

A&M CARE HEALTH PLAN

Updated April 2017



THE TEXAS A&M
UNIVERSITY SYSTEM

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. 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 A&M Care plans are funded by The Texas A&M University System, and medical benefits are administered by Blue Cross and Blue Shield of Texas (BCBSTX). Pharmacy benefits are administered by Express Scripts. This booklet provides a summary of your health 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 **bold**. 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.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions. The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan. All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Espanol

Para información sobre sus beneficios en Español, llame 1 (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:

- Work at least 20-hours a week, and
- Your appointment is expected to continue for at least a term of at least 4 ½ months, and
- You are eligible for retirement benefits as a member of the Teachers Retirement System of Texas (TRS) or you are enrolled in graduate student-level classes at an A&M System institution as a condition of employment.
- You are also eligible if you are a postdoctoral fellow.

Through the Affordable Care Act, you may also become eligible for coverage after working for 12 months at an average of 30 hours per week or more.

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.

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 which you have received a court order to provide health care coverage.

To cover a dependent on your A&M Care health plan, you will be required to provide specific

documents to verify your relationship.

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 requesting approval 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 60th 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 employer contribution eligibility date.

On the first of the month following your 60th 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** 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, you must pay the full monthly premium yourself until you become eligible to receive the employer contribution.

Current Employee Continuing Enrollment

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

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

Retiree Eligibility

If you were retired from or employed in a benefits-eligible position with the A&M System on August 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 September 1, 2003, but you met the above criteria as of August 31, 2003, you qualify for retiree benefit coverage under these criteria. If you are in TRS and you retire after August 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 August 31, 2003, or if you left A&M System employment before August 31, 2003, and did not meet the criteria listed at left as of August 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.

Former Employees

You are eligible for coverage as a retiree if you are a former employee who meets the eligibility criteria. You may apply for coverage within 60-days of meeting these 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 September 1 or December 1.

Your Options

The A&M Care plans are available to active and retired employees. If you are retired and you (and any dependents you wish to enroll) are all enrolled in Medicare and you work for the A&M System no more than four consecutive months of the plan year for 50% time or more, 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 dependent coverage during Annual Enrollment (changes effective September 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 the specific dependent documentation required by the A&M System to add or change coverage for dependents.

Newborn Children

If you are covered by the plan, your newborn child (children) is automatically covered from birth for 31 days. The effective date for newborns remains the date of birth if the child is added within 60-days of birth. The premium due date is the first of the month following birth and premiums will be collected from that point forward. Coverage will be effective the first of the month following receipt of the form in the Human Resources office.

Newborn grandchildren, who meet eligibility for coverage, are not automatically covered and must be added via a Dependent Enrollment Change form after the birth of the child. Coverage will become effective the first of the month following receipt of the form in the Human Resources office.

To continue the coverage for a newborn, you must complete and return a Dependent Enrollment/Change form along with the specific dependent documentation required by the A&M System to your Human Resources office within 60-days of the child's birth. Otherwise, coverage for that child will end after 31-days. Your next opportunity to enroll the child will be the next Annual Enrollment period or your next Change in Status.

Cost of Coverage

You and the A&M System may share the premium cost of health coverage. You will pay your share on a before-tax basis.

Each month, beginning with the month after your 60th day of employment, your employer makes a contribution toward your health coverage and you may be responsible for paying 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. Your spouse's and your children's premiums will be deducted on a pretax basis as well.

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

If you are a tobacco user (which includes, but is not limited to, cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, or any other product containing tobacco) your monthly insurance premium will be higher. The additional charge will be \$30 for an employee and \$30 for a covered spouse who use tobacco products. The maximum additional premium is \$60 a month.

If you did not elect to enroll in coverage during your benefit eligibility period, but instead were defaulted into the A&M Care health plan, you were also defaulted as a tobacco user.

You can change your tobacco user designation or the designation of someone covered under your health plan during the year if you or your spouse begins using tobacco, or if you or your spouse becomes a non-tobacco user for three consecutive months. To make a change, you must complete a Tobacco User Change Form and submit it to your Human Resources office. The change will become effective the first of the month following submission of the form.

If it is unreasonably difficult due to a health factor or if it is medically inadvisable for you or your spouse to stop using tobacco products, you may complete the Tobacco Cessation Physician Affidavit Form, have it signed by your physician, and return it to your Human Resource office so that the additional premium for tobacco usage may be waived. The Tobacco Cessation Physician Affidavit Form must be completed on an annual basis in order for the additional premium to be waived for each successive plan year.

How Health Coverage Works

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 has 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. While BCBSTX's Medical Policies serve as one set of guidelines for determining if a service is covered by the plan, 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 your A&M System assigned UIN, with a three-digit prefix as your member number. You will receive a separate drug plan ID card from Express Scripts (see "[Prescription Drugs](#)").

Network and Out-of-Network

Whether you receive network or out-of-network benefits depends on which **doctors** and **hospitals** you choose. 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 Texas, the Blue Choice network is available. If you live or are traveling anywhere outside Texas, but within the United States, the BlueCard network is available. If you live or are traveling outside of the United States, the BlueCard Worldwide network is available. You may call BlueCard Access using the toll-free number on the back of your ID card, 1 (800) 810-BLUE (2583), to find out if a specific **doctor** or **hospital** is in the network. BlueCard

Access is available 24 hours a day, 7 days a week. You may also search for **doctors** on the BCBSTX website at www.bcbstx.com/tamus.

Other Blue Cross and Blue Shield Plans outside of Texas, called Host Blue Plans may have contracts with certain health care **providers** in their service areas. When you receive health care services through BlueCard (network **providers** in the United States, but 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 Plan passes on to BCBSTX.

If You Are Retired

If you are a retiree for whom Medicare is not primary, 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.

Retirees and spouses, for whom Medicare is primary, are not eligible for office visit copays because of the need to coordinate with Medicare. For more information about coordination with Medicare (see "[Coordination of Benefits](#)").

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.

