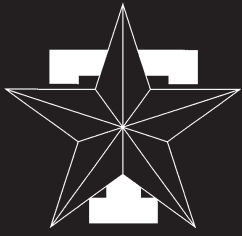




The Texas A&M University System

Your A&M System Health Plan

Updated September 2011



INTRODUCTION

The Texas A&M University System provides health benefits to protect you and your family from the high cost of health care.

Few things in life are as important as your health—and the health of your family. Staying healthy is the ideal for all of us, but sometimes that’s not possible. Whether it’s minor or major, an illness or an injury, we all have a need for health care at some point. And at that point, getting quality care at an affordable price is our biggest concern.

Your Texas A&M University System Health Plan can help ease your concerns. Your health coverage helps you pay the cost of medical care—whether that cost is modest or extreme. The plan helps ensure that you and your family have access to the help you need to protect your health.

The A&M Care plans are funded by The Texas A&M University System, and claims are administered by BlueCross BlueShield of Texas, Inc. (BCBSTX).

This booklet provides a summary of your medical coverage in everyday language. Most of your questions can be answered by referring to this booklet.

Terms that have a specific meaning or may be unfamiliar to you appear in italics. These are defined in the “Definitions” section at the end of this booklet.

This plan is governed by this booklet plus additional administrative details.

This booklet is neither a contract of current or future employment nor a guarantee of payment of benefits. The System reserves the right to change or end the benefits described in this booklet at any time for any reason.

Clerical or enrollment errors do not obligate the plan to pay benefits. Errors, when discovered, will be corrected according to the provisions of the plan description and published procedures of the A&M System.

ESPAÑOL

Para información sobre sus beneficios en Español, llame (866) 295-1212 (oprima “2” para español).

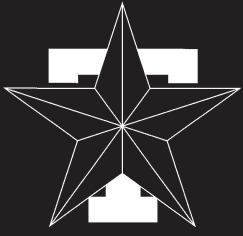
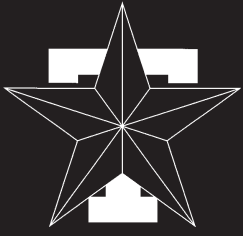


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PARTICIPATION

All full-time and many part-time employees and retirees and their eligible dependents are eligible for health coverage. Coverage can begin on your first day of work.

You and your dependents are eligible to participate in the A&M Care health plans if you:

- ☆ are eligible to participate in the Teacher Retirement System of Texas (TRS) or Optional Retirement Program (ORP), and
- ☆ work at least 50% time for at least 4½ months.

You and your dependents are also eligible if you are a graduate student employee who works at least 50% time for at least 4½ months, or if you are a postdoctoral fellow. To be eligible for coverage as a retiree, you must meet the criteria listed in the chart on the next page.

Eligibility for this plan is subject to change by the A&M System or the Texas Legislature.

ELIGIBLE DEPENDENTS

You may choose to cover any or all of your eligible dependents. Dependents eligible for coverage include:

- ☆ your spouse, and
- ☆ your dependent children younger than 26.

Your spouse must be a spouse as defined by Texas law. Children include:

- ☆ a natural child,
- ☆ an adopted child,
- ☆ a stepchild who has a regular parent/child relationship with you,
- ☆ a foster child under a legally supervised foster care program,
- ☆ a child for whom you are the legal guardian or legal managing conservator and with whom you have a regular parent/child relationship,
- ☆ a grandchild who lives with you, and
- ☆ a dependent for whom you have received a court order to provide health care coverage.

You will be asked to provide legal papers to verify your relationship to any dependent.

Coverage for a child may continue beyond age 26 only if the child is mentally or physically unable to earn a living and is dependent on you for support. You must notify your Human Resources office of the child's disability before the child's 26th birthday. This will allow time for you to obtain and complete the necessary forms for coverage to continue. Periodically, you may be required to provide evidence of the child's continuing disability and your support.

ENROLLING IN THE PLAN

Coverage for you and your dependents can take effect either on your hire date or

on your employer contribution eligibility date (the first of the month after your 90th day of employment) if you enroll before, on or within seven days after your hire date.

If you enroll beyond the seventh day after your hire date, but during your 60-day enrollment period, your coverage can take effect either on the first of the following month or on your employee contribution eligibility date.

On the first of the month following your 90th day of employment or benefit eligibility, you will automatically be enrolled in employee-only coverage under the A&M Care plan, unless

during your 60-day enrollment period you:

- ☆ elect different coverage,
- ☆ elect coverage for your dependents, or
- ☆ waive coverage on yourself.

If you do not make any changes during your enrollment period, you must wait until you have a Change in Status (see page 6–7) or until the next Annual Enrollment period to enroll.

Likewise, if you gain a new dependent, you must enroll that dependent within 60 days or wait until the next Annual Enrollment period.

If you choose to have your health coverage take effect before your employer contribution eligibility date,

RETIREE ELIGIBILITY

If you were retired from or employed in a benefits-eligible position with the A&M System on Aug. 31, 2003, you are eligible for health coverage as a retiree when:

- you are at least age 55 and have at least 5 years of service credit, or your age plus years of service equal at least 80, or you have at least 30 years of service, and
- you have 3 years of service with the A&M System, and
- the A&M System is your last state employer.

If you left A&M System employment before Sept. 1, 2003, but you met the above criteria as of Aug. 31, 2003, you qualify for retiree benefit coverage under these criteria.

If you are in TRS and you retire after Aug. 31, 2003, you must also provide documentation that you are receiving or have applied to receive your TRS annuity payments.

If you were hired by the A&M System in a benefits-eligible position after Aug. 31, 2003, or if you left A&M System employment before Aug. 31, 2003, and did not meet the criteria listed at left as of Aug. 31, 2003, you are eligible for health coverage as a retiree when:

- you are at least age 65 and have at least 10 years of service credit, or your age plus years of service equal at least 80 and you have 10 years of service credit, and
- you have 10 years of service with the A&M System, and
- the A&M System is your last state employer.

If you are in TRS, you must also provide documentation that you are receiving or have applied to receive your TRS annuity payments.

you must pay the full monthly premium yourself.

If you are not a new employee, but you are enrolling in the plan during Annual Enrollment, your coverage will take effect the following Sept. 1.

If you are enrolling in the plan because of a Change in Status (see below), your coverage will take effect the first of the month after you enroll.

FORMER EMPLOYEES

You are eligible for coverage as a retiree if you are a former employee who meets the eligibility criteria listed on the previous page.

You may apply for coverage within 60 days of meeting this criteria or within 60 days of leaving a TRS-eligible position with another state employer after meeting the eligibility criteria. In these cases, you may choose to have your coverage become effective on the first of the month following the date the Human Resources office receives your application or on your employer contribution eligibility date (the first of the month that falls at least 90 days after the Human Resources office receives your application).

If you do not enroll on one of these dates, you may enroll during a later Annual Enrollment period. In that case, you can choose to have your coverage become effective on the next Sept. 1 or Dec. 1.

YOUR OPTIONS

The A&M Care plan is available to active and retired employees. If you are retired and you (and your spouse, if you wish to enroll him/her) are both on Medicare and you are working for the A&M System no more than six months of the plan year, you have the choice of the 65 PLUS plan.

You also have a choice of four levels of coverage:

- ☆ employee/retiree only,
- ☆ employee/retiree and spouse,
- ☆ employee/retiree and children, or
- ☆ employee/retiree and family (spouse and children).

If you enroll your dependents, you must enroll them in the same plan in which you enrolled yourself.

CHANGE IN STATUS

You can change your A&M Care plan choice, coverage level or dependents covered only during Annual Enrollment (changes effective Sept. 1) or within 60 days of a Change in Status.

Changes in Status include:

- ☆ employee's marriage or divorce or death of employee's spouse,
- ☆ birth, adoption or death of a dependent child,
- ☆ change in employee's, spouse's or dependent child's employment status that affects benefit eligibility,

- ☆ child becoming ineligible for coverage due to reaching age 26,
- ☆ changes in the employee's, spouse's or a dependent child's residence that would affect eligibility for coverage,
- ☆ employee's receipt of a qualified medical child support order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) medical coverage for a child,
- ☆ changes made by a spouse or dependent child during his/her annual enrollment period with another employer,
- ☆ the employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid, or
- ☆ significant employer- or carrier-initiated changes in or cancellation of the employee's, spouse's or dependent child's coverage.
- ☆ The employee or dependent reaching the lifetime maximum for all benefits from a non-A&M System health plan (health plan changes only)
- ☆ The employee or dependent child loses coverage under the state Medicaid or child health plan or becomes eligible for premium assistance under the Medicaid or child health plan.

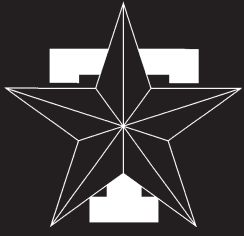
Changes in coverage must be consistent with the Change in Status. For example, if you have a baby, you may add that child to your coverage, but you may not drop your other children.

A divorce is considered official when the trial court announces its decision in open court or by written memorandum filed with the clerk.

You must provide dependent documentation to add or change coverage for dependents.

NEWBORN CHILDREN

If you are covered by the plan, your newborn child or children are automatically covered from birth for 31 days. However, to keep coverage, you *must* complete a dependent Enrollment form with supporting documentation and return to your Human Resources office within 60 days of the child's birth. Otherwise, coverage for that child will end after 31 days. You must then wait until the next Annual Enrollment period or until you have another Change in Status to enroll the child.



COVERAGE COST

You and the System share the cost of health coverage. You can pay your share on a before-tax basis.

Each month, beginning with the month after your 90th day of employment, your employer makes a contribution toward your health coverage and you must pay part of the cost yourself.

If coverage for you or your dependents begins in the middle of a month, you must pay your share of the premium for the entire month.

Through the Pretax Premiums Plan, your share of any premium is automatically deducted from your paycheck on a pretax basis. This means you never pay federal income tax or Social Security tax on the money you pay for your health coverage.

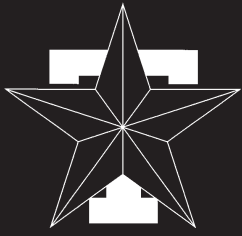
When you pay premiums on a pretax basis, your taxable income is reduced. This may mean that your eventual Social Security benefit could be reduced. However, the reduction is quite small. Your base pay, for purposes of pay increases and benefits based on pay, is not reduced.

If you participate, your spouse's and your children's premiums will be deducted on a pretax basis as well.

If you would prefer to have your contributions paid after taxes have been deducted, contact your Human Resources office for the correct form.

You may change to or from pretax premiums only during Annual Enrollment each year (effective Sept. 1).

If you are retired, you are not eligible for pre-tax premiums unless you are re-employed by the A&M System and pay for health coverage through payroll deduction.



HOW HEALTH COVERAGE WORKS

Whether you receive network or non-network benefits depends on where you live, unless you are retired and eligible for Medicare (see “If You Are Retired,” page 10).

You or your dependents choose which health care providers to use. BCBSTX is not liable for any act or omission by any health care provider and as no responsibility for a health care provider's failure or refusal to provide services or supplies to you or your dependents.

The health care provider determines the care and treatment you or your dependents receive. BCBSTX does not control, influence or participate in health care treatment decisions made by your health care providers.

The health care providers, their employees, their agents and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX. They are independent contractors.

When you enroll, you will receive a plan ID card that you present when you access services. Your ID card will include an ID number that is not your Social Security number. You will receive a separate drug plan ID card from Medco (see “Prescription Drugs,” page 36).

NETWORK AND NON-NETWORK

For active employees and retirees for whom Medicare is not primary, how benefits are paid depends on whether you live in a network service area or a non-network service area. This is determined by your home ZIP code.

All Texas counties except Donley, Hansford, Lipscomb, Ochiltree and Wheeler are network areas. If you live outside of Texas but within the United States, you are in a network area. You may call your Human Resources office or BCBSTX Customer Service, (866) 295-1212, to find out if you live in a network service area.

If you live in a Texas non-network area and are not eligible for Medicare, you will receive network benefits if you travel to a network area and use a network *doctor* or *hospital*.

NETWORK AND OUT-OF-NETWORK

If you live in a network service area, whether you receive network or out-of-network benefits depends on which *doctors* and *hospitals* you choose.

If you live in a network area, each time you need medical care, you can choose to use a *network* or *out-of-network doctor* or *hospital*. You will receive higher benefits from the plan if you use a network provider.

If you live in a network area in Texas, the BlueChoice network is available. If you live or are traveling anywhere outside Texas, the BlueCard network is available.

You may call BCBSTX Customer Service at (866) 295-1212 to find out if a specific *doctor* or *hospital* is in the network or to request a directory for your area. Customer service is available Monday-Friday 8 a.m to 8 p.m. CST. You may also search for doctors on the BCBSTX web page (www.bcbstx.com).

If you are outside Texas, you may call the toll-free number on the back of your ID card, (800) 810-2583, to locate a BlueCard network *doctor* or facility in your area.

Other Blue Cross and Blue Shield Plans outside of Texas, called Host Blue, may have contracts with certain health care providers in their service areas. When you receive health care services through BlueCard (network providers outside of Texas) from a provider who does not have a contract with BCBSTX, the amount you pay for covered services is based on the lower of the billed charges or the negotiated price that the Host Blue passes on to BCBSTX.

In general, the next few pages show how each of the types of benefits work. More specific information is shown in the comparison chart on pages 18–19.

IF YOU ARE RETIRED

If you are a retiree for whom Medicare is not primary and you live in a network area, you receive network benefits if you use a network provider and out-of-network benefits if you use a provider not in the network. Your spouse will receive the same benefits if Medicare is not primary for him/her.

All retirees and their spouses for whom Medicare is primary receive non-network benefits no matter where they live or what providers they use. Retirees and spouses for whom Medicare is primary are not eligible for network benefits because of the need to coordinate with Medicare.

For more information about coordination with Medicare, see page 59.

When this plan coordinates with Medicare, benefits are calculated as if you are enrolled in Medicare parts A and B, even if you do not enroll in both parts. For this reason, you should enroll in Medicare parts A and B as soon as you become eligible.

