and are not covered by any of the Select Products. Benefits for eligible expenses incurred for treatment of complications of pregnancy may be considered the same as for treatment of sickness. For further explanation of "complications of pregnancy," please refer to the definition section in the specimen contracts. To request a copy of the specimen contract, please complete a Producer Supply Order Form and fax the request to (972) 766-8253. This order form can be downloaded from the Web site at bcbstx.com. Simply select "Producers," then "Forms," then "Individual Products Downloadable Forms." Only one specimen contract set per office, please.

Contact Information

Resources	Services	Contact Information	
Hallmark Services Corporation	Completed application and underwriting correspondence	Mail to: BCBSTX Hallmark Services Corporation PO Box 3236 Naperville, IL 60566-7236	
		Overnight delivery only: BCBSTX Hallmark Services Corporation 1100 Warrenville Road, Suite 300 Naperville, IL 60563	
	Health underwriting questions and application status Health contract and policy changes, policy issue and premium billing information	Producers call:	(888) 697-0679
	Health claims questions	Members call:	888) 697-0683
Blue Cross and Blue Shield of Texas	Preauthorization for benefits	Members call:	(800) 441-9188
		Fax:	800) 252-8815 or (800) 492-0742
		Fax Referral Department:	(800) 572-0864 or (800) 462-3272
Provider Network Information	Provider Finder:	bcbstx.com/onlinedirectory/index	
		BlueChoice and ParPlan for Texas:	(800) 441-9188
		BlueCard – Out of State Network:	(800) 810-2583
Producer Service Unit	Forms, including Producer Supply Order Form Advertising guidelines and pre-approved ads	Producer website: yourcmsupplyportal.com	
	Producer assistance and training	Producers call:	(800) 531-4457
Commissions Department	Questions regarding: • Commission • Agent of record • Errors & omissions update • License update	Producers call:	(855) 782-4272
		Fax:	(918) 549-3039

BlueCross BlueShield of Texas