Non-Represented Specialists

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 \$30 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 \$30 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 use a Blue Choice 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 Blue Choice or BlueCard networks, you pay \$20 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 \$30 per visit. See “[Definitions](#)” 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 20% and the plan pays the remaining 80% until you reach your out-of-pocket maximum. After that, the plan pays 100% of most remaining eligible expenses, 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 preauthorizing coverage (except BlueCard network **doctors** outside Texas; see “[Preauthorization and Reviews](#)”),
- you pay only \$20 for most **PCP** services related to a pregnancy and 20% 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. See “[Covered Expenses](#)” for a list of covered office services.

Network Benefits at a Glance		
Doctor’s Office Visits	Other Services	
You pay \$20 for PCP visits; \$30 for specialist visits	You pay your annual deductible of \$400	
	You pay 20%	The plan pays 80%
The plan pays 100% of remaining costs in most cases.	Once you reach the out-of-pocket maximum of \$5,000 plus your deductible, the plan pays 100% of remaining eligible expenses.	

Out-of-Network Benefits

If you 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 \$400 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 eligible expenses to the out-of-pocket maximum. Then the plan pays 100% of most remaining eligible 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			
Doctor's Office Visits		Other Services	
You pay 50% (after \$800 deductible)	The plan pays 50% (after \$800 deductible)	In addition to an \$800 annual deductible for most services, , you also pay a per admission hospital deductible of \$400	
		You pay 50%	The plan pays 50%
The plan pays 100% of remaining costs in most cases.		Once you reach the out-of-pocket-maximum, \$10,000/person/plan year plus the \$800 deductible, the plan pays 100% of most remaining eligible expenses.	

Medicare-Primary, 65 Plus, and J Plan Benefits

For most Medicare-primary and 65 PLUS **doctor** or **hospital** services, you must first meet your annual deductible. Under the A&M Care and 65 PLUS plans, BlueCross BlueShield 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 most remaining eligible expenses. If you are eligible for Medicare as your primary carrier and are not working, or if you enroll in 65 PLUS, you do not necessarily need to use a network **provider**. However, you must use Medicare **providers** to receive the highest benefit from both Medicare and the A&M Care plans. If you use a private contracting physician who does not participate in Medicare, the A&M care plan will still pay benefits as the secondary payer, as if it was processed through Medicare first. This will increase your out-of-pocket costs. Be sure to check with your **provider** to see if they are a Medicare **Provider**. Non-working retirees and dependents with Medicare Parts A and B do not have to preauthorize the services listed under [Preauthorization and Reviews](#).

J Plan

The US Department of State has specific insurance requirements related to individuals in the United States on a J visa. Benefit eligible employees on a J-1 or J-2 visa and their family members who enroll in an A&M System health plan will be enrolled in the J Plan in order to ensure J visa insurance requirements are met. Currently, the benefits within the J Plan are the same as those in the A&M Care plan, including the BlueCross BlueShield in- and out-of-network benefits.

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. If you cover only one dependent, the maximum deductible is two times the individual deductible. If Medicare is not your primary carrier, you have separate deductibles for network services and out-of-net-work services. **Hospital** deductibles (which are only applicable to out-of-network **hospital** admissions) do not count toward meeting your annual deductible.

Deductibles (Per Person/Plan Year)		
	Network	Out-of-Network
A&M Care	\$400	\$800; \$400 hospital deductible per non-emergency admission
65 Plus	\$400	Not Applicable
J Plan	\$400	\$800; \$400 hospital deductible per non-emergency admission
Express Scripts (Prescription Drug Deductible)	All plans include a \$50/person annual deductible (with a 3-person maximum)	

Copayment

A copayment is a set dollar amount you pay for a service. The plan pays all other costs for that service in most cases. 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](#)”, and “[Surgery Expenses](#)”, for exceptions). The plan pays all other eligible expenses. If you have a routine office visit with a network **specialist** and the contracted amount for that **specialist** is less than the \$30 office visit co-payment, 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 your copayment amount and may also be responsible for deductible and coinsurance.

- Network **doctor** office visits (all plans except 65 PLUS): \$20 for **primary care physician (PCP)**; \$30 for **specialist**.
- Express Scripts drug card (all plans): \$10 for generic, \$35 for brand-name formulary and \$60 for brand-name non-formulary for a 30-day supply, after \$50 deductible.
- Express Scripts mail-order drugs (all plans): \$20 for generic, \$70 for brand-name formulary and \$120 for brand-name non-formulary for a 90-day supply, after \$50 deductible.

See “Prescription Drugs”, for additional costs related to the use of brand-name drugs when a generic drug is available and other plan restrictions.

Copayments*					
	PCP	Specialist	Generic Drug	Formulary Drug	Non-Formulary Drug
A&M Care	\$20	\$30	\$10	\$35	\$60
65 Plus	N/A	N/A	\$10	\$35	\$60
J Plan	\$20	\$30	\$10	\$35	\$60

*These benefits assume you use a network doctor.

Cost Sharing

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

Cost Sharing (After Deductible)		
	Network	Out-of-Network
A&M Care	Plan pays 80% You pay 20%	Plan pays 50% You pay 50%
65 Plus	Plan pays 80% You pay 20%	N/A
J Plan	Plan pays 80% You pay 20%	Plan pays 50% You pay 50%

Hospital Deductible

If you 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 hospitalizations. However, you must meet your annual deductible before benefits will be paid.

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

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 your annual deductible, co-insurance, and copayments. Once you have 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. Out-of-network **hospital** deductibles do not count toward the out-of-pocket maximum. You have a separate out-of-pocket maximum for network and out-of- network benefits.

Your Annual Out-of-Pocket Maximums*						
	A&M Care		J Plan		65 Plus Plan	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Coinsurance, office visit & prescription drug copayments, prescription drug deductible	\$5,000	\$10,000	\$5,000	\$10,000	\$1,400	N/A
Medical Deductible	\$400	\$800	\$400	\$800	\$400	N/A
Total	\$5,400	\$10,800	\$5,400	\$10,800	\$1,800	N/A

*Non-covered medical or prescription drug expenses, prescription drug penalties such as the mandatory generic substitution penalty and out-of-network **hospital** deductibles are not included in calculating the out-of-pocket maximum. **Note:** BCBSTX and Express Scripts exchange out-of-pocket data so claims are processed correctly.