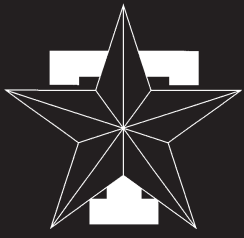
NONREPRESENTED SPECIALTIES

If you need to see a specialist and no network *doctor* with that specialty is in your area, you may be able to see a local specialist not in the network for a \$45 copayment. You or your *doctor* must call BCBSTX in advance to discuss the situation and seek approval. If you need to travel to a larger city for a specialist, you must use a network specialist if one is available in order to receive network benefits, including the \$45 copayment.

REFERRALS

While you are not required to obtain a referral from your network *doctor* to see a specialist, in some cases you may wish to do so. Ideally, your network *doctor* will refer you only to other network *doctors*. *However, it is your responsibility to check to be sure any doctor you see is in the network if you wish to receive network benefits.*

Physicians have individual contracts with BCBSTX. If you go to a doctor in a group practice, be sure the doctor treating you is in the network. If you go to an out-of-network *doctor* on referral from your network *doctor*, you will receive out-of-network benefits. You may contact BCBSTX if you believe that you must see a particular out-of-network specialist. BCBSTX will evaluate the situation and determine whether to allow network benefits.



NETWORK BENEFITS

If you live in a network area and use a BlueChoice or BlueCard network doctor or hospital, you receive network benefits.

If you go to a *primary care physician* (PCP) or primary care physician's assistant who participates in the BlueChoice or BlueCard networks, you pay \$30 for an office visit and most related services. Related services include most lab tests and X-rays performed in conjunction with the office visit even if they are done later. The plan pays all other eligible costs. If you go to a *specialist*, or specialist's physician assistant, you pay \$45 per visit. See pages 68 for definitions of PCP and specialist.

For most other services, including inpatient and outpatient *hospital* services and in-office surgeries costing \$500 or more, you must first meet your annual deductible. Then you pay 30%

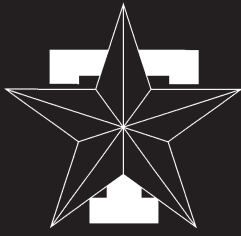
and the plan pays the remaining 70% until you reach your out-of-pocket maximum. After that, the plan pays 100% of most remaining eligible expenses, excluding copayments, for the rest of that plan year.

Using network *doctors* and *hospitals* has many advantages, including:

- ☆ no claim forms,
- ☆ no *reasonable and customary* limits,
- ☆ the *doctor* is responsible for pre-authorizing coverage (except BlueCard network *doctors* outside Texas; see “Pre-authorization and Reviews,” pages 25–26),
- ☆ you pay only \$30 for most *PCP* services related to a pregnancy and 30% up to the out-of-pocket maximum after you meet your annual deductible for pregnancy-related *hospital* services, and
- ☆ full coverage for most preventive care—you pay only the office visit copayment. See page 23 for a list of covered office services.

BENEFITS AT A GLANCE

DOCTOR'S OFFICE VISITS	OTHER SERVICES	
You pay \$30 for PCP visits; \$45 for specialist visits	You pay your annual deductible of \$700	
	You pay: 30%	The plan pays: 70%
The plan pays 100% of remaining costs	Once you reach the out-of-pocket maximum of \$5,000, the plan pays 100% of remaining eligible expenses, excluding office visits, copayments, the deductible, and prescription drug copayments and prescription drug deductibles.	



OUT-OF-NETWORK BENEFITS

If you live in a BlueChoice or BlueCard network area and choose to use doctors and hospitals that are not members of the network, you receive out-of-network benefits.

For most out-of-network *doctor* or *hospital* services, you must first meet your annual deductible. For hospitalization, you must also pay a deductible each time you or a family member is hospitalized. The hospital deductible is \$700 for the A&M Care plan. You are also responsible for pre-authorizing hospitalizations.

After the deductible, you pay 50% and the plan pays 50% of *most* remaining eligible expenses up to the out-of-pocket maximum. Then the plan pays 100% of most remaining expenses.

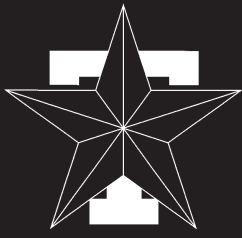
When you choose to receive services from a provider that does not contract with BCBSTX (a non-contracting Provider), you receive Out-of-Network Benefits. Benefits are covered services that will be reimbursed based on the BCBSTX non-contracting allowable amount, which in most cases is less than the allowable amount applicable for BCBSTX contracted Providers. The non-contracted Provider is not required to accept the BCBSTX non-contracting allowable amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting allowable amount and the non-contracting Provider's billed charges. You will be responsible for the balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan and any applicable deductibles, co-insurance amounts and copayment amounts.

OUT-OF-NETWORK BENEFITS AT A GLANCE

You pay your annual deductible (twice the network deductible).

You pay 50%	The plan pays 50%	For each hospitalization, you also pay a <i>hospital</i> deductible.	
		You pay 50%	The plan pays 50%

Once you reach the out-of-pocket maximum, the plan pays 100% of remaining eligible expenses, excluding the deductible, office visit copayments and prescription drug copayments and prescription drug deductibles.



NON-NETWORK AND 65 PLUS BENEFITS

If you live in a non-network area, or if you are eligible for Medicare as your primary carrier and are not working, or if you enroll in 65 PLUS, your benefits will be the same no matter which doctors and hospitals you use.

For most non-network and 65 PLUS doctor or hospital services, you must first meet your annual deductible.

Then under the A&M Care plan, including 65 PLUS, Blue Cross will calculate what they would pay if you had no other insurance. If that is

greater than the remainder, they will pay all of the remainder. Otherwise, they will pay their normal reimbursement. After that, under all plans, the plan pays 100% of remaining eligible expenses except prescription drug copayments and prescription drug deductibles.

If you are younger than age 65 and are willing to drive to an area where network providers are available, you have the option of using network providers and receiving network benefits, as explained on pages 9 and 10.

Non-working retirees and dependents with Medicare parts A and B do not have to pre-authorize the services listed on pages 25 and 26.

A&M CARE J PLAN

The A&M Care J plan is only available to employees on a J-1 or J-2 visa and their family members. Their visas require them to have a plan with a maximum deductible of **\$500** and a maximum coinsurance amount of **25%**. The benefits within the plan are essentially the same as those in the A&M Care plan, including the BlueCross BlueShield in- and out-of-network benefits, with the following differences:

In-network services

\$500 deductible per person/plan year

\$1,500 maximum family deductible

**\$30 copay for primary care Dr
\$45 copay for specialist**

You pay 25% and the plan pays 75% up to your out-of-pocket maximum

\$5,000 per person annual out-of-pocket maximum excluding deductibles and visits and drug copays

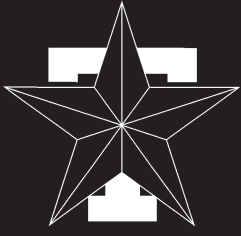
Non-network services

**\$1,000 deductible per person/plan year;
\$500 hospital deductible for non-emergency services**

\$3,000 maximum family deductible

You pay 50% and the plan pays 50% up to your out-of-pocket maximum

\$10,000 per person annual out-of-pocket maximum excluding deductibles and visits and drug copays



PLAN BENEFITS

All of the plans pay benefits based on deductibles, copayments, cost sharing, and plan maximums and limits.

Understanding the terms defined in this section is important to knowing how your plan works.

ANNUAL DEDUCTIBLE

For some health care services, you must first pay an annual plan year deductible before you receive benefits for those services.

If you have dependent coverage, your maximum deductible for all family members is three times the individual deductible. All expenses incurred by any combination of three or more family members go toward meeting the family deductible. If you cover only one dependent, the maximum deductible is two times the individual deductible.

If you live in a BlueChoice or BlueCard network area and Medicare is not primary, you have separate deductibles for network services and out-of-network services. If you get some care in-network and some out-of-network, your network expenses apply only to the network deductible. However, your out-of-network expenses apply to both the network and out-of-network deductibles.

Doctor's office visit and drug copayments and drug and hospital deductibles do not count toward meeting

this deductible. You must continue to pay these expenses even after you have met your annual deductible.

See Wellness Programs on page 43 for information on how you can receive deductible credit for you and your family members.

HOSPITAL DEDUCTIBLE

If you live in a BlueChoice or BlueCard network area and go to an out-of-network *hospital*, you must pay a *hospital* deductible each time you or a covered dependent is admitted to the *hospital*. This deductible is in addition to the annual deductible.

You pay no *hospital* deductible for network or non-network hospitalizations. However, you must meet your annual deductible before benefits will be paid.

COPAYMENTS

A copayment is a set dollar amount you pay for a service. The plan pays all other costs for that service. If the amount the *doctor* charges for a service is less than your copayment, you pay only what the *doctor* charges.

If you go to a network *doctor* for an office visit, you pay one copayment for most services performed during that visit (see "Certain Diagnostic Procedures," page 21, and "Surgery Expenses," page 30, for exceptions). The plan pays the rest.

If you have a routine office visit with a network *specialist* and the contracted amount for that *specialist* is less than the \$45 office visit copayment, you pay only the contracted amount. If the bill for that visit also includes charges for lab work and/or x-rays, you still pay only the contracted office visit amount. However, if the bill includes charges for other services

(such as office surgery), you will pay the remaining copayment amount.

COST SHARING

You and the plan share many costs on a percentage basis. For these expenses, after you meet your deductible, you pay 30% under A&M Care and 20% under the 65 PLUS and the plan pays the remaining percentage.

COPAYMENTS

- Network doctor office visits (all plans except 65 Plus): \$30 for *primary care physician (PCP)*; \$45 for *specialist*.
- Medco drug card (all plans): \$10 for generic, \$35 for brand-name formulary and \$60 for brand-name nonformulary for a 30-day supply.
- Medco mail-order drugs (all plans): \$20 for generic, \$70 for brand-name formulary and \$120 for brand-name nonformulary for a 90-day supply.

See “Prescription Drugs,” pages 39-40, for additional costs related to the use of brand-name drugs when a generic drug is available.

DEDUCTIBLES (PER PERSON/PLAN YEAR)

	<i>Network</i>	<i>Non-network</i>	<i>Out-of-network</i>
<i>A&M Care</i>	\$700	\$700	\$1400
<i>65 PLUS</i>	\$500		

Medco prescription drug deductible Both A&M Care plans include a \$50/person annual deductible (with a 3-person maximum) on prescription drug purchases.

COST SHARING (AFTER DEDUCTIBLE)

	<i>Network</i>	<i>Non-network</i>	<i>Out-of-network</i>
<i>A&M Care 700</i>	Plan pays 70%/ You pay 30%	Plan pays 70%/ You pay 30%	Plan pays 50%/ You pay 50%
<i>65 PLUS</i>	Plan pays 80%/ You pay 20%		

Out of Pocket Maximums

A&M Care: network and non-network: \$5,000; out-of-network: \$10,000;

65PLUS: \$1,400

If you live in a network area and use out-of-network *doctors, hospitals* or other providers, you and the plan each pay 50%.

Out of Pocket Maximum

The out-of-pocket maximum is generally the most you will have to spend each plan year on each family member for the annual deductible and your co-insurance. Once you've met the out-of-pocket maximum, the plan pays 100% of *most* remaining expenses for that family member for the rest of that plan year.

If you have dependent coverage, your maximum out-of-pocket expenses for all family members is two times the individual maximum. All expenses you share with the plan for any combination of three or more family members will go toward meeting the family out-of-pocket maximum.

The deductible, office visit copayments, prescription drug copayments, prescription drug deductibles and out-of-network *hospital* deductibles do not count toward the out-of-pocket maximum. Likewise, you must continue to pay these expenses out of your pocket after you have met the out-of-pocket maximum.

If you live in a network area, you have a separate out-of-pocket maximum for network and out-of-network benefits. Network expenses apply only to the network maximum, but out-of-network expenses apply to both the out-of-network and network maximums.

Lifetime Maximum

With the exception of certain specified limits for services such as chiropractic care, and home health care, there is no lifetime benefit maximum.

Comparison Chart

The charts shown on the following pages give you more information on how the plans work and how they compare.

Other Plan Limits

Spinal skeletal system treatment is limited to 30 visits per person each plan year. See page 32 for more information.

Hospice care is limited to six months with possible extension for an additional six months. Bereavement counseling is limited to 15 visits. See page 22 for more information on hospice care.

Prescription Drugs

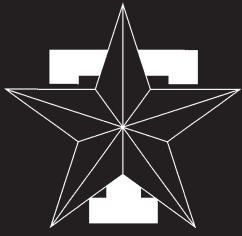
The A&M Care plans' prescription drug program, administered by Medco, has a separate annual deductible. After you meet the deductible, you pay a copayment for each drug purchase, at a participating pharmacy or through mail order. In most cases, the plan pays the rest. For more information on this program, see "Prescription Drugs," pages 36-41.

Plan Year

Annual deductibles, out-of-pocket maximums and annual limits are based on the plan year, which runs from Sept. 1 through Aug. 31.

Health Plan Provision	A&M Care (Network)	A&M Care (Out-of-Network)
Deductible	\$700 per person per plan year. \$50 per person per plan year for prescription drugs.	\$1,400 per person per plan year, plus \$500 per person per hospitalization. \$50 per person per plan year for prescription drugs.
Out-of-pocket maximum	\$5,000 per person per plan year, excludes annual deductible, drug deductible and office visit and drug copayments.	\$10,000 per person per plan year, excludes annual deductible, hospital and drug deductibles and office visit and drug copayments.
Office visits	You pay \$30/visit (\$45/visit if visiting a specialist); the plan pays the rest. This does not apply to office surgeries that are performed in a doctor's office and cost at least \$500.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. Then the plan pays 100%.
Hospital services (Includes inpatient, outpatient and diagnostic procedures performed by a hospital provider)	After you meet your annual deductible, the plan pays 70% and you pay 30% up to the out-of-pocket maximum. Then the plan pays 100%.	After you meet your annual and hospital deductibles, the plan pays 50% and you pay 50% up to the out-of-pocket maximum. Then the plan pays 100%.
Preventive care	No office visit copayment	No office visit copayment.
Maternity care and well-baby care	You pay \$30 for your first office visit. The plan pays 100% of all other doctor's charges. After you pay your annual deductible, the plan pays 70% and you pay 30% of hospital charges up to your out-of-pocket maximum. Then the plan pays 100%.The deductible is waived for the first four days of well-baby care for the newborn.	After you pay your annual and hospital deductibles, the plan pays 50% and you pay 50% for doctor and hospital charges up to your out-of-pocket maximum. Then the plan pays 100%. The deductible is waived for the first four days of well-baby hospital care for the newborn.
Home health care and private duty nursing	After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. There is a 60 visit per person per plan year maximum.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. There is a 60 visit per plan year maximum.
Skilled nursing facility	After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. There is a 60 day maximum/per person per plan year.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. There is a 60 day maximum/per person per plan year.
Inpatient mental health	After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum.
Outpatient mental health	You pay \$30 per visit.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum.
Prescription drugs (These copayments apply after you meet the \$50 prescription drug deductible, at a participating pharmacy.)	With your prescription card, for a 30-day supply, you pay \$10 for generic, \$35 for brand-name formulary and \$60 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.	With your prescription card, for a 30-day supply, you pay \$10 for generic, \$35 for brand-name formulary and \$60 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.