Plan Limits

Spinal skeletal system treatment is limited to 30 visits per person each plan year. See “[Covered Expenses](#)” 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 “[Hospice Benefits](#)” for more information on hospice care. Home Health and Private Duty Nursing is limited to 60 visits per person per plan year. See “[Home Healthcare and Private Duty Nursing](#)” for more information on Home Health and Private Duty Nursing. **Skilled Nursing Facility** care is limited to 60 days per person per plan year. See “[Skilled Nursery Facility Care](#)” for more information on **Skilled Nursing Facility** care. Other plan limitations may exist.

Plan Year

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

Prescription Drugs

The A&M Care plans’ prescription drug program, administered by Express Scripts, 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](#)”.

Health Plan Provision	A&M Care & J Plan (Network)	A&M Care & J Plan (Out-of-Network)
Deductible	\$400 per person per plan year. \$50 per person per plan year for prescription drugs.	\$800 per person per plan year, plus \$400 per person per hospitalization. \$50 per person per plan year for prescription drugs.
Out-of-pocket maximum	\$5,000 per person per plan year, plus annual deductible.	\$10,000 per person per plan year, plus annual deductible. Hospital deductibles are excluded.
Office visits (Co-pays)	You pay \$20/visit (\$30/visit if visiting a specialist) the plan pays the rest in most cases. 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, out-patient and diagnostic procedures performed by a hospital provider	After you meet your annual deductible, the plan pays 80% and you pay 20% 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	Not covered
Maternity care and well- baby care	You pay \$20 for your first office visit. The plan pays 100% of all other doctor's charges. After you pay your annual deductible, the plan pays 80% and you pay 20% 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.
Home health care and private duty nursing	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 limit 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-visit limit per plan year.
Skilled nursing facility	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 limit 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 limit per person per plan year.
Inpatient mental health	After you meet your annual deductible, the plan pays 80% and you pay 20% 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.

Health Plan Provision	A&M Care & J Plan (Network)	A&M Care & J Plan (Out-of-Network)
Outpatient mental health	You pay *\$20/*\$30 per office visit. You may pay more for clinic or out-patient hospital visits.	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 non-formulary drugs. You can buy a 90-day supply of maintenance drugs at many pharmacies for three copayments with a 90-day prescription. For a 90-day supply by mail order, you pay two co-payments. Generic substitution is required in most cases.	If using a nonparticipating pharmacy, you file a claim for reimbursement with Express Scripts. You will be reimbursed for 75% of the reasonable and customary charges after the deductible and copayment; pharmacies by paying three copayments; a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.
*\$30 co-pay would apply for specialists such as Neuropsychologist, Licensed Marriage & Family Therapist, and Partial Day Psychiatric.		

Health Plan Provision	A&M Care Medicare Primary	A&M Care 65 PLUS
Deductible	\$400 per person per plan year. \$50 per person per plan year for prescription drugs.	\$400 per person per plan year. \$50 per person per plan year for prescription drugs.
Out-of-pocket maximum	\$5,000 per person per plan year, plus annual deductible.	\$1,400 per person per plan year, plus annual deductible.
Office visits	After you meet your annual deductible, the plan pays 80% and you pay 20% 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 the out-of-pocket maximum. Then the plan pays 100%.
Hospital services (includes inpatient, out-patient and diagnostic procedures performed by a hospital provider)	After you meet your annual deductible, the plan pays 80% and you pay 20% 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 the out-of-pocket maximum. Then the plan pays 100%.
Preventive care	The plan pays 100% for routine tests and immunizations.	The plan pays 100% for routine tests and immunizations.

Health Plan Provision	A&M Care Medicare Primary	A&M Care 65 PLUS
Maternity care and well-baby care	After you pay your annual deductible, the plan pays 80% and you pay 20% 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.
Home health care and private duty nursing	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 limit 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-visit limit per person per plan year.
Skilled nursing facility	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 limit 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 limit per person per plan year.
Inpatient mental health	After you meet your annual deductible, the plan pays 80% and you pay 20% 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	After you meet your annual deductible, the plan pays 80% and you pay 20% 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.
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 non-formulary 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 co-payments. 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 non-formulary 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 co-payments. Generic substitution is required in most cases.

Covered Expenses

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

All of the health plans cover medically necessary services for the treatment of injuries or illnesses, including alcoholism, chemical dependency and certain serious mental illnesses. In addition, preventive care is covered. While the plans pay benefits a little differently, as described in the “How Health Coverage Works” section of this booklet, 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”. Expenses that are not covered are listed beginning on page 30. If you cannot find a service or supply in either section, call BCBSTX Customer Service, 1 (866) 295-1212, or Express Scripts Member Services, 1 (866) 544-6970, to find out if the expense is covered.

Categories of Expenses Addressed in this Section:

- Acquired Brain Injury
- Ambulance Service
- Breastfeeding Support, Services and Supplies
- Certain Diagnostic Procedures
- Clinical Trials
- **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
- X-rays

This section also addresses preauthorization and receiving care while traveling.

Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible expenses include the following services as a result of and related to an Acquired Brain Injury:

- Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior
- Neurophysiological testing - An evaluation of the functions of the nervous system;
- Neurophysiological treatment - Interventions that focus on the functions of the nervous system;
- Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation – The process (es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury. **Therapy** means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury. Treatment for an Acquired Brain Injury may be provided at a **hospital**, an acute or post-acute rehabilitation **hospital**, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Ambulance Service

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

Breastfeeding Support, Services and Supplies

Benefits will be provided for breastfeeding counseling and support services when rendered by a **Provider**, during pregnancy and/or in the post-partum period. Benefits include the rental (or at the Plan's option, the purchase) of manual or electric breast pumps, accessories and supplies. Limited benefits are also included for the rental only of **hospital** grade breast pumps. You may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual, electric or **hospital** grade breast pump, accessories and supplies. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form. If you use an Out-of-Network **Provider**, the benefits may be subject to any applicable Deductible, Coinsurance, Copayment and/or benefit maximum. Contact Customer Service at the toll-free number on the back of your Identification Card for additional information.

Certain Diagnostic Procedures

No matter where you receive services, benefits for some procedures are paid on a cost-sharing basis, 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

Clinical Trials

Benefits for Eligible Expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Doctor's Office Visits

You pay \$20 for a primary care **doctor's** office visit to a network **doctor** and you pay \$30 for a **specialist's** office visit. Preventive care is not covered if provided by a non-network **doctor**.

Doctor Office Services (Network Only)	
<i>One copayment is taken per doctor, per day</i>	
Office Setting Services	A&M Care Will Cover:
Office visit	100% after copayment
Consultation	100% after copayment
Certain Preventive Care visits	100%
Chemotherapy and radiation	100% after copayment
Injections (except allergy injections)	100% after copayment
Allergy injections when billed separately	100%
Lab — office	100% after copayment
Independent lab	100%
X-ray — office (including mammograms)	100% after copayment
Radiologist	100% outpatient of doctor's office
Maternity — initial visit	100% after copayment
— remaining visits	100%
Office surgery — less than \$500	100% after copayment
— \$500 or more	80% after deductible
Medical supplies and equipment	80% after deductible
Allergy test	100% after copayment
Speech therapy	100% after copayment
Chiropractic care/physical therapy*	100% after copayment
Occupational modalities in conjunction with physical therapy*	100% after copayment
Mental health/substance abuse	100% after copayment

Preventive hearing exam	100% after copayment
Treatment of eye diseases	100% after copayment
Routine eye exam (one visit/per year/per person) with copay for in network visit; medical visit for a member w/a medical eye condition, paid like any other visit, \$20/\$30 copay	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.

Emergency Care

If you need emergency care, you should go to the nearest emergency facility. If you go to a non-network emergency facility for non-emergency care, you will receive out-of-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 Healthcare and Private Duty Nursing

The plan covers home health care and private duty nursing. 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),
- 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).

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 only for you, your spouse and your children who are covered under this plan.

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 preauthorize all hospitalizations, including those for mental health, serious mental illness and substance abuse; see section “Preauthorization and Reviews.”

Laboratory Services

The plans cover:

- lab tests and other diagnostic services, and
- skin testing for allergies and RAST testing up to the cost of skin testing.

Maternity Care

The plan covers prenatal, delivery and postnatal expenses related to pregnancy. See “Mother/Baby Program” for more information.

If you go to a network **PCP** or OB/GYN, you pay \$20 for your first office visit and the plan pays all other **PCP** or OB/GYN charges related to your pregnancy. Network **hospital** charges and all out-of-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 \$20 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 preauthorize your delivery expenses before you are four months pregnant; please see “[Mother/Baby Program](#)”. You must preauthorize 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.

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 (pads and bras) 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 Blue Choice or BlueCard medical equipment supplier.

Mental Health

The plan covers inpatient and out-patient treatment of mental health. Inpatient treatment is paid the same as any other illness, however, benefits must be preauthorized before admission, see “[Preauthorization and Reviews](#)”. 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. Outpatient treatment at a net-work **provider** is covered at 100%, after a \$20 copayment. 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. **Residential treatment centers** are generally not covered for adults.

Preventive Care Services

Preventive Care Services will be provided for the following covered services:

- evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
- with respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The Preventive Care Services listed in items a. through d. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at <http://www.bcbstx.com> or call BCBSTX Customer Service at 1 (866) 295-1212.

Examples of covered services included are routine annual physicals; immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for prostate cancer and colorectal cancer; smoking cessation counseling services; healthy diet counseling; and obesity screening/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Examples of covered services for women with reproductive capacity are female sterilization procedures and Outpatient Contraceptive Services; FDA-approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner; and specified FDA-approved contraception methods with a written prescription by a Health Care Practitioner provided in this section or in PHARMACY BENEFITS if applicable under ESI from the following categories: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. To determine if a specific contraceptive drug or device is included in this benefit, contact BCBSTX Customer Service at 1 (866) 295-1212 or ESI Customer Service at 1(866) 544-6970. The list may change as FDA guidelines are modified. Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Women's Preventive Health Services - Contraceptive Information page. You may, however, have coverage under other sections of this Benefit Booklet, subject to any applicable Coinsurance Amounts, Deductibles, Copayment Amounts and/or benefit maximums.

Preventive Care Services provided by an In-Network **Provider** and/or a Participating Pharmacy for the items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will not be subject to Coinsurance Amounts, Deductibles, Copayment Amounts and/or dollar maximums.

Preventive Care Services provided by an Out-of-Network **Provider** and/or a non-Participating Pharmacy for the items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will be subject to Coinsurance Amounts, Deductibles, Copayment Amounts and/or applicable dollar maximums.

Deductibles are not applicable to immunizations covered under *Benefits for Childhood Immunizations provision*.

Covered services not included in items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will be subject to Coinsurance Amounts, Copayment Amounts and/or applicable dollar maximums.

Your A&M Care plan covers certain preventive health services 100% with no copayment, deductible or coinsurance when using a network **provider**. These services include: routine physicals, well-baby care, office visits and preventive tests including preventive colonoscopies performed at network stand-alone facilities or out-patient network **hospitals**, except outpatient diagnostic procedures listed under “Covered Expenses”. If you go to an out-of-network **doctor**, you receive no benefits for routine physical exams, well-baby care or other preventive care services. Your **doctor** must code preventive care expenses as such 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 80% after you meet your 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; depression 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; depression screening

Cancer Screenings

- Breast cancer mammography, Breast cancer chemoprevention counseling and medications
- Cervical cancer pap test for women
- BRCA risk assessment & genetic counseling/testing
- Colorectal cancer screenings including fecal occult; blood testing, sigmoidoscopy or 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
- Contraceptives

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/counseling and support
- Gestational diabetes screening

Professional Services

The plan covers:

- **doctor's** services,
- services of a certified registered nurse anesthetist, licensed nurse practitioner, advanced nurse practitioner, Nurse Midwives who are Certified by the AMBCE (American Midwifery Certification Board Examination) and ACNM (American College of Nurse Midwives), or licensed physician's assistant, and
- licensed physiotherapist's services, if a reasonable chance of improvement is likely
- one routine vision exam per person/per plan year for a **specialist** copayment.