A&M Care (Non-Network)	A&M Care 65 PLUS	Health Plan Provision
\$700 per person per plan year. \$50 per person per plan year for prescription drugs.	\$500 per person per plan year. \$50 per person per plan year for prescription drugs.	Deductible
\$5,000 per person per plan year, excludes annual deductible, drug deductible and office visit and drug copayments.	\$1,400 per person per plan year, excludes annual deductible, excluding hospital and drug deductibles and office visit and drug copayments.	Out-of-pocket maximum
After you meet your annual deductible, the plan pays 70% and you pay 30% up to the out-of-pocket maximum. Then the plan pays 100%.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. Then the plan pays 100%.	Office visits
After you meet your annual deductible, the plan pays 70% and you pay 30% up to the out-of-pocket maximum. Then the plan pays 100%.	After you meet your annual and hospital deductibles, the plan pays 80% and you pay 20% up to the out-of-pocket maximum. Then the plan pays 100%.	Hospital services (Includes inpatient, outpatient and diagnostic procedures performed by a hospital provider)
The plan pays 100% for routine tests and immunizations.	The plan pays 100% for routine tests and immunizations.	Preventive care
After you pay your annual deductible, the plan pays 70% and you pay 30% for doctor and hospital charges up to your out-of-pocket maximum. Then the plan pays 100%. The deductible is waived for the first four days of well-baby care for the newborn.	Maternity care is not applicable.	Maternity care and well-baby care
After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. There is a 60 visit per person per plan year maximum.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. There is a 60 visit per person per plan year maximum.	Home health care and private duty nursing
After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. There is a 60 day maximum/per person per plan year.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. There is a 60 day maximum/per person per plan year.	Skilled nursing facility
After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum.	Inpatient mental health
After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum.	Outpatient mental health
With your prescription card, for a 30-day supply, you pay \$10 for generic, \$35 for brand-name formulary and \$60 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.	With your prescription card, for a 30-day supply, you pay \$10 for generic, \$35 for brand-name formulary and \$60 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.	Prescription drugs (These copayments apply after you meet the \$50 prescription drug deductible, at a participating pharmacy.)



COVERED EXPENSES

The plan covers medically necessary expenses, including hospitalization, doctor's fees, prescription drugs, and equipment and supplies. Most preventive care is covered.

All of the health plans cover medically necessary services for the treatment of injuries or illnesses, including alcoholism, chemical dependency, certain serious mental illnesses and preventive care.

For non-network and out-of-network providers, the plan covers up to the *reasonable and customary* fee for services and supplies.

While both plans pay benefits a little differently, as described in the "How Health Coverage Works"

section of this booklet (pages 9–11), the services and supplies covered are identical.

This section lists the expenses covered by the plan. For information on prescription drug coverage, see "Prescription Drugs" on page 36. Expenses that are not covered are listed beginning on page 32. If you cannot find a service or supply in either section, call BCBSTX Customer Service, (866) 295-1212, or Medco Member Services, (866) 544-6970, to find out if the expense/medication is covered.

AMBULANCE SERVICE

Reasonable and customary charges for transportation by professional ambulance to or from the nearest *hospital* or sanitarium that can provide adequate treatment are covered.

CATEGORIES OF EXPENSES COVERED IN THIS SECTION:

- ☆ Ambulance Service
- ☆ Certain Diagnostic Procedures
- ☆ Doctor's Office Visits
- ☆ Emergency Care
- ☆ Home Health Care and Private Duty Nursing
- ☆ Hospice Benefits
- ☆ Hospitalization
- ☆ Laboratory Services
- ☆ Maternity Care
- ☆ Medical Supplies
- ☆ Mental Health
- ☆ Preventive Care
- ☆ Professional Services
- ☆ Skilled Nursing Facility
- ☆ Spinal Skeletal System Treatment
- ☆ Substance Abuse
- ☆ Surgery Expenses
- ☆ Transplants and Replacements

This section also addresses pre-authorization and receiving care while traveling.

CERTAIN DIAGNOSTIC PROCEDURES

No matter where you receive services, benefits for some procedures are paid on a cost-sharing basis (see page 16), even at a network provider, after you meet the necessary deductible(s).

These include, but are not limited to:

- ☆ arthroscopy
- ☆ bone scan
- ☆ cardiac stress test
- ☆ CT scan
- ☆ endoscopic procedures, which include:
 - esophagoscopy
 - endoscopy, UGI
 - colonoscopy (excluding preventive colonoscopies)
 - cystourethroscopy
 - laparoscopy
 - flexible sigmoidoscopy
- ☆ MRI
- ☆ myelogram
- ☆ PET scan
- ☆ ultrasound

DOCTOR'S OFFICE VISITS

You pay \$30 for a *primary care doctor's* office visit to a network *doctor* for the types of care shown on page 23, and you pay \$45 for a *specialist's* office visit.

Only medically necessary treatment is covered from doctors not in the network.

EMERGENCY CARE

If you need emergency care, you should go to the nearest emergency facility. If you live in a network area, benefits will be paid at the network level. If you live in a non-network area, you will receive regular non-network benefits.

An emergency is a condition that would result in permanent disability or death if the condition were to go untreated.

Examples of emergencies are unconsciousness, severe bleeding, heart attack, serious burns and serious breathing difficulties.

HOME HEALTH CARE AND PRIVATE DUTY NURSING

The plan covers *home health care* and private duty nursing. This benefit is limited to 60 visits per person per plan year.

Covered expenses include:

- ☆ part-time or intermittent nursing care by a licensed vocational nurse or registered *nurse*,
- ☆ part-time or intermittent home health aide services,
- ☆ physical, speech, and respiratory therapy by persons licensed to perform these services,
- ☆ medical supplies, drugs and medicines prescribed by a *doctor*, and
- ☆ laboratory services provided by a home health agency.

Supplies, drugs, medicines and lab services will be covered only if they would be covered by the plan in the absence of *home health care*.

Benefits will not be paid for:

- ☆ food or meals delivered to the home,
- ☆ social casework, homemaker, sitter or companion services,
- ☆ purchase or rental of durable medical or dialysis equipment (but this may be covered by another provision of the plan; see page 27),
- ☆ services primarily for *custodial* care such as bathing, dressing, cooking and grooming,
- ☆ transportation services,
- ☆ services not listed in the *doctor's* treatment plan, and
- ☆ services rendered while you are in a hospice, *hospital* or *skilled nursing facility* (but these may be covered by another provision of the plan; see below and pages 25 and 30).

Benefits for *home health care* and private duty nursing will be covered only if:

- ☆ the care is medically necessary for a totally disabled person who would otherwise be hospitalized, and
- ☆ the services are provided by a home health agency, although the private duty nursing may be provided by a *nurse* who is not employed by the home health agency.

Other requirements for coverage are that:

- ☆ the patient be under the direct care of a *doctor*,

- ☆ the *doctor* write a treatment plan before treatment begins,
- ☆ the treatment plan be reviewed by BCBSTX before treatment begins, and
- ☆ the treatment plan be certified by the *doctor* and BCBSTX at least once a month during treatment.

HOSPICE BENEFITS

Hospice benefits are covered when the *doctor* certifies that the patient is terminally ill and expected to live six months or less. Benefits may be extended for a second six months, but will not be paid for more than 12 months.

Covered hospice expenses are:

- ☆ room and board,
- ☆ services and supplies while confined in a hospice,
- ☆ part-time nursing care by or under the supervision of a registered *nurse*,
- ☆ home health aide services,
- ☆ physical, speech and respiratory therapy by persons licensed to provide these services,
- ☆ counseling services by a licensed social worker or pastoral counselor,
- ☆ bereavement counseling by a licensed social worker or pastoral counselor for the family for up to 15 visits, and
- ☆ any *doctor*-ordered service including *custodial care*.

Bereavement counseling is covered for you and your dependents who are covered under this plan.

DOCTOR OFFICE SERVICES (Network Only)

One copayment is taken per *doctor*, per day

OFFICE SETTING SERVICES	A&M CARE
1. Office visit	100% after copayment
2. Consultation	100% after copayment
3. Chemotherapy and radiation	100% after copayment
4. Injections (except allergy injections)	100% after copayment
5. Allergy injections when billed separately	100%
6. Lab—office	100% after copayment
7. Independent lab	100%
8. X-ray—office (including mammograms)	100% after copayment
9. Radiologist	100% outpatient or <i>doctor's</i> office
10. Maternity –initial visit	100% after copayment
–remaining visits	100%
11. Office surgery –less than \$500	100% after copayment
–\$500 or more	70% after deductible
12. Medical supplies and equipment	70% after deductible
13. Allergy test	100% after copayment
14. Speech therapy	100% after copayment
15. Chiropractic care/physical therapy*	100% after copayment
16. Occupational modalities in conjunction w/physical therapy*	100% after copayment
17. Mental health/substance abuse	100% after copayment
18. Preventive hearing exam for children only	100% after copayment
19. Treatment of eye diseases	100% after copayment

**These services combined are limited to 30 visits per person each plan year, when performed in conjunction with modalities of the spine.*

HOSPITALIZATION

The plans cover:

- ☆ semiprivate room and board,
- ☆ medical services and supplies,
- ☆ intensive nursing care,
- ☆ outpatient services, and
- ☆ medical treatment given by or in the presence of a *doctor*.

You must pre-authorize all hospitalizations, including those for mental health, serious mental illness and substance abuse; see pages 25 –26.

LABORATORY SERVICES

The plan covers:

- ☆ X-ray exams (except for dental), lab tests and other diagnostic services,
- ☆ X-ray and radiation therapy,
- ☆ skin testing for allergies and RAST testing up to the cost of skin testing, and
- ☆ low-dose mammography screening on an annual basis for women age 35 and older to detect breast cancer (see “Preventive Care,” page 29).

MATERNITY CARE

The plan covers prenatal, delivery and postnatal expenses related to pregnancy. See page 42 for information about the Mother/Baby Program.

If you go to a network *PCP*, you pay \$30 for your first office visit and the plan pays all other *PCP* charges related to your pregnancy. Network *hospital* charges and all out-of-network and non-network maternity expenses are subject to the deductible and cost sharing.

If the pregnancy results in a miscarriage and is not completed, the plan requires a \$30 copayment for each office visit, and all additional hospital services are subject to the deductible and cost sharing amounts.

The plan covers maternity expenses for covered employees and their covered dependents.

Voluntary termination of pregnancy is covered only in cases where the mother’s life is endangered or the pregnancy resulted from a criminal act. However, *complications* arising from a voluntary termination of pregnancy are covered.

Amniocentesis and chorionic villus sampling (CVS) are also covered.

You should pre-authorize your delivery expenses before you are four months pregnant; please see the “Mother/Baby Program” on page 42. You must pre-authorize within 48 hours of admission to the hospital for delivery or complications.

The plan will cover a hospital stay for mother and baby of 48 hours following vaginal delivery or 96 hours following a cesarean section. The doctor, in consultation with the mother, may discharge the mother and baby sooner. The plan will not require special authorization (other than that described on this page) for stays of this length or provide financial incentives for shorter stays.

PRE-AUTHORIZATION AND REVIEWS

Certain services must be reviewed and approved in advance by BCBSTX before you can receive benefits. This is done to ensure that you receive appropriate care in a cost-effective setting. *If you use a Texas BlueChoice network doctor, your doctor will take care of this for you. If you use a non-network or out-of-network doctor or a BlueCard (outside Texas) network doctor, you are responsible for calling or having your doctor call BCBSTX. You pay a \$500 penalty if you do not pre-authorize services. If you are hospitalized outside Texas, you or a family member must pre-authorize your hospitalization with BCBSTX.*

Non-working retirees and dependents with Medicare Parts A & B do not have to pre-authorize hospital stays. Retirees and dependents not on Medicare must follow pre-authorization rules.

You must call BCBSTX at (800) 441-9188 before you use these services:

- ☆ Hospitalization: You or your *doctor* must call BCBSTX before you or a covered dependent is hospitalized. BCBSTX will review the medical necessity of hospitalization and either tell you the number of days of hospitalization that will be covered or suggest an alternative to hospitalization, such as outpatient surgery. For an emergency hospitalization, you, your *doctor* or a family member must call BCBSTX within 48 hours after admission. Emergency means care is needed immediately.
- ☆ Extended Care Services: You or your *doctor* must call BCBSTX to pre-authorize home health care, *skilled nursing facility* admissions, physical, occupational and speech therapy, and hospice services.
- ☆ Mental Health Care and Serious Mental Illness: **All services** and supplies for inpatient and day treatment facility admissions for mental health care must be pre-authorized *before* you receive them. The telephone number for pre-authorizing mental health services is (800) 528-7264. If you use a BlueChoice network *doctor*, your mental health care will be pre-authorized for you. Otherwise, it will be up to you to pre-authorize the services. (You must pre-authorize if you are using a BlueCard network doctor, which is a network doctor in another state or country.)
- ☆ Home Infusion Therapy: Home infusion therapy is intravenous infusion or injection of fluids done in the home setting. You or your *doctor* must pre-authorize home infusion therapy treatment before you receive the services or supplies. Your *doctor*

PRE-AUTHORIZATION AND REVIEWS (CONTINUED)

must submit a treatment plan to BCBSTX, and it must be approved every 30 days for the therapy to continue.