Skilled Nursing Facility

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

- be pre-certified 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 out-patient treatment of substance abuse (chemical dependency) the same as other illnesses. Benefits must be preauthorized, see "[Preauthorization and Reviews](#)".

Surgery Expenses

Surgeries costing less than \$500 and performed in a **doctor's** office are covered for a \$20 copayment if you use a network **PCP** (\$30 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.

Benefits must be preauthorized, see “Preauthorization and Reviews”.

X-rays

- X-ray exams (except for dental),
- X-ray and radiation therapy,
- Low dose mammography screening on an annual basis for women age 35 and older to detect breast cancer (see “Preventive Care”).

Preauthorization 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 Blue Choice network **doctor**, your **doctor** will take care of this for you. If you use an out-of-network **doctor** or a BlueCard (outside Texas, but in the United States) network **doctor** or a Blue Cross Blue Shield Global Core (outside of the United States) network **doctor**, you are responsible for calling or having your **doctor** call BCBSTX. You pay a \$500 penalty if you do not preauthorize services. 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. If you are hospitalized outside Texas, you or a family member must preauthorize your hospitalization with BCBSTX.

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

You must call BCBSTX using the toll-free preauthorization number on the back of your ID card, 1 (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 preauthorize home health care, **skilled nursing facility** admissions, physical, occupational and speech therapy, and hospice services.
- Mental Health Care, Serious Mental Illness,

and Chemical Dependency: All services and supplies for inpatient and day treatment facility admissions for mental health and chemical dependency care must be preauthorized using the toll-free preauthorization number on the back of your ID card, 1 (800)-528-7264, before you receive them. If you use a Blue Choice network **doctor**, your mental health/chemical dependency care will be pre-authorized for you. Otherwise, it will be your responsibility to preauthorize the services. (You must preauthorize if you are using a BlueCard or Blue Cross Blue Shield Global Core 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 preauthorize home infusion therapy treatment before you receive the services or supplies. Your **doctor** must submit a treatment plan to BCBSTX, and it must be approved every 30-days for the therapy to continue.
- Outpatient treatment of Mental Health Care, Serious Mental Illness and Chemical Dependency:
 - Psychological testing
 - Neuropsychological testing
 - Electroconvulsive therapy
 - Intensive Outpatient Program
 - Repetitive Transcranial Magnetic Stimulation

In addition to preauthorization, 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 preauthorize 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, 15 additional days may be needed for the review. If so, you will be notified of this during the initial day period.

Care While Traveling

If you are traveling outside of Texas within the United States or overseas and you need urgent but non-emergency care, you should call the BlueCard Access toll free number on your ID card at 1 (800) 810-BLUE (2583) for assistance in locating a network **doctor**. 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.

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 preauthorize with BCBSTX (see “Preauthorization,” pages 26-27). 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:

- BlueCard Worldwide is a network of participating physicians and **hospitals** outside the United States. You can get a list of these **hospitals** from your Human Resources office, by calling the BlueCard Access toll free number on your ID card at 1 (800) 810-BLUE (2583), or by visiting BCBSTX online at www.bcbstx.com/tamus.
- 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.
- Preauthorization is not necessary.

Plan rules for coverage and BCBSTX Medical Policies are still applicable for determining whether services are 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 for the “Guide to Using Your Benefits While Traveling”.

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”.

If you cannot find a specific expense listed in this section or in the list of covered expenses call BCBSTX Customer Service at 1 (866) 295-1212 to determine its coverage status.

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 in section “Preventive Care”,
- 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
 - repair or replacement of sound natural teeth and supporting tissue due to an external accident while you are covered by the plan, but only within 24 months of the accident. (An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.) Since some dental problems can be treated in more than one way, the plan will pay benefits based on the generally accepted treatment that provides adequate care at the lowest cost,
- 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 scholastic education or vocational training, for medical social services, except as part of hospice services (see “Hospice Benefits”),
- for food allergy testing, except when medically necessary for a diagnosis,
- for orthoptics or visual training, LASIK surgery, radial keratotomy, eyeglasses or contact lenses, except those due to cataract surgery immediately after surgery,
- for hearing aids or devices, except as described under “Special Programs”,
- 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, invitro fertilization, embryo implant or transplant and gamete intra-fallopian transfer,
- for gender reassignment surgery unless based on medical necessity and in conjunction with a diagnosis of gender dysphoria,
- for vitamins or over-the-counter drugs, even if prescribed, except prescribed prenatal vitamins,
- 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 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 non-ambulatory 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:
 - 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 **doctor** or obtaining medical records,
- for biofeedback or other behavior modification services.
- for services or supplies provided for the following:
 - Cognitive rehabilitation therapy: Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;
 - Cognitive communication therapy: Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
 - Neurocognitive rehabilitation - Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
 - Neurocognitive therapy - Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
 - Neurofeedback therapy - Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental

performance and behavior, and stabilized mood;

- Post-acute transition services - Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration; and
- Community reintegration services - Services that facilitate the continuum of care as an affected individual transitions into the community.

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:

- Surgery performed on the wrong body part.
- Surgery performed on the wrong patient.
- The wrong surgical procedure performed on a patient.
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility.
- An infant discharged to the wrong person.
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO – incompatible blood or blood products.
- Death or serious disability, including kernicterus, associated with failure to identify and treat hyper-bilirubinemia in neonates during the first 28-days of life.
- Artificial insemination with the wrong donor sperm or donor egg.

- 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 plan includes a prescription drug program administered by Express Scripts.

Express Scripts administers the prescription drug part of the A&M Care plans. You will receive a separate ID card from Express Scripts. You should use your Express Scripts card, not your BCBSTX card, to purchase drugs at a pharmacy. Express Scripts has a nationwide network of more than 60,000 retail pharmacies. If you have questions about prescription drugs, call Express Scripts at the Customer Service toll-free number on the back of your ID card, 1 (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 eligible 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 more than one option for purchasing prescription drugs:

- If you go to a participating Express Scripts pharmacy and show your Express Scripts drug card, you pay \$10 for generic, \$35 for brand-name formulary and \$60 for brand-name non-formulary drugs for a 30-day supply.
- For maintenance drugs, you can order a 90-day supply by mail from Express Scripts. You pay two copayments. You will 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 Express Scripts. You will be reimbursed for 75% of the **reasonable and customary charges** after deducting the appropriate deductible and copayment.
- You can request a refill through a retail pharmacy once you have used 75% (or about 23-days) of your medication and through mail order when you 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 prescription drug plan has 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 non-formulary 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.
- If you cannot take the generic drug for a documented medical reason, your **doctor** can call Express Scripts 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 non-formulary brand-name 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 \$110 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 August 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.

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 non-formulary drug by contacting Express Scripts at 1 (866) 544-6970. If this is approved, you will receive the non-formulary drug

and pay only the formulary copayment. A committee at Express Scripts 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 included on the facility bill and processed by BCBSTX, the medical carrier for the Plan.

Prior Authorization

Certain prescription drugs require prior authorization before Express Scripts will pay claims. Prior authorization is when Express Scripts 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 step 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 Express Scripts with his/her diagnosis of your condition, along with any other necessary information. To do this, your **doctor** must call Express Scripts at 1 (866) 544-6970. In some cases, your pharmacist can provide this information if it is included on the prescription. Once this information is provided, Express Scripts will determine whether to cover the drug for your condition.

Specialty Pharmacy

Express Scripts has Accredo Pharmacy to assist A&M Care plan participants who use specialty medications. 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 plan participants must use the Accredo Pharmacy to fill specialty medication prescriptions. More information on **specialty drugs** is available by calling 1 (800) 922-8279. Copays for certain specialty medications may be set to the maximum of the current plan design or any available manufacturer-funded copay assistance that results in an equal-to or lesser-out-of-pocket cost for the member. Patient assistance will not be considered as true out of pocket for members and may not apply to deductible and out of pocket maximums.

For the above mentioned specialty medications, all prescriptions, including the first one, must be filled through Express Script's Mail Order Specialty Pharmacy - Accredo .

Coordination of Benefits

Express Scripts does not coordinate benefits with other prescription coverage or discount programs.

Smoking Cessation and Weight Loss

Express Scripts provides coverage of prescription smoking cessation and weight loss products. Products available for these diagnoses have refill limits.

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 if you enroll in Medicare Part D so that you are not asked 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 in a later year. (October 15 – December 7).

If you drop or lose A&M System coverage, you don't have to wait until the normal Part D enrollment period to enroll. In fact, in this case, you must enroll in Medicare Part D within 63 days after your coverage ends or you may be required to pay more to enroll in Medicare Part D later. 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 as described below, 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 1 (800) 772-1213 TTY 1 (800) 325-0778 or visit SSA online at www.socialsecurity.gov. Medicare Part D is offered through private, Medicare-approved prescription drug plans. All Medicare drug plans will offer a standard level of coverage set by Medicare. The cost will vary with the plan. 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://assets.system.tamus.edu/files/benefits/pdf/medicare_creditable_coverage_letter.pdf or from your Human Resources office.

Prescription Drugs

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 38),
- anorectics or those used for weight control (except as covered under the weight loss program, as explained on page 38),
- 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.

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 mom-to-be through their prenatal and postpartum 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.

Case Management

When you have a catastrophic illness or injury that is likely to result in long **hospital** stays and big bills, Case Management may be able to 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, 1 (866) 295-1212.

Blue Access for Members (BAM)

Blue Access for Members (BAM) is the online resource center for A&M Care Plan participants. Go to www.bcbtx.com/tamus to get started.

Well on Target

This program contains health and wellness resources to help you manage your health including: Self-directed courses, Life Points program, track your diet, your personal wellness program, and more. This also includes the Health Assessment (HA) which provides information on your overall health status and specific health aspects such as sleep and nutrition. When health risks are identified, you also receive recommendations for making healthy changes. When you take the HA, your annual deductible will be reduced by \$50. Your spouse is also eligible for a \$50 deductible reduction if he/she completes the online HA.

Benefits Value Advisor

BlueCross Blue Shield Benefits Value Advisors can help you plan for your health care. You can call a Benefits Value Advisor to:

- Give you a cost estimate for a number of health care services or procedures
- Schedule your **doctor** or procedure appointments for some services and procedures
- Help you with general information on your condition or diagnosis
- Assist you with precertification

A Benefits Value Advisor can help you and your covered family members find contracting, network **providers** for a number of health care services including:

- CT scans
- MRIs
- Endoscopy or colonoscopy procedures
- Back or spinal surgery
- Knee or shoulder surgery
- Hip or joint replacement surgery

To reach a Benefits Value Advisor, call the toll-free Customer Service number, 1 (866) 295-1212, on the

back of your BCBSTX ID card and ask to speak to a Benefits Value Advisor.

The 24/7 Nurseline

The NurseLine can help when you or a family member have a health problem or concern. You can reach a registered nurse 24 hours a day, 7 days a week by calling the 24/7 Nurseline toll-free number, 1 (800) 581-0368, on the back of your BCBSTX ID card. These nurses can offer medical advice on health conditions like asthma, back pain, diabetes, dizziness, severe headaches, high fever, cuts, bruises, sore throats, and much more. For medical emergencies, call 911.