If you do not pre-authorize, you must pay a \$500 penalty in addition to any deductibles or shared costs you otherwise pay. The penalty will not apply to any out-of-pocket maximums. Where services or supplies are not considered medically necessary, the plan will pay no benefits.

In addition to pre-authorization, BCBSTX will perform these reviews:

- ☆ **Concurrent Review and Discharge Planning:** While you are hospitalized, BCBSTX will evaluate your progress and, if necessary, adjust the number of days of approved hospitalization. BCBSTX will notify you and your *doctor* of any change in the number of days that will be covered. BCBSTX also will work with you and your *doctor* to find alternatives to hospitalization, such as home health care, that will allow you to leave the *hospital* sooner and receive the care you need.
- ☆ **Retrospective Review:** BCBSTX also will review hospitalizations and surgeries once treatment is finalized. Any treatment previously not authorized that appears to have been medically necessary will be considered for benefits.

If BCBSTX decides not to pre-authorize a service, you will receive a notification letter from BCBSTX. If you or your *doctor* disagrees with the decision, you may request a review of that decision by having your *doctor* call the contact person indicated in the notification letter or by submitting a written request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044.

During the 30 days after you request the review, you can submit additional information and comments to BCBSTX regarding your claim, and you may review any relevant documents held by BCBSTX.

Within 30 days of receiving your review request, BCBSTX will send you its decision regarding the claim. In some cases, an additional 15 days may be needed for the review. If so, you will be notified of this during the initial 30-day period.

MEDICAL SUPPLIES

The plan covers:

- ☆ oxygen and its administration,
- ☆ blood and other fluids for the circulatory or digestive systems,
- ☆ artificial limbs and eyes if natural limbs and eyes are lost,
- ☆ casts, splints, trusses, braces, crutches and surgical dressings,
- ☆ diabetic supplies except insulin, which is covered under the plan's prescription drug benefits,
- ☆ surgical implants or prosthetic appliances prescribed by a doctor after a mastectomy is performed on a person while covered by this plan,
- ☆ replacement of prosthetics (including but not limited to glass eyes, breast implants and limbs) if deemed medically necessary by BCBSTX,
- ☆ special dietary supplements for treatment of phenylketonuria (PKU) or other inheritable diseases when recommended by a doctor,
- ☆ orthotics if prescribed by a doctor and deemed medically necessary by BCBSTX,
- ☆ purchase or rental of kidney dialysis equipment,
- ☆ rental or purchase, at the plan's option, of other hospital-type equipment such as wheelchair, hospital bed, iron lung, equipment for treatment of respiratory paralysis or use of oxygen, and
- ☆ repair or replacement of parts due to normal wear.

If you live in a network service area, you will receive a higher reimbursement if you use a BlueChoice or BlueCard medical equipment supplier.

MENTAL HEALTH

The plan covers inpatient and outpatient treatment of mental health. Inpatient treatment is paid the same as any other illness, however, benefits **must** be pre-authorized before admission, see page 25. Inpatient care will only be covered if the individual requires acute care as a bed patient due to the nature of the services rendered or the individual's condition, and the individual cannot receive safe or adequate care as an outpatient. The necessity for an inpatient setting must be substantiated by the admitting physician.

Inpatient treatment is paid the same as any other illness, however, benefits must be precertified.

Treatment for a dependent child in a *crisis stabilization unit* or *residential treatment center* will be considered an eligible expense if the child has a serious mental illness that impairs thought, reality perception, emotional process, judgment or behavior. The center is covered only if the child would otherwise require *hospital* care and services are provided according to a treatment plan through providers who are licensed or operated by a state agency or board.

Outpatient treatment at a network provider is covered at 100%, after a \$30 copayment.

CARE WHILE TRAVELING

If you are traveling within the United States and you need urgent but nonemergency care, you should call the BlueCard toll-free number on your ID card for assistance in locating a network doctor in your area. Benefits will be paid at the network level if you use a network doctor and at the out-of-network level if you use a doctor not in the network, unless you are overseas in an area where there is no network coverage. In this case, you will still receive network benefits.

If you or a family member has an emergency while away from home, you should seek care immediately at the nearest emergency facility. If you or a family member is hospitalized, you must pre-authorize with BCBSTX (see “Pre-authorization,” pages 25026). After you file a claim, the plan will pay network benefits for those expenses.

☆ If you are traveling outside the United States, several plan provisions apply:

BlueCross BlueShield has a worldwide hospital network in which participating hospitals can file claims electronically. You can get a list of these hospitals from your Human Resources office, by calling BCBSTX customer service at (800) 810-BLUE, or by visiting BCBSTX online at <http://www.bcbstx.com>.

- ☆ All billing must be submitted in English or with a translation and must include details of the services received.
- ☆ Charges must be converted into American currency at the exchange rate in effect at the time the claim is processed.
- ☆ Pre-authorization is not necessary.
- ☆ Treatments not normally covered or that are not recognized forms of treatment in the U.S. will not be covered.
- ☆ Transportation costs are covered only when treatment cannot be provided at your location and only to the nearest place where treatment is available.

If you plan to travel, contact your Human Resources office or visit System Benefits Administration online at <http://www.tamus.edu/assets/files/benefits/pdf/publications/travel.pdf> for “A Guide to Using Your Benefits While Traveling.”

PREVENTIVE CARE

Your health care benefits provide certain preventive health services paid at 100 %, with no copayment, deductible or coinsurance when using a network provider.

This includes preventive tests, including preventive colonoscopies, performed at network stand-alone facilities or out-patient network *hospitals* except those outpatient diagnostic procedures listed on page 21.

You receive benefits for routine physicals and well-baby care.

If you live in a network area and go to an out-of-network *doctor*, you receive *no* benefits for routine physical exams, well-baby care or other preventive care.

If you live in a non-network area, you can still receive the preventive care benefits.

Your *doctor* must code preventive care expenses correctly on the bill so BCBSTX will know they are preventive benefits. If the tests result in a diagnosis of an illness, they will not be considered preventive and will be paid under the normal plan benefits copayment or 70% after deductible.

Preventive Care Covered Items/Services

Children and Adolescents

Newborns

- Screening for hearing loss, hypothyroidism, sickle cell disease and phenylketonuria (PKU)
- Gonorrhea preventive medication for eyes

Immunizations

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type B
- Hepatitis A and B
- Human Papillomavirus (HPV)
- Influenza (Flu); Measles, Mumps, Rubella
- Meningococcal; Pneumococcal (pneumonia)
- Inactivated Poliovirus; Rotavirus
- Varicella (chickenpox)

General Health Screenings

- Medical history for all children throughout development
- Height, weight and Body Mass Index (BMI) measurements
- Developmental screening; Autism screening
- Behavioral assessment
- Visual acuity screening
- Oral health risk assessment
- Hematocrit or hemoglobin screening
- Obesity screening and weight management counseling; Lead screening, Dyslipidemia screening, Tuberculin testing, Depression screening;
- Alcohol and drug use assessment; Counseling to prevent sexually transmitted infections, (STIs)
- Cervical dysplasia screening, HIV screening

Adults

General Health Screenings

- Blood pressure screening, Cholesterol screening, Type 2 diabetes screening, HIV and sexually transmitted infections (STIs), screenings

Cancer Screenings

- Breast cancer mammography, Breast cancer chemoprevention counseling
- Cervical cancer pap test for women
- Colorectal cancer screenings including fecal occult, blood testing, sigmoidoscopy/colonoscopy
- Prostate cancer (PSA) screening for men

Health Counseling

- Healthy diet; Weight loss; Tobacco use; Alcohol misuse; Depression; Prevention of sexually transmitted infections (STIs); Use of aspirin to prevent cardiovascular disease

Immunizations

- Hepatitis A and B; Herpes Zoster; Human Papillomavirus (HPV); Influenza (Flu); Measles, Mumps, Rubella; Meningococcal; Pneumococcal (pneumonia); Tetanus, Diphtheria, Pertussis Varicella (chickenpox),

Men

- Abdominal aortic aneurysm one-time screening

Women

- Osteoporosis screening
- Chlamydia infection screening
- Gonorrhea and syphilis screening

Pregnant Women

- Anemia screening for iron deficiency
- Tobacco cessation counseling
- Syphilis screening
- Hepatitis B screening
- Rh incompatibility blood type testing
- Bacteriuria urinary tract infection screening
- Breastfeeding education

PROFESSIONAL SERVICES

The plan covers:

- ☆ *doctor's* services,
- ☆ services of a certified registered nurse anesthetist, licensed nurse practitioner, advanced nurse practitioner, licensed midwife or licensed physician's assistant, and
- ☆ licensed physiotherapist's services, if a reasonable chance of improvement is likely

The services of a psychological associate are covered only under the clinical supervision of a licensed psychologist/psychiatrist who is employed by the System and meets the guidelines of the Texas State Board of Examiners of Psychologists. In addition, the services must be part of a treatment plan that is reviewed and approved by the psychologist every three months.

SKILLED NURSING FACILITY

The plan covers care in a skilled nursing facility. To be covered, the skilled nursing facility care must:

- ☆ be precertified before care is received,
- ☆ be part of a treatment plan submitted by your doctor and approved by BCBSTX before care is received,
- ☆ be recertified every 30 days, and
- ☆ not be custodial.

SPINAL SKELETAL SYSTEM TREATMENT

The plan covers manual manipulation and modalities of the spinal skeletal system and surrounding tissue to restore proper alignment of bones and proper function of nerves and joints. Treatment is limited to 30 visits during any plan year. You may not have more than one visit in a single day. X-rays are paid as a separate expense under the normal plan benefits.

SUBSTANCE ABUSE

The plan covers inpatient and outpatient treatment of substance abuse (chemical dependency) the same as other illnesses.

SURGERY EXPENSES

Surgeries costing less than \$500 and performed in a doctor's office are covered for a \$30 copayment if you use a network PCP (\$45 if you use a specialist). Surgeries performed inpatient or outpatient at a hospital or surgeries costing \$500 or more performed in a doctor's office will be covered at the appropriate cost-sharing level after you meet your annual deductible (and hospital deductible if out-of-network). The \$500 surgery cost is based on the contracted amount set by BCBSTX, rather than the billed amount submitted by the doctor.

The plan covers:

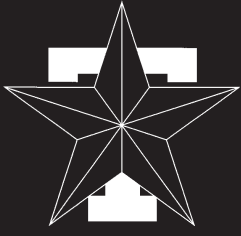
- ☆ anesthetics and their administration,
- ☆ surgeon's fees, and
- ☆ donation and storage charges of your own blood for use during your own surgery.

If you have a mastectomy, the plan will cover the surgery as well as reconstruction of the affected breast and the other breast to provide symmetry. The plan will also cover prostheses and services in connection with other complications resulting from the mastectomy, including lymphedemas. Expenses for these services are covered in the same manner as most other surgery-related expenses and are subject to normal plan limits.

TRANSPLANTS AND REPLACEMENTS

When the recipient is covered by the plan, the plan covers the donor and recipient for the following organ and tissue transplants and replacements:

- ☆ cornea,
- ☆ artery or vein,
- ☆ kidney,
- ☆ kidney and pancreas,
- ☆ joint replacement,
- ☆ heart valve replacement,
- ☆ implantable prosthetic lenses in connection with cataracts,
- ☆ prosthetic bypass or replacement vessels,
- ☆ bone marrow,
- ☆ heart,
- ☆ heart and lung, and
- ☆ liver.



EXPENSES NOT COVERED

Some expenses are not covered by your health plan. These include expenses for solely cosmetic procedures, experimental treatment or employment-related injuries.

Some health care expenses are not covered by the plan. Most of these are listed below. Others that are specific to a certain medical service, supply or provider are listed in the section “Covered Expenses” where those services, supplies or providers are discussed. For information on prescription drug expenses that are not covered, see “Prescription Drugs” on pages 36-37.

If you cannot find a specific expense listed in this section or in the list of covered expenses beginning on page 23, call BCBSTX Customer Service at (866) 295-1212.