Temporary ID Cards

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

In-Network Doctor and Hospital Locator

Get phone numbers, addresses and directions for **doctors**, **hospitals** and other medical facilities.

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 find the typical cost of a health care procedure from a list of common medical conditions. You enter the plan member name and zip code to help determine a cost estimate for a specified medical procedure.

Blue365® Discount Programs

Blue Cross and Blue Shield of Texas offers discounts on various health and wellness areas

through Blue365®. With this program, employees save money on health and wellness products and services from top retailers that are not covered by insurance. A claim or referral is not required to participate in the program. Blue365® includes:

1. EyeMed and Davis Vision

The vision discount through Blue365 offer savings on eyeglasses, contact lenses, eye exams, accessories and laser vision correction. Note: This is not insurance. When contacting any retailer or **provider** in the network, be sure to refer to the discount program.

2. TruHearing® and Beltone™

Members may get possible savings on hearing tests, evaluations, and hearing aids. Discounts may also be available for their immediate family members.

3. Dental Solutions

Members may get dental savings with Dental Solutions. Members may receive a dental discount card that provides access to discounts of up to 50 percent at more than 61,000 dentists and more than 185,000 locations.

4. Jenny Craig®, Seattle Sutton's® and Nutrisystem®

Members have access to savings from weight loss programs including membership fees (where applicable), nutritional products and services, and healthy meals.

5. RetrofitSM

Discounted online weight loss coaching sessions are available to members.

6. Reebok | SKECHERS®

Discounts on Reebok and Skechers athletic equipment and clothing online.

7. SeniorLink Care™

SeniorLink Care offers members support to help their aging family members or friends lead fulfilling and comfortable lives. Members can save on a three or 12-month membership.

8. Handstand Kids

The Handstand Kids Cookbook series features the languages and cuisines of Italy, Mexico, China and many other countries. Members may save up to 25 percent on cooking accessories and Cookbook Kits.

9. Snap Fitness™

Members may get a discount on personal-training sessions, fitness facilities, membership fees, and meal planning services.

Filing Claims and Appeals

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

If you use a Blue Choice or BlueCard **doctor** or **hospital**, you file no claim forms. For services from out-of-network **providers**, you must file a claim for health benefits. To file a claim, be sure your name and Member ID 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 itemized 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. 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)

Appeals Procedures or Review of Claim Determinations

Claim Determinations

When the Claim Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claim Administrator and the Plan Administrator. You have the right to seek and obtain a full and fair review by the Claim Administrator of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If a Claim Is Denied or Not Paid in Full On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision as described in Claim Appeal Procedures below.

If the claim is denied in whole or in part, you will receive a written notice from the Claim Administrator with the following information, if applicable:

- The reasons for determination;
- A reference to the Health Benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;

- Subject to privacy laws and other restrictions, if any, 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 the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement
 - of your right, if any, to bring a
 - civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- 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;
- 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 upon 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 Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant

within three days of oral notification;

- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

1. Urgent Care Clinical Claim is any Pre-Service Claim that requires Preauthorization, as described in this Benefit Booklet, for benefits for medical care or Treatment with respect to which the application of 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.
2. Pre-Service Claim is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. Post-Service Claim is notification in a form acceptable to the Claim Administrator 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, identification 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 the Claim Administrator may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within	24 hours
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within	48 hours after receiving notice
The Claim Administrator must notify you of the Claim determination (whether adverse or not): if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than	72 hours
after receiving the completed Claim (if the initial Claim is incomplete), within	48 hours

* You do not need to submit Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Claim Administrator must notify you within	5 days
If your Claim is incomplete, the Claim Administrator must notify you within	15 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within	45 days after receiving notice
The Claim Administrator must notify you of any adverse Claim determination (whether adverse or not): if the initial Claim is complete, within	15 days*
after receiving the completed Claim (if the initial Claim is incomplete), within	30 days
If you require post-stabilization care after an Emergency within	the time appropriate to the circumstance not to exceed one hour after the time of request

* This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within	30 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within	45 days after receiving notice
The Claim Administrator must notify you of the Claim determination (whether adverse or not): if the initial Claim is complete, within	30 days*
after receiving the completed Claim (if the initial Claim is incomplete), within	45 days
If you require post-stabilization care after an Emergency within	the time appropriate to the circumstance not to exceed one hour after the time of request

*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Concurrent Care

For a benefit determination relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

Claim Appeal Procedures

Definitions

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a claim, Pre-Service Claim or Urgent Care Clinical Claims, or make payment for, a benefit resulting from the application of any utilization review, as well as 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 the Claim Administrator or your Employer and the Claim Administrator or your Employer 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 an Adverse Benefit Determination.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by the Claim Administrator or your Employer at the completion of the Claim Administrator's or Employer's internal review/appeal process.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care **provider**, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claim

Administrator will provide you with notice at least 24-hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited preservice or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24-hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24-hours of request. The Claim Administrator shall render a determination on the appeal within 24-hours after it receives the requested information, but no later than 72-hours after the appeal has been received by the Claim Administrator.

How to Appeal an Adverse Benefit Determination

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

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 as it is necessary 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 the Claim Administrator at the number on the back of your ID card.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, you may call or write to the Claim Administrator's Administrative Office. The Claim Administrator will need to know the reasons

why you do not agree with the denial or partial denial. Send your request to:
Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claim Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of your claim review, you have the option of presenting evidence and testimony to the Claim Administrator. 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.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal determination will be made by a Physician associated or contracted with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the

appeals must be finally decided by the Claim Administrator or your Employer.

If you have any questions about the claims procedures or the review procedure, write to the Claim Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Timing of Appeal Determinations

Upon receipt of a non-urgent preservice appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claim Administrator.

Upon receipt of a non-urgent post-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claim Administrator.

Notice of Appeal Determination

The Claim Administrator 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, by a written notice of the determination. The written notice to you or your authorized representative will include:

1. A reason for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, 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. Diagnosis/treatment codes with their meanings and the standards used are also available upon request;
4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;

5. In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
6. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
7. 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;
8. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
9. 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;
10. A description of the standard that was used in denying the claim and a discussion of the decision;
11. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claim Administrator's or your Employer'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, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1 (800) 521-2227. The Claim Administrator Customer Service Helpline is accessible from 8:00 A.M. to 8:00 P.M., Monday through 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. In addition, 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 (as described above) 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).

1. Request for External Review. Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review.
2. Preliminary Review. Within five business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
 - You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
 - The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
 - You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final

regulations. Please read the Exhaustion section below for additional information and exhaustion of the internal appeal process; and

- You or your authorized representative has provided all the information and forms required to process an external review. You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 1 (866) 444-EBSA (3272)).

3. Referral to Independent Review Organization (IRO). When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). 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 the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.

- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice 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 is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within five business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of

the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Claim Administrator 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 the Claim Administrator.

- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - Your medical records;
 - The attending health care professional's recommendation;
 - Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating **provider**;
 - 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;

- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
4. 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 the Claim Administrator and you or your authorized representative. The notice of final external review decision will contain:
- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care **provider**, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - The date the IRO received the assignment to conduct the external

review and the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- 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;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator or you or your authorized representative;
- A statement that judicial review may be available to you or your authorized representative; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

5. **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 Claim Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. **Request for expedited external review.** The Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:
 - An Adverse Benefit Determination, if the Adverse Benefit Determination involve a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - 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 would jeopardize 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, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.
3. **Referral to Independent Review Organization (IRO).** Upon a determination that a request is eligible for external review

following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the Standard External Review section above. The Claim Administrator 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 electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

- 4. Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the Standard External Review section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives 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 the Claim Administrator and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and 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 or not your request is appropriate for expedited external review or if the expedited

internal review process must be completed before external review may be requested. You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or 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.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions. The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan. All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Prescription drug claims through Express Scripts

The Express Scripts 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 Express Scripts 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). Express Scripts 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. Express Scripts is authorized to provide to the IRO the appeal files and other related information necessary for the IRO to conduct external reviews.

Summary of Express Scripts IRO Exchange of Information

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

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 payer, the A&M Care benefit is based on the amount the other plan does not pay. **Allowable amounts** are compared and if the BCBSTX **allowable amount** is the same or lower than the primary carrier's **allowable amount**, no additional payment is made. If the BCBSTX 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 that covers you as an active employee pays first.

Claimant	Primary Plan	Secondary Plan
Wife	Wife's	Husband's
Husband	Husband's	Wife's
Child	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.		

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.

Although many factors dictate whether your A&M System health plan or Medicare will be primary or secondary, in general, coverage is determined by the status of the A&M health plan policy holder. If the policy holder is Medicare-eligible and working at the A&M System at least 50% time (20 hours a week) for at least 4½ consecutive months, the A&M System health plan will be primary to Medicare for you and your spouse (if your spouse is covered under your plan).

For more information, you can review the booklet Medicare and Other Health Benefits: Your Guide to Who Pays First, available at: <https://www.medicare.gov/Pubs/pdf/02179.pdf> or you can contact Medicare to get a copy. You can also review the fact sheets on the System Benefits Administration website at: <http://www.tamus.edu/business/benefits-administration/employee/retiree-benefits/medicare-information/>.

When Medicare should be the primary payer, 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 begin their benefit calculation with the total charge, or the assigned charge if the **doctor** accepts assignment. The example on the next page shows you how each plan coordinates with Medicare. For this example, assume you have had office visits throughout the year and have met your Medicare deductible by September 1, when the new plan year begins. Because you've already met your Medicare deductible, charges for any office visits between September 1 and December 31 will be paid at 80% by Medicare. The full charge will apply toward your A&M Care plan deductible.

Beginning January 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 claim, and there is no limit to what the **doctor** may charge. However, the A&M Care plan will still treat the claim as if Medicare had paid.

Medicare Coordination Examples for the A&M Care Plans								
Date of Service	Doctor's Charge	Medicare Allows	Medicare Contracted Provider Writes Off	Applied to Medicare Deductible (Jan-Dec)	Amount Medicare Pays	Applied to TAMUS Deductible (Sept - Aug)	Amount TAMUS Plan Pays	You Pay
09/10/16	\$135	\$125	\$10		\$100	\$125	\$0	\$25
09/30/16	\$55	\$50	\$5		\$40	\$50	\$0	\$10
10/15/16	\$107	\$100	\$7		\$80	\$100	\$0	\$20
11/05/16	\$205	\$175	\$30		\$140	\$125	\$35	\$0
01/22/17	\$197	\$185	\$12	\$183	\$2		\$148	*\$35
02/15/17	\$270	\$225	\$45		\$180		\$45	\$0
03/25/17	\$325	\$300	\$25		\$240		\$60	\$0
05/07/17	\$570	\$500	\$70		\$400		\$100	\$0
06/15/17	\$237	\$225	\$12		\$180		\$45	\$0
	\$2,101	\$1,885	\$216	\$183	\$1,362	\$400	\$433	\$81

A&M Care Plan/65 PLUS Plan: FY17 \$400 deductible; Medicare Part B Deductible: CY17 \$183

*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 \$148. Since Medicare paid \$183, that leaves a \$35 balance for you to pay. [$\$183 - \$148 = \$35$].)

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 caused 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.

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 defined by TRS and have less than 10 years of service (but you have at least three years of creditable service in a benefits eligible position with the A&M System, if you were employed by the A&M System on August 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 **doctor's** certification of disability is 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 benefits under COBRA for 18 months. You are not eligible for the employer contribution. You may be able to continue COBRA coverage for 11 months beyond the initial COBRA period 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 A&M System on your last day of active employment.

Survivors: If your dependents were covered at the time of your death, your spouse can continue coverage indefinitely and your 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.

COBRA Continuation Coverage

In some cases, you, your spouse (including a former spouse) and your children have the option to extend coverage beyond the time coverage would normally end by paying the full cost of coverage