Expenses that are *not* covered include, but are not limited to, those:

- ☆ for accidental injury or illness related to any employment or for which the patient is entitled to or has received benefits or a settlement from any workers’ compensation or occupational disease law,
- ☆ due to war or any act of war, whether declared or undeclared,
- ☆ that would not have been made if you did not have this coverage,
- ☆ that you are not legally obligated to pay, except charges from a tax-supported institution of the State of Texas for care of mental illness or retardation and charges for services or materials provided under the Texas Medical Assistance Act of 1967,
- ☆ for services or supplies furnished by an agency of the U.S. or a foreign government, unless excluding the charges is illegal,
- ☆ for services or supplies provided by a person who holds a Master of Science in Social Work unless the individual is also a *doctor* or holds a license as an advanced clinical practitioner except under hospice,
- ☆ for services while you are not under the direct care of a *doctor*,
- ☆ for treatments by a *doctor* that are not within the scope of his/her license,
- ☆ for services of a person who is a member of your or your spouse’s immediate family or who lives with you,
- ☆ for treatments that are not medically necessary, except those preventive benefits described on page 29,
- ☆ for services and materials in excess of the *reasonable and customary charge*,
- ☆ for which benefits are not provided under this plan,
- ☆ for dental services, appliances, including TMJ splints, or supplies, except:
 - *hospital* charges if medically necessary, or

Expenses not covered - continued

- repair or replacement of sound natural teeth due to an accident while you are covered by the plan, but only within 24 months of the accident,
- ☆ for acupuncture, unless provided by a licensed medical *doctor* as treatment for a medical diagnosis,
- ☆ for cosmetic surgery or treatment, except due to:
 - an accident that occurred while you were covered by the plan,
 - the surgical removal or reconstruction of breast tissue due to an illness,
 - a birth defect if your child is continuously covered by this plan from date of birth, or
 - surgical reconstruction or correction of a defect resulting from surgery while you were covered by the plan,
- ☆ for removal of skin tags,
- ☆ for surgical removal of fatty tissue or excess skin, including breast reduction, unless medically necessary as determined by BCBSTX,
- ☆ for treatment of obesity, except if approved in advance by BCBSTX, surgical treatment of morbid obesity,
- ☆ for marriage counseling,
- ☆ for family counseling, except for one visit that includes the covered patient and is billed under the patient's name,
- ☆ for scholastic education or vocational training,
- ☆ for medical social services, except as part of hospice services (see page 22),
- ☆ for food allergy testing, except when medically necessary for a diagnosis,
- ☆ for eye exams, orthoptics or visual training, LASIK surgery, radial keratotomy, eyeglasses or contact lenses, except those due to cataract surgery immediately after surgery or as described on page 42,
- ☆ for hearing aids or devices, except as described on page 44,
- ☆ for hair wigs,
- ☆ for Jobst or other similar support stockings except in connection with a diagnosis of diabetes,
- ☆ for care, treatment, services or supplies that are considered experimental or investigative under generally accepted medical standards (call BCBSTX customer service at (866) 295-1212 to find out if treatment will be covered),
- ☆ for travel, even if recommended by a *doctor*,
- ☆ for voluntary interruption of pregnancy, except where the life of the mother is in danger or the pregnancy is the result of a criminal act and complications resulting from voluntary termination,
- ☆ for reversal of sterilization,
- ☆ for infertility treatment, including artificial insemination, in vitro fertilization, embryo implant or transplant and gamete intrafallopian transfer,
- ☆ for sex change surgery,
- ☆ for vitamins or over-the-counter drugs, even if prescribed, except prescribed prenatal vitamins,

Expenses not covered - continued

- ☆ for any services or supplies provided for dietary and nutritional services, except for an inpatient nutritional assessment program provided in and by a hospital and approved by the claims administrator or for diabetic management services provided by or under the direction of a doctor,
- ☆ for services or supplies provided for *custodial care*, except those described on page 22 for hospice care,
- ☆ for services or supplies provided for treatment of adolescent behavior disorders including conduct disorders and oppositional disorders,
- ☆ for occupational therapy services that do not consist of traditional physical therapy modalities and are not part of an active multidisciplinary physical rehabilitation program designed to restore lost or impaired body function,
- ☆ for services or supplies provided primarily for:
 - environmental sensitivity,
 - clinical ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists, or
 - inpatient allergy testing or treatment,
- ☆ for services or supplies for routine foot care, such as:
 - cutting or removal of corns or callouses, trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking feet and using skin creams to maintain skin tone of both ambulatory and bedfast patients,
- services performed in the absence of localized illness, injury or symptoms involving the foot,
- any treatment (including prescription drugs) of a fungal (mycotic) infection of the toenail in the absence of clinical evidence of mycosis of the toenail or compelling medical evidence documenting that the patient either has a marked limitation of ambulation requiring active treatment of the foot or, in the case of a nonambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment, and
- excision of a nail without using an injectable or general anesthetic,
- ☆ for services or supplies provided for the following modalities:
 - videofluoroscopy,
 - intersegmental traction,
 - EMGs,
 - manipulation under anesthesia, and
 - muscle testing through computerized kinesiology machines such as isestation, digital myograph and dynatron, and
- ☆ for appointments that are not kept, completion of forms, phone conversations with a physician or obtaining medical records.

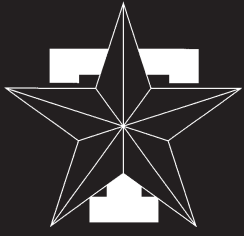
Expenses Not Covered - continued

☆ BCBS will not pay the additional costs resulting from hospital-based preventable medical errors. Five principles or guidelines will be used when a "serious hospital acquired condition" or "never event" occurs, involving determination, by a medical director, whether the event was preventable, within control of the hospital, the result of a mistake and resulted in significant harm to the patient. These principles will be applied to determine whether reimbursement to the hospital should be reduced for the additional costs related to the event. "Never events" include:

1. Surgery performed on the wrong body part.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient.
4. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility.
5. An infant discharged to the wrong person.
6. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

7. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life.
8. Artificial insemination with the wrong donor sperm or donor egg.
9. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility.

Other conditions may apply as identified by the Centers for Medicare and Medicaid Services, (CMS).



PRESCRIPTION DRUGS

The A&M Care plans include a prescription drug program administered by Medco.

Medco administers the prescription drug part of the A&M Care plans. You receive a separate ID card with a separate ID number from Medco.

You should use your Medco card, not your BCBSTX card, to purchase drugs at a pharmacy. Medco has a nationwide network of more than 60,000 retail pharmacies.

If you have questions about prescription drugs, call Medco at (866) 544-6970.

PRESCRIPTION DRUG DEDUCTIBLE

The plan includes a \$50-per-person annual deductible (with a 3-person maximum). This deductible applies to the first \$50 in prescription drugs that each covered person buys, whether at a retail pharmacy or through mail order. After you meet the deductible, you pay the applicable copayments (see next section) for any remaining drug purchases through the end of the plan year.

If you meet the deductible on a prescription drug purchase, but it

doesn't cover the full cost of the drug, the copayment will be applied to the rest of the cost. If the remaining cost is less than the copayment, you will pay only the remaining cost. If the remaining cost is more than the copayment, you pay only the copayment.

PURCHASING PRESCRIPTION DRUGS

You have four options for purchasing prescription drugs:

- ☆ If you go to a participating Medco pharmacy and show your Medco drug card, you pay \$10 for generic, \$35 for brand-name formulary and \$60 for brand-name nonformulary drugs for a 30-day supply.
- ☆ For maintenance drugs, you can order a 90-day supply by mail from Medco. You pay two copayments. You receive your prescription within 10 to 14 days of ordering.
- ☆ You may purchase a 90-day supply at certain retail pharmacies, but you will pay three copayments.
- ☆ You can go to a nonparticipating pharmacy for your prescription and file a claim for reimbursement with Medco. You will be reimbursed 75% of the *reasonable*

and customary charges after you pay your \$50 prescription drug deductible and a \$10 (generic), \$35 (brand-name formulary) or \$60 (brand-name nonformulary) copayment.

REFILLS

Members can request a refill through a retail pharmacy once they have used 75% (or about 23 days) of their medication and through mail order when they have used 75% (about 68 days) of the medication. Refill requests made too soon will be rejected. (Percent usage is based on the prescribed dosing instructions as given by prescribing doctor.)

Mandatory Drug Substitution:

The A&M Care plans have a mandatory generic drug substitution policy. It applies when a generic substitute is available for a brand-name drug.

Here's how the program works:

- ★ You will automatically be given a generic drug, if available. If you request the brand-name drug, you will pay the difference in cost between the generic and brand-name drug as well as the brand-name formulary or nonformulary copayment.
- ★ If your doctor has written "Brand Name Medically Necessary" on the prescription, you will receive the brand-name drug and will pay the difference in cost between the generic and brand-name drug as well as the brand-name formulary or non-formulary copayment.

HOW THE DEDUCTIBLE WORKS

- ★ Bill's first drug purchase after Sept. 1 is a generic drug that costs \$20. Bill will pay the full \$20, which will apply toward his deductible. The second drug he purchases is a \$100 brand-name formulary mail-order drug. He will pay \$100. The first \$30 of that will complete his \$50 deductible, and the remaining \$70 will be his copayment (two \$35 copayments for a 90-day supply). The plan will pay the remaining cost of that drug (\$10). Bill has now met his deductible, so he will pay only the drug copayments for any other prescription drugs he purchases through August 31.
- ★ Laura's first prescription drug purchase of the year is two generic drugs totaling \$60 at a retail pharmacy. She will pay the full \$60. The first \$50 meets her deductible. Because the remaining cost of the drugs (\$10) is less than the copayment for two generic drugs (\$20), she pays only the remaining cost of the drugs. After that, Laura will pay only the drug copayments for any other prescription drugs she purchases through Aug. 31.
- ★ Bryan has coverage on himself, his wife and their two children. By May, the two children have each met the \$50 deductible and will pay only copayments for drug purchases made during the remainder of the plan year. Bryan, on the other hand, is \$20 away from meeting his deductible, while his wife is \$10 away. In June, Bryan purchases a brand-name formulary drug totaling \$70. He pays \$55 (\$20 to meet his deductible and \$35 for his brand-name formulary copayment). In August, Bryan's wife purchases a \$50 brand-name formulary drug. Because three covered family members have met their prescription deductibles, Bryan's wife no longer has to meet her deductible. She will pay only the \$35 copayment.

☆ If you cannot take the generic drug for a documented medical reason, your *doctor* can call Medco to request a medical override for the brand-name drug. If this is approved, you will receive the brand-name drug and will pay only the formulary or nonformulary brand-name copayment.

Formulary Override: If you cannot take a formulary drug for a documented medical reason, your doctor can, in advance, request a medical override for the nonformulary drug by contacting Medco at 1-800-417-1764. If this is approved, you will receive the nonformulary drug and pay only the formulary copayment. You may have your doctor send in a request that your drug be added to the Medco formulary. A committee at Medco reviews formulary additions and deletions.

Drugs While Hospitalized: Drugs you receive while hospitalized or in a *skilled nursing facility*, convalescent *hospital* or hospice will be paid as part of the benefits for that facility.

PRIOR AUTHORIZATION

Certain prescription drugs require prior authorization before Medco will pay claims. Prior authorization is when Medco conducts a clinical review of a drug to verify that it is the most appropriate way to treat a condition.

Drugs that require prior authorization typically are expensive, have uses not approved by the FDA, or have the potential to be used inappropriately.

Some medications have a quantity limitation. This limitation is typically in place for medications that have an abuse potential or for medications that have been determined by the FDA to be safe only in limited amounts.

Other medications may be subject to contingent therapy protocol. This means that coverage of a requested medication is approved if you have tried certain other medications first but they did not work, or if you have specific medical conditions that prevent you from trying the alternatives.

To purchase a drug subject to review, your doctor must provide Medco with his/her diagnosis of your condition, along with any other necessary information. To do this, your doctor must call Medco at (800) 417-1764. In some cases, your pharmacist can provide this information if it is included on the prescription.

Once this information is provided, Medco will determine whether to cover the drug for your condition.

SPECIALTY PHARMACY

Medco has Accredo Pharmacy to assist A&M Care participants who use specialty medications to treat chronic illnesses. The Accredo Pharmacy offers:

- ☆ Delivery of up to a 30-day supply of medication to the individual's home or physician's office.
- ☆ Around-the-clock access to a staff of pharmacists, nurses and care coordinators who understand the individual's condition.
- ☆ Educational materials, support and home instruction.
- ☆ Better coordination of care with the individual's physician.

A&M Care participants using specialty medications may obtain their first prescription at retail, but will be required to go through the Accredo Pharmacy for subsequent refills.

More information on specialty drugs is available by calling (800) 922-8279.

COORDINATION OF BENEFITS

Medco **does not** coordinate benefits with other prescription coverage or discount programs.

SMOKING CESSATION AND WEIGHT LOSS

Medco provides limited coverage of prescription smoking cessation and weight loss products. You must receive authorization from Medco before you can participate in either program.

To participate in the weight loss program, you must have either a body mass index that is higher than 40 or a body mass index higher than 35 but suffer from weight-related diseases, such as diabetes or heart disease.

Medco will follow medical guidelines to determine whether you qualify for either program, and the products will have refill limits.

To find out whether you qualify for either program, you or your doctor can call Medco at (800) 417-1764.

MEDICARE PART D

All A&M System health plan prescription drug benefits have been certified to be comparable to or better than those provided by the Medicare Part D prescription drug plan. This means that if you have A&M System health coverage and become eligible for Medicare Part D but decide to enroll at a later date, you will not have to pay a higher premium than you would have paid if you'd enrolled when you first became eligible. You may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium.

Medicare Part D is available if you qualify for Medicare Part A and/or Part B. Enrolling or not enrolling in Medicare Part D will not change your enrollment in Parts A and/or B and will not impact the non-prescription drug part of your A&M System health coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare or during the Medicare open enrollment period later year. (For 2011 - dates are October 15 - December 7). If you drop or lose your A&M System

health coverage and don't enroll in Medicare Part D within 63 days after your coverage ends, you may be required to pay more to enroll in Medicare Part D later. In this case, you may enroll as soon as you drop or lose A&M System coverage and don't have to wait until the normal Part D enrollment period.

Because System health plans usually provide better drug benefits at a lower cost, Medicare Part D enrollment is not necessary for most System employees and retirees enrolled in System health plans. However, if you qualify for financial assistance, you will save on Part D premiums, copayments and coinsurance, which could mean you would benefit from Part D. Financial assistance is available to Medicare beneficiaries with incomes up to 150% of the Federal Poverty Level and limited resources. To determine if you qualify for financial assistance with Medicare Part D, you can contact the Social Security Administration (SSA) at (800) 772-1213 (TTY 800-325-0778) or visit SSA online at www.socialsecurity.gov.

Medicare Part D is offered through private, Medicare-approved prescrip-

tion drug plans. All Medicare drug plans will offer a standard level of coverage set by Medicare. The cost will vary with the plan. The average plan is about 32.50/month, if you decide to enroll in a Medicare prescription drug plan. You will also have to pay a \$250-a-year deductible.

If you are eligible for Medicare, you can be enrolled in both your System health plan and Medicare Part D, but you cannot receive prescription drug benefits from both plans. Your options include keeping your A&M System health coverage and not enrolling in Part D, or keeping your A&M System health coverage and also enrolling in Part D. If you enroll in Part D, drug coverage will continue to be a part of whichever A&M System health plan you currently have, and your System health premiums will not decrease.

You are entitled to receive a notice of creditable coverage at any time. It is available online at http://tamus.edu/assets/files/benefits/pdf/medicare_creditable_coverage_letter.pdf or from your Human Resources office.

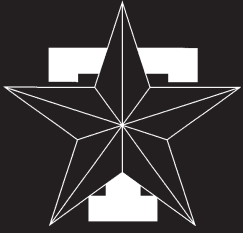
PRESCRIPTION DRUGS NOT COVERED

Prescription drugs that are not covered include, but are not limited to:

- ☆ those that are experimental or investigative,
- ☆ those that you are entitled to receive at no charge under any

- workers' compensation program,
- ☆ nicotine or those containing nicotine or other smoking-deterrent medications (except as covered under the smoking cessation program, as explained on page 39),
- ☆ anorectics or those used for weight control (except as covered under the weight loss program, as explained on page 39),
- ☆ tretinoin (Retin A) for cosmetic use if you are 26 or older,
- ☆ those used to treat or cure baldness,
- ☆ over-the-counter drugs, except for insulin, therapeutic devices or appliances,
- ☆ refills in excess of the amount specified by the *doctor*,
- ☆ refills more than one year after the *doctor's* original order,
- ☆ those used for the treatment of medically diagnosed male impotence (some may be covered subject to dispensing limits),
- ☆ contraceptive devices, or
- ☆ those used in the treatment of infertility.

In addition, the A&M System, at its discretion, may limit, restrict or elect to not cover new prescription medications that become available to plan participants.



SPECIAL PROGRAMS

The plan offers several special, voluntary programs to help you get the best value from your health coverage.

The plan offers several additional programs, services and education pieces that can help you get the most for your health-care dollar. All of these programs are voluntary.

MOTHER/BABY PROGRAM

Special Beginnings is a maternity program that can help guide a woman through their pre-natal and post-partum care. The program provides participants with support and education, pregnancy risk factor identification and ongoing attention/monitoring from pregnancy to six weeks after delivery.

You will be contacted by BCBSTX after you precertify your hospitalization to offer enrollment in the program. We encourage you to precertify before four months or when you are hospitalized for a complication during pregnancy.

Once you are registered, you will be sent a questionnaire to fill out and return. Based on your answers, the Mother/Baby Program will evaluate your risk for premature delivery. If you are high risk, your *doctor* will be notified so he/she will be aware that you may need special treatment.

DAVIS VISION

The A&M Care plans do not cover annual eye exams. However, BCBSTX offers discounts on exams, frames, lenses and laser vision correction through Davis Vision. You simply go to a participating provider and show your A&M Care ID card to receive the discount. Provider information is available at www.davisvision.com (enter 2295 as your client control number) or by calling (800) 501-1459. A flier listing the discounts is also available online at www.tamus.edu/offices/benefits/programs/DavisVisionFlier.pdf.

CASE MANAGEMENT

When you have a catastrophic illness or injury that is likely to result in long *hospital stays* and big bills, Case Management can help you identify more comfortable and less expensive alternatives.

Case Management can look at your situation and develop alternatives to long-term hospitalization that may provide better and more convenient care, such as care in your home. Case Management can remove the plan limitations on some forms of alternative care to allow you to take advantage of these for longer periods, thus avoiding further hospitalization.

Case Management will automatically review your case when they learn of a likely long-term hospitalization through precertification.

You can learn more about Case Management by calling BCBSTX, (866) 295-1212

WELLNESS PROGRAMS

Blue Access for Members (BAM) is the online resource center for A&M Care Plan participants. Go to bcbctx.com to get started. Resources include:

PERSONAL HEALTH MANAGER AND HA

Health and wellness resources to help you manage your health including: Interactive Symptom Checker, “Ask a question” via secure messaging, track your diet and personal wellness program. This also includes the Health Assessment (HA) which provides information on your overall health status and specific health aspects such as sleep and nutrition, as well as helpful tips. When health risks are identified, you also receive recommendations for making healthy changes. When you take the HA, your annual deductible will be credited \$50. Your spouse is also eligible for a \$50 deductible credit if he/she completes the on-line HA.

THE 24/7 NURSELINE

The Nurseline can help when you or a family member has a health problem or concern. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week at (800) 299-0274.

TEMPORARY ID CARDS

If you have lost your card, you can print a temporary card by going to bcbstx.com. The printed document will serve as proof of insurance for any upcoming doctor or hospital visit. You can also order a new card.

IN-NETWORK DOCTOR AND HOSPITAL LOCATOR

Get phone numbers, addresses and directions for providers (doctors, hospitals and other medical facilities).

FITNESS PROGRAM FINDER

Find a fitness center that fits your needs. Low monthly fees and no annual commitment.

CLAIM INFORMATION

View, download and/or print copies of your Explanation of Benefits (EOB) for recent and past doctor visits.

COMPARE TREATMENT COSTS

A cost estimator tool allows you to review and compare total treatment costs for procedures performed using national PPO cost ranges for various procedures.

A cost estimator tool allows you to find the typical cost of a health care procedure from a list of common medical conditions. You can enter information, such as age, gender and state or zip code to help determine a cost estimate for a specified medical procedure. It can be found under the My Coverage tab.

ANNUAL EXAM DEDUCTIBLE CREDIT

As each family member visits a physician for an annual physical exam, \$50 will be credited toward his/her annual deductible, if it has not already been met.

DISCOUNT HEARING PROGRAM

The A&M Care plans offer a discount hearing program through TruHearing. This program allows you to receive discounts of 30% to 60% off of the manufacturer suggested retail price for digital hearing instruments.

The program also includes a free hearing screening, hearing instrument fitting and related services through the TruHearing network of participating providers.

More information is available in an online flier at www.tamus.edu/benefits/programs/TruHearingFlier.pdf or on the TruHearing web site, www.TruHearing.com.

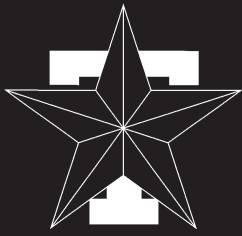
To access the program, call the tollfree customer service number, 1-866-581-9466, between 8 a.m. and 8 p.m., Central Time, Monday through Friday.

NOTICE ABOUT THE EARLY RETIREMENT PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program.

The Early Retiree Reinsurance Program is a Federal program established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor (the A&M System) may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families. If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.



FILING CLAIMS

If you use a network doctor, you file no claims. For other services, you file for reimbursement with BCBSTX. If a claim is denied, you may follow an appeal process.

If you use a BlueChoice or BlueCard *doctor or hospital*, you file *no* claim forms.

For other services, you must file a claim for health benefits. To file a claim, be sure your name and Social Security number and the patient's name are on the bill. The bill must also include the diagnosis code, the date of service, the service provided and the procedure code for that service. If information is missing, payment of your benefits may be delayed. Each time you file a claim, you must include a BCBSTX claim form, available from your Human Resources office. Mail the bill with the claim form to:

BlueCross BlueShield of Texas, Inc.
Claims Division
P.O. Box 660044
Dallas, Texas 75266-0044

You may choose to have payment made directly to your *doctor* or other provider, or you may pay the bill yourself and have payment made to you.

Be sure to keep a copy of your claim for your records. You must send the original bill to BCBSTX.

You may want to wait until you have enough expenses to satisfy your deductible before submitting your first claim. However, you need to file all claims for a plan year soon after the plan year ends on Aug. 31. All claims from a plan year *must* be postmarked by Jan. 31 of the next plan year. The plan is not obligated to pay claims received after that date.

If you live in Texas, are retired and enrolled in Medicare, you may have Medicare send your claims directly to BCBSTX.

You cannot assign your rights and benefits under the plan to anyone at any time. In the absence of a written agreement with a health care provider, BCBSTX can make benefit payments to the provider or to you at BCBSTX's option to fulfill its responsibility to pay benefits under the plan.

REVIEW OF CLAIM DETERMINATIONS (APPEALS)

Claim Determinations

The Claims Administrator (BCBSTX) will receive, review and process claims consistent with procedures established in writing between BCBSTX and the Plan Administrator (the A&M System. BCBSTX will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If BCBSTX requires further information to process the claim, they will request it within that 30-day period. If you do not follow the procedures for filing a pre-service claim, you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim (as defined below)). A “pre-service claim” is a non-urgent request for benefits or a determination in advance of obtaining medical care. Notification may be oral unless the claimant requests written notification.

You have the right to obtain a full and fair review by BCBSTX of any determination of a claim, a request for Preauthorization, or any other determination made by the BCBSTX in accordance with the benefits and procedures detailed in your Health Benefit Plan.

The following timelines apply to the various types of claims filed:

1. An “*urgent care/expedited clinical claim*” is any pre-service claim for benefits for medical care or treatment in situations where regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment. For benefit determinations relating to urgent care/expedited clinical appeal (as defined below), notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
2. For non-urgent pre-service claims, notice will be provided within 15 days after receipt of the claim by BCBSTX.
3. For post-service claims, within 30 days after receipt of the claim by BCBSTX. A “post-service claim” is notification in a form acceptable to BCBSTX that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, id number, the name and address of

the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which BCBSTX may request in connection with services rendered to you.

4. For post-stabilization care after an Emergency, a determination will be made within the time appropriate to the circumstance not to exceed one hour after the time of request. If BCBSTX determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, BCBSTX shall notify you or your authorized representative in writing of the need and reason for the extension, and the expected date of decision. In no event shall such extension exceed 15 days from the end of the initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

If a claim is denied, you will receive a written notice from BCBSTX with the following information, if applicable:

- The reasons for determination;
- A reference to the Health Benefit Plan provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- Any internal rule, guideline, protocol or other similar criterion relied

on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an urgent care clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification;
- Contact information for an office of health insurance consumer assistance or ombudsman.

Claim Appeal Procedures

Medical claims through BlueCross BlueShield

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care

provider may appeal on his/her own behalf. Your designation of a representative must be in writing, to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call BCBSTX at the number on the back of your ID card.

Claim Appeal Procedures - Definitions

An "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to make payment for, a benefit, including a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by BCBSTX or the A&M System and BCBSTX or the A&M System reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also considered an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A “Final Internal Adverse Benefit Determination” means an Adverse Benefit Determination that has been upheld by BCBSTX or the A&M System at the completion of the internal review/appeal process.

Prescription drug claims through Medco

The Medco coverage authorization program includes the following processes: prior authorization, step therapy, quantity duration/dose duration, quantity per dispensing event, and dose optimization including initial determinations and first level appeals.

Review and appeals management handled directly by Medco includes initial determinations and first level appeals.

Second level appeals and urgent appeals include potential transmission of the case to an Independent Review Organization (IRO).

Medco has entered into an arrangement with three IROs which have been accredited by a nationally recognized private accrediting organization. These IROs will conduct an independent external review of an adverse benefit determination and issue a final external

review decision. Medco is authorized to provide to the IRS the appeal files and other related information necessary for the IRS to conduct external reviews.

Summary of Medco-IRO Exchange of Information

1. Medco receives an external appeal request in writing or verbally
2. Medco will send case information to the IRO after confirming the patient is eligible for the external appeal
3. Medco will communicate to the claimant the name and contact information for the IRO reviewing their appeal
4. IRO will communicate decision back to Medco
5. Medco will document the decision and make any changes/payments required by such decision
6. IRO will communicate decision to the claimant

Urgent Care/Expedited Clinical Appeals

An urgent care/expedited clinical appeal is an appeal of a clinically urgent nature, including but not limited to, procedures or treatments ordered by a health care provider and/or continued

hospitalization. At least 24 hours before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, BCBSTX will provide you with notice and an opportunity to appeal. For ongoing treatment, coverage will continue during the appeal process.

Upon receipt of the appeal, BCBSTX will notify the party filing the appeal, within 24 hours, of the information needed to review the appeal. Additional information must be submitted within 24 hours of the request. BCBSTX shall render an appeal determination within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by BCBSTX.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any claim determination, request for Preauthorization, or other determination made by BCBSTX. Within 180 days after you receive notice of a denial or partial denial, you may call or write to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

You may designate a representative to act for you in the review procedure. Your designation must be in writing to protect against disclosure of information about you except to your authorized representative. BCBSTX will honor telephone requests for information; however, such inquiries will not constitute a request for review. You have the option of presenting evidence and testimony to BCBSTX by phone or in person at a location of BCBSTX's choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

BCBSTX will provide you or your representative with any new or additional evidence or rationale and any other information/documents used to review your claim whether or not the information was considered in the initial determination. New or additional evidence will be provided to you or your authorized representative in advance of the final decision on appeal in order to allow you to respond. The appeal determination will be made by a Physician

associated or contracted with BCBSTX and/or by external advisors who were not involved in the initial denial of your claim. Before you or your representative may bring action to recover benefits, the claimant must exhaust the appeal process, must raise all issues with respect to a claim and must file an appeal or appeals to be finally decided by BCBSTX or the A&M System.

If you have questions about the claims filing or review procedures, write to BCBSTX's Administrative Office or call the toll-free Customer Service Helpline number in this Benefit Booklet or on your ID Card.

Other Appeals

Upon receipt of a non-urgent, pre-service appeal, BCBSTX shall render an appeal determination as soon as practical, but less than 30 days after the appeal has been received by BCBSTX. Upon receipt of a non-urgent, post-service appeal, BCBSTX shall render a determination of the appeal as soon as practical, but less than 60 days after the appeal has been received by BCBSTX.

Notice of Appeal Determination

BCBSTX will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended

the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. A reason for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, the identification of the claim, date of service, health care provider, claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of BCBSTX's external review processes and how to initiate an external review;
5. In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a state-

ment that a copy of such information will be provided free of charge on request;

8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim.

If BCBSTX's or the A&M System's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party. Your external review rights are described in the Standard External Review section below.

If You Need Assistance

If you have questions about the claims or review procedure, write or call BCBSTX Headquarters at 1-800-521-2227. BCBSTX's Customer Service Helpline is accessible 8:00 - 8:00, Monday - Friday.

Claim Review Section

Blue Cross and Blue Shield of Texas

P. O. Box 660044

Dallas, Texas 75266-0044

If you need assistance with the internal claims and appeals or the external

review processes that are described below, you may call the number on the back of your ID card for contact information. For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Standard External Review

You or your authorized representative may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

Within 4 months after the date of receipt of a notice of a (Final) Adverse Benefit Determination from BCBSTX, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

Preliminary review - Within 5 business days following the date of receipt of the external review request, BCBSTX must complete a preliminary review of the request to determine whether:

- a. You are, or were, covered under the plan at the time the health care item or service was requested,
- b. The (Final) Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan;
- c. You have exhausted the BCBSTX internal appeal process unless you are not required to exhaust the internal appeals process. (Read the Exhaustion section below for additional information; and
- d. You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within 1 business day after BCBSTX completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period or 48 hours following receipt of the notice, whichever is later, to complete the appeal request. If your claim is not eligible for external review, the reasons it is ineligible, and contact information for the Department of Labor's Employee Benefits Security Administration (866-444-EBSA (3272) will be provided.

Referral to Independent Review

Organization (IRO). When an eligible request for external review is completed within the time period allowed, BCBSTX will assign the matter to an IRO. The IRO assigned will be accredited by URAC or another nationally-recognized accrediting organization.

BCBSTX must contract with at least 3 IROs for assignments under the plan and rotate claims assignments among them. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide:

- a. Utilization of legal experts where appropriate to make coverage determinations.
- b. Timely written notification to you or your authorized representative of the request's acceptance for external review. This will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO may, accept and consider additional information submitted after 10 business days.

- c. Within 5 business days after the IRO assignment, BCBSTX must provide to the assigned IRO the documents and any information considered in making the (Final) Adverse Benefit Determination. If BCBSTX fails to timely provide such, the assigned IRO may terminate the external review and make a decision to reverse the (Final) Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify BCBSTX and you or your authorized representative.
- d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to BCBSTX. Upon receipt of any such information, BCBSTX may reconsider the (Final) Adverse Benefit Determination that is the subject of the external review. Reconsideration by BCBSTX must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSTX decides to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, BCBSTX must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSTX.
- e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim and not be bound by any decisions or conclusions reached during BCBSTX's internal claims and appeals process. In addition to the information provided, the assigned IRO, to the extent the information is available and the IRO considers it appropriate, will consider the following:
1. Your medical records;
 2. The attending health care professional's recommendation;
 3. Reports from appropriate health care professionals and other documents submitted by BCBSTX, you or your treating provider;
 4. The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 5. Appropriate practice guidelines, which must include evidence-based standards and may include other practice guidelines developed by the Federal government, national or profes-

- sional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by BCBSTX, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 7. The opinion of the IRO's clinical reviewer(s) after considering information in this notice.
- f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSTX and you or your authorized representative.
- g. The notice of final external review decision will contain:
1. A description of the reason for the request for external review, including information to identify the claim (dates of service, health care provider, claim amount (if applicable), diagnosis code and its meaning, the treatment code and its meaning, and the reason for the previous denial);
 2. The date the IRO received the request to conduct the external review and the date of the IRO decision;
 3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either BCBSTX or you or your authorized representative;
 6. A statement that judicial review may be available to you or your authorized representative; and
 7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.
- h. After a final decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by BCBSTX, State or Federal oversight agency upon

request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

- i. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claims Administrator must immediately provide coverage or payment for the claim.

Expedited External Review

1. *Request for expedited external review.* BCBSTX must allow a request for an expedited external review at the time you receive:
 - a. An Adverse Benefit Determination, if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or our ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum

function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. *Preliminary review.* Immediately upon receipt of the request for expedited external review, BCBSTX must determine whether the request meets the requirements set forth in the Standard External Review section above. BCBSTX must immediately send you a notice of its determination that meets the requirements set forth in Standard External Review section above.
3. *Referral to independent review organization.* If the request is eligible for external review, BCBSTX will assign an IRO. BCBSTX must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO. The assigned IRO must consider the information or documents described above under the procedures for standard review. The assigned IRO must review the claim and is not bound by any deci-

sions or conclusions reached during BCBSTX's internal claims and appeals process.

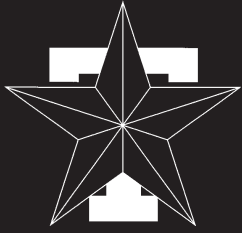
4. *Notice of final external review decision.* The IRO is required to provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but not more than 72 hours after receiving the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSTX and you or your authorized representative.

Exhaustion

You have the right to request external review once you have received the Final Internal Adverse Benefit Determination. For *expedited internal review*, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether the expedited internal review process must be completed before external review may be requested. You may request external review if BCBSTX waives the internal review process or BCBSTX fails to comply with the internal claims and appeals process. If BCBSTX fails to comply with the inter-

nal claims and appeals process, you also have the right to pursue any available remedies under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.



COORDINATION OF BENEFITS

Your health benefits are coordinated with other group plans and Medicare. The plan also has subrogation rights when an injury occurs.

In many families, especially if both husband and wife work, family members may be covered by more than one health plan. Each plan pays benefits, but the plans coordinate their payments so that the total payments are not more than 100% of the allowable expenses. Coordination of benefits (COB) rules determine the sequence of payments.

One plan has primary responsibility and pays first; the other plan has secondary responsibility and pays benefits for any additional covered expenses. When A&M Care is the secondary payor, the A&M Care benefit is based on the amount the other plan does not pay. Allowable amounts are compared and if the BlueCross BlueShield of Texas allowable amount is the same or lower than the Medicare allowable amount, no additional payment is made. If the BlueCross BlueShield of Texas amount is more than the primary carrier, then

payment is made up to the allowable amount.

A plan that has no coordination of benefits provision is always primary. If a husband and wife both cover the family under plans through their employers and both plans have COB provisions, the chart below shows which plan is designated as primary or secondary under COB rules.

If the parents of a covered dependent child are divorced, the plan of the parent who has financial responsibility for that child's health care expenses under a court decree is primary. If no decree establishes financial responsibility, the plan of the parent with custody is primary. If there is no financial decree and the parent with custody remarries, that parent's plan is primary, the stepparent's plan is secondary and the other natural parent's plan pays third.

If you or your spouse are covered under one employer's plan as a retired or laid-off employee and under another plan as an active employee, the plan

CLAIMANT	PRIMARY PLAN	SECONDARY PLAN
<i>Wife</i>	Wife's	Husband's
<i>Husband</i>	Husband's	Wife's
<i>Child</i>	Parent's whose birthday is earliest in the calendar year*	Other parent's

* *This assumes both plans have this rule. If not, the other plan's rules determine which plan is primary.*

that covers you as an active employee pays first. If none of these rules apply, the plan that has covered the person for the longest period will pay first. These rules apply to any other group coverage or government program, except Medicaid. Any personal health care policies you may have are not affected by the COB rules.

Coordination With Medicare

If you are retired, not working for the A&M System and eligible for Medicare, Medicare will automatically be your primary plan and the A&M Care plan will be your secondary plan. However, if you are working for the A&M System, the A&M Care plan will

be primary during the months in which you actually work. If you work September through May, your A&M Care plan will be primary all year. While your A&M Care plan is primary, your A&M Care benefits will be the same whether or not you are enrolled in Medicare Part B. When this plan coordinates with Medicare, benefits are calculated as if you are enrolled in Medicare parts A and B, even if you do not enroll in both parts. All A&M Care plans calculate their benefits based on the total charge — or the assigned charge if the doctor accepts assignment. The example below shows you how each plan coordinates with Medicare. For this example, assume you have had

Medicare Coordination Examples for the A&M Care Plans

Service Date	Doctor's charge	Medicare Pays	65 PLUS			A&M Care		
			Applied to Deductible	Plan Pays	You Pay	Applied to Deductible	Plan Pays	You Pay
9/10	\$ 150	\$ 120	\$150	\$ 0	\$30	\$150	\$ 0	\$30
9/30	\$ 75	\$ 60	\$ 75	\$ 0	\$15	\$ 75	\$ 0	\$15
10/15	\$ 125	\$ 100	\$125	\$ 0	\$25	\$125	\$ 0	\$25
11/5	\$ 200	\$ 160	\$150	\$ 40	\$ 0		\$ 40	\$ 0
1/22	\$ 175	†\$ 16		\$140	*\$19		\$145	*\$19
2/15	\$ 225	\$ 180		\$ 45	\$ 0		\$ 45	\$ 0
3/25	\$ 300	\$ 240		\$ 60	\$ 0		\$ 60	\$ 0
5/7	\$ 500	\$ 400		\$100	\$ 0		\$100	\$ 0
6/15	\$ 225	\$ 180		\$ 45	\$ 0		\$ 45	\$ 0
	\$1,975	\$1,456	\$500	\$430	\$89		\$535	\$89

† A portion of this charge applies toward your 2011 calendar-year Medicare deductible.

* Because A&M Care's normal payment is less than the remaining amount, you will owe the provider a small amount.

To calculate this amount, figure the amount the plan would pay if you did not have Medicare, this will be maximum the plan will pay. (For example, service date 1/22, under the 65 Plus plan, your A&M Care plan deductible has already been met and 80% of the charge is \$140. Since Medicare paid \$16, that leaves a \$19 balance for you to pay. [$\$175 - \$16 - \$140 = 19$].)

office visits throughout the year and have met your Medicare deductible by Sept. 1, when the new plan year begins. Because you've already met your Medicare deductible, charges for any office visits between Sept. 1 and Dec. 31 will be paid at 80% by Medicare. The 20% you pay will apply toward your A&M Care plan deductible. Beginning Jan. 1, you will need to meet another Medicare deductible. This chart shows how your benefits are calculated as you continue to have doctor's visits with various tests and procedures.

Some doctors do not participate in Medicare except for emergency or urgent care. They are called "private contract" doctors. If you enter into a private contract arrangement with a doctor, Medicare will not pay the receipt, and there is no limit to what the doctor may charge. However, the A&M Care plan will still treat the claim as if it had first been sent to Medicare for payment.

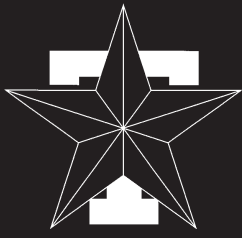
OVERPAYMENTS

If BCBSTX overpays a claim for any reason, BCBSTX has the right to recover the overpaid amount from you.

RIGHT OF SUBROGATION

You or one of your covered dependents could receive benefits from the health plan for an injury that was caused by another person or organization. If you receive payment from the party that cause the injury, you must pay the plan back for any benefits you received. Any amount you receive that is more than the plan paid in benefits is yours.

If you do not try to collect damages from the person or organization that caused your injury, the plan may require that you try to obtain a settlement or that your legal rights of recovery against any party for loss be assigned to the plan so it can recover the benefits paid to you.



WHEN COVERAGE ENDS

In most cases, coverage ends on the last day of the month in which your employment ends. You can continue your coverage under COBRA for a limited time.

Your coverage will end on the earliest of the following dates:

- ☆ the last day of the month in which your employment ends or you become ineligible for coverage,
- ☆ the last day of the last month for which you pay your share, if any, of the cost of coverage,
- ☆ the last day of the plan year if you elect during Annual Enrollment not to continue coverage,
- ☆ the last day of the month in which you elect to terminate coverage due to a Change in Status, or
- ☆ the day this plan ends.

Coverage for your dependents ends on the earliest of the following dates:

- ☆ the day your coverage ends,
- ☆ the last day of the month in which the dependent stops meeting the eligibility requirements,
- ☆ the last day of the month for which you pay your full share, if any, of the cost for dependent coverage,
- ☆ the last day of the plan year if you elect during Annual Enrollment not to continue dependent coverage,
- ☆ the last day of the month in which you elect to drop dependent

coverage due to a Change in Status, or

- ☆ the day the plan stops offering dependent coverage.

You will receive a certificate of group coverage when you end your participation in this plan. However, you may request this form at any time while you are covered under this plan and for up to 24 months following the end of coverage by contacting your Human Resources office.

WHEN COVERAGE IS EXTENDED

In some cases, your coverage can be extended due to changes in your System employment.

Approved Leave of Absence: If you take a paid leave, your coverage can continue and your share of premiums, if any, will continue to be deducted from your pay.

If your leave is unpaid, you may make arrangements to pay your premiums. Unless you are on FMLA (see below), you do not receive an employer contribution toward your coverage while you are on unpaid leave.

Should you drop your health coverage while on an unpaid leave, your coverage will automatically be reinstated when you return to work, regardless of the plan year. You have 60 days after your return to make enrollment changes.

Family or Medical Leave: If you take an unpaid leave of absence, the employer contribution toward your health coverage normally will end. However, if you take a family or medical leave under the Family and Medical Leave Act (FMLA), the state contribution toward your coverage will continue for up to 12 weeks. If you do not pay your share of the premiums while on family or medical leave, your coverage will be dropped.

Your eligible dependents' coverage will be automatically reinstated when you return from family or medical leave, and you have 60 days after your return to make enrollment changes.

Total Disability: If you become disabled, your coverage will continue, if you continue to pay any premiums, while you are on sick leave or vacation. You must pay to continue coverage while you are on leave without pay or workers' compensation leave.

If you qualify for disability retirement under TRS, whether or not you are a member of TRS, your coverage can continue throughout your disability if you continue to pay any premiums. You will continue to receive the state contribution toward your coverage.

If you become disabled as than 10 years of service (but you have at least three years of credit-position with the A&M System, if you were employed by the A&M System on Aug. 31, 2003, but

at least 10 years of service if you were employed after that date), you may continue your coverage and receive the state contribution for the same number of months equal to your months of service credit.

In all cases, a physician's required periodically, but no more than once a year. Your health coverage and employer contribution will end when you are no longer disabled, unless you return to work or meet the requirements for retiree insurance coverage.

If you don't qualify for disability retirement, you may continue months. You are not eligible for the employer contribution. You may be able to continue if you are approved for Social Security disability benefits while on COBRA.

Retirement: You may continue health coverage if you meet the requirements listed on page 5 and you had health coverage through the System on your last day of active employment.

Survivors: If your dependents were covered at the time of your death, your spouse can continue children can continue coverage until they no longer meet the dependent requirements if:

- ☆ you were any age and had at least five years of TRS or ORP creditable service, including at least three years creditable service in a benefits-eligible position with the A&M System, and your last state employment was with the A&M System.

- ★ your age and service combined totals at least 80 years,
- ★ you were any age and had at least 30 years of service, or
- ★ you were a retiree of the A&M System.

If you were a disability retiree with coverage for only a certain number of months after retirement (see previous page), your dependents can retain coverage for the number of months of coverage you had remaining at the time of your death.

Your dependents must pay to continue coverage.

If your dependents do not qualify under this provision to continue coverage, or if they qualify only for temporary coverage, they may qualify for COBRA coverage as explained later in this section.

Part-Time Employee: If your budgeted employment is reduced to less than 50% time after you have been covered by this plan for at least 4½ continuous months, you can continue your health coverage. You must make arrangements to pay the premium with no employer contribution.

COBRA Coverage Continuation

In some cases, you, your spouse (including a former spouse) and your children have the option to extend coverage beyond the time it would normally end

by paying the full cost of coverage. The chart below describes these cases.

If, in anticipation of a divorce, you drop your spouse's health coverage during Annual Enrollment or due to a change in status, under certain circumstances, your spouse will be offered COBRA continuation coverage from the date of the divorce. Coverage will not be available for the time between the date you first dropped your spouse's coverage and the divorce date.

You must notify the System when you or family members experience certain events that would cause coverage to end. In other cases, you will not have to provide notification, election and payment deadlines. Failure to meet these deadlines will cause you or your dependents to lose your right to continue health coverage. After you notify the System of an event or after an event not requiring notification, the System will send enrollment forms within 14 days directly to the person eligible for extended coverage. Included with the enrollment forms will be information about rights to extended coverage and the costs of this coverage. To continue coverage, you and/or your covered family members must pay the full premium plus an additional 2% to cover administrative costs. The cost of coverage will be approximately 50% higher during the final 11 months of COBRA coverage due to a Social

COBRA Qualifying Events and Continuation Periods

If. . .

Then. . .

Your employment ends for any reason
(other than gross misconduct)...

or

You go on leave without pay...

or

Your hours are reduced so that you are
no longer eligible...

Coverage for you and/or your covered
family members can be extended for
up to 18 months.

You die...

or

You divorce or legally separate...

Coverage for your covered family
members can be extended for up to 36 months.

Your covered child no longer qualifies for coverage...

Coverage for the child can be extended
for up to 36 months.

You elect extended coverage due to
employment termination, leave without
pay or reduction in hours and you or a
covered family member qualifies for
Social Security disability benefits within
60 days of the date coverage ends...

Coverage for the disabled person and
all covered family members can be
extended for up to 29 months.

COBRA Timeline

If . . .

- ☆ You divorce, or
- ☆ Your child becomes ineligible for coverage

If...

- ☆ You leave employment,
- ☆ Your hours are reduced,
- ☆ You go on leave without pay, or
- ☆ You die

Then...

You and/or your dependents have **60** days after the event to notify Human Resources of the event.

The A&M System has **14** days after your notification to send you and/or your dependents a COBRA enrollment form.

You and/or your dependents have **60** days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form.

You and/or your dependents have **45** days after making your election to payback premiums.

Then...

The A&M System has **14** days after the event (or notification of your death) to send you and/or your dependents a COBRA enrollment form.

You and/or your dependents have **60** days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form.

You and/or your dependents have **45** days after making your election to payback premiums.

If you or your dependent becomes eligible for Social Security disability benefits within **60** days of the date your coverage ended, you or your dependent must notify your Human Resources office within **60** days of receiving notice from the Social Security Administration and before the end of the initial 18-month COBRA period. *If you and/or your dependents miss any of these deadlines, you and/or your dependents forfeit your rights to continue coverage.*

COBRA Information

Health Care Service Corporation
P.O. Box 0081
Chicago, IL
60690-0081

Phone: 888-541-7107

Security-eligible disability if the disabled person alone or the disabled person and other family members elect to extend coverage during that period. The cost will remain 2% higher if the disabled person does not extend coverage but family members do.

If you and covered family members elect extended coverage due to your termination of employment or reduction in hours, your covered family members may elect an additional extension period of up to 18 months (for an overall total of 36 months) if during the initial extension period:

- ☆ you die,
- ☆ you divorce, or
- ☆ you become entitled to Medicare.

If your child stops qualifying for coverage (for example, due to marriage or age) during the initial extension period, that child may extend coverage for an additional 18 months (for an overall total of 36 months).

To be eligible for the additional extended coverage, your covered family members must notify the A&M System within 60 days of the occurrence of one of these events.

When a person on 18 months of COBRA coverage becomes disabled within the first 60 days of COBRA coverage, that person and other covered family members may extend COBRA coverage for an additional 11 months. To do so, the disabled person or a family member must notify their Human Resources office of the disabled person's eligibility for Social

Security disability benefits. This notification must be made within 60 days of the disabled person receiving the determination from the Social Security Administration and before the end of the initial 18-month COBRA period.

Coverage stops before the end of the extension period if:

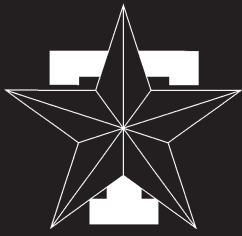
- ☆ the required premium is not paid,
- ☆ you or a family member becomes covered under another group health plan, unless that plan has a pre-existing condition provision that limits your benefits,
- ☆ you or a dependent becomes entitled to benefits under Medicare, or
- ☆ the System no longer offers health coverage to its employees.

RISK POOL

Conversion to an individual health insurance policy is not available when your coverage under this plan ends.

However, the State of Texas has established a Statewide Health Insurance Risk Pool for Texans who cannot obtain health insurance because of their medical history. You may be eligible for coverage under this program. If you would like more information on this coverage, you may call a toll-free telephone number, (888) 398-3927, or write to:

Texas Health Insurance Risk Pool
P.O. Box 90259
Indianapolis, IN 46290-0259



DEFINITIONS

Many terms used in describing health benefits have very specific meanings, and some are unfamiliar to most of us. Here's what these terms mean when used in this booklet.

The following terms are italicized when they are used in this booklet. These are the definitions for these terms as they are used in this booklet and in connection with your health plan.

Crisis stabilization unit means a 24-hour residential program that is short-term, provides intensive supervision and is licensed or certified by the Texas Department of Mental Health and Mental Retardation.

Custodial care means care (including room and board) that:

- ☆ is given mainly to help a person with personal hygiene or to perform the activities of daily living, and
- ☆ can, under generally accepted medical standards, be safely and adequately given by people who are not trained or licensed medical or nursing personnel.

Some examples of *custodial care* are training or help to get in and out of bed, bathe, dress, prepare special diets, eat, walk, use the toilet, or take drugs or medicines.

These services are custodial regardless of who recommends, provides, or directs the care, or where the care is given.

Doctor means a person who is legally licensed to practice medicine. See *Primary Care Physician* and *Specialist*.

Home health care agency means a *hospital* or other organization:

- ☆ licensed or certified under a public health law or a similar law to provide home health care services, or
- ☆ recognized as a *home health care agency* by Medicare.

Hospital means a facility that:

- ☆ is legally licensed,
- ☆ provides a broad range of 24-hour-a-day medical services for sick and injured persons by, or under the supervision of, a staff of *doctors*, and
- ☆ provides 24-hour-a-day nursing care by, or under the direction of, a *nurse*.

Nurse means a registered professional nurse (R.N.).

Primary Care Physician (PCP)

means a general or family practitioner, an internal medicine doctor, a pediatrician or an obstetrician/gynecologist.

Reasonable and customary charge

means the lowest of:

- ☆ the usual charge by the *doctor* or other provider of the services or supplies for the same or similar services or supplies,
- ☆ the usual charge of most other *doctors* or other providers of similar training or experience in the same geographic area for the same or similar services or supplies, or
- ☆ the actual charge for the services or supplies.

Residential treatment center means an institution that:

- ☆ provides residential care and treatment for unmarried dependents younger than 18, and
- ☆ is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

Skilled nursing facility means a place that:

- ☆ provides room and board and 24-hour-a-day nursing care by, or under the direction of, a *nurse*,
- ☆ is accredited as an extended care facility by the Joint Commission on Accreditation of Hospitals or is recognized as an extended care facility by Medicare, and
- ☆ is not, other than incidentally, a hotel, motel, place for rest, or place for *custodial care*, the aged, drug addicts or alcoholics.

Specialist means any doctor or licensed practitioner physician's assistant who is not a general or family practitioner, an internal medicine doctor, a pediatrician or an obstetrician/gynecologist. This includes:

- ☆ audiologists,
- ☆ chiropractors,
- ☆ dentists,
- ☆ dietitians,
- ☆ midwives,
- ☆ optometrists,
- ☆ osteopaths,
- ☆ podiatrists,
- ☆ professional counselors,
- ☆ psychologists, and
- ☆ speech pathologists.

Services of a midwife will be covered only if the midwife is an advanced nurse practitioner (certified nurse) or a *licensed* midwife. Services of *certified* midwives are not covered.

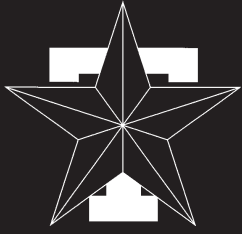
Services by other professionals will be considered as services performed by a specialist if the services are recommended by a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) and the services performed are within the scope of the professional's license. These include services performed by:

- ☆ a licensed dietitian,
- ☆ a provisional licensed dietitian under the supervision of a licensed dietitian,
- ☆ a licensed marriage and family therapist,
- ☆ a licensed hearing aid fitter and dispenser,

- ☆ an advanced clinical practitioner,
- ☆ a licensed physical therapist,
- ☆ a licensed occupational therapist, or
- ☆ a licensed psychological associate.

Services of advanced clinical practitioners, licensed chemical dependency counselors and licensed professional counselors are covered if these providers are in the BlueChoice or BlueCard network or if you are referred to one of these providers by a *doctor*.

See professional services on page 30 for additional provider information.



ADMINISTRATIVE AND PRIVACY INFORMATION

Here are some other facts about the plan you might want to keep handy.

PLAN NAME

The official name of this plan is The Texas A&M University System Group Health Program. The more familiar names for these plans are A&M Care and 65 PLUS.

PLAN SPONSOR

Director of Risk Management
and Benefits Administration
The Texas A&M University System
John B. Connally Building
301 Tarrow Dr., 5th Floor
College Station, TX 77840
Mail Stop: 1117 TAMU
(979) 458-6330

PLAN ADMINISTRATOR

The plan administrator is the Director of Risk Management and Benefits Administration. Contact at the address shown for the Plan Sponsor.

TYPE OF PLAN

The health plan is a group plan providing medical benefits. The Pretax Premiums Plan is a flexible benefit plan under section 125 of the IRS tax code.

CLAIMS ADMINISTRATOR

The Texas A&M University System is liable for all benefits under this plan. However, BlueCross BlueShield of Texas, Inc. (BCBSTX), in accordance with an administrative service agreement between BCBSTX and The Texas A&M University System, supervises and administers the payment of medical claims. Medco, in accordance with an administrative agreement between Medco and The Texas A&M University System, supervises and administers the payment of prescription drug claims.

Medical claims should be sent to:
BlueCross BlueShield of Texas, Inc.
Claims Division
P.O. Box 660044
Dallas, Texas 75266-0044

Prescription drug claims not purchased with the prescription drug card should be sent to:

Medco
P.O. Box 650322
Dallas, TX 75265-0322

Mail-order drug claims should be sent to:

Medco
P.O. Box 650322
Dallas, TX 75265-0322

The A&M Care Plan legal documents govern all plan benefits. You may examine a copy of the documents or obtain a copy for a copying fee by contacting the Plan Sponsor.

PLAN FUNDING

The health plan is self-funded through employer and employee contributions. The Pretax Premiums Plan is self-funded through employee contributions. This means the money you, the System and the state put into the plans is the same money that is used to pay benefits.

PLAN YEAR

Plan records are kept on a plan-year basis. The plan year begins each Sept. 1 and runs through the next Aug. 31.

EMPLOYER IDENTIFICATION NUMBER

74-2648747

GROUP NUMBER

039993

AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You may obtain a copy, at no charge, of the A&M System's procedures for qualified medical child support orders by contacting your Human Resources office.

PRIVACY INFORMATION

The A&M System, BlueCross BlueShield of Texas (BCBSTX) and Medco must gather certain personal information to administer your health benefits. They maintain strict confidentiality of your records, with access limited to those who need information to administer the plan or your claims.

BCBSTX and Medco gather information about you from your applications, claims and other forms. They also have personal health information that comes in from your claims, your health care providers and other sources used in managing your health care administration. The A&M System will not use the disclosed information to make employment-related decisions or take employment-related actions.

BCBSTX, Medco and the A&M System have strict policies and procedures to protect the confidentiality of personal information. They maintain physical, electronic and procedural safeguards to protect personal data from unauthorized access and unanticipated threats or hazards.

Names, mailing lists and other information are not sold to or shared with outside organizations. Personal information is not disclosed except where allowed or required by law or unless you give permission for information to be released. These disclosures are usually made to affiliates, administra-

tors, consultants, and regulatory or governmental authorities. These groups are subject to the same policies regarding privacy of our information as we are.

The A&M System may use and disclose your protected health information (PHI) without your written authorization or without giving you the opportunity to agree or disagree when your PHI is required:

- ☆ for treatment
- ☆ for payment
- ☆ for health care operations
- ☆ by law or, under certain circumstances, by law enforcement
- ☆ because of public health activities
- ☆ because of lawsuits and other legal proceedings
- ☆ for organ and tissue donation
- ☆ to avert a serious threat to health or safety (under certain circumstances)
- ☆ because of health oversight activities
- ☆ for worker's compensation
- ☆ because of specialized government functions (under certain circumstances)
- ☆ in cases of abuse, neglect or domestic violence
- ☆ by coroners, medical examiners or funeral directors

The A&M System can also use and disclose PHI without your written authorization when dealing with individuals involved in your care or payment for your care. However, you will have an opportunity to agree or disagree. If you do not object, the A&M System can use and disclose your PHI for this reason.

Details regarding the above situations are found in The Texas A&M University System's Notice of Privacy Practices. For an additional copy of the notice, please contact your benefits office or visit our website at www.tam.us.edu/benefits/publications/brochures/HIPAAprivacy.pdf.

If you have questions about the BCBSTX privacy policy, please write to:

Privacy Questions
P.O. Box 786
Chicago, IL 60690-0786

If you feel your privacy rights have been violated, you may file a complaint with the A&M System by contacting the Privacy Official at (979) 458-6330. You may also contact the Secretary of the United States Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201 to file a complaint.

FUTURE OF THE PLAN

While The Texas A&M University System intends to continue these plans indefinitely, it may change, suspend or end the plans at any time for any reason.

System Benefits Administration
John B. Connally Building
The Texas A&M University System
301 T arrow Dr., 5th Floor
College Station, TX 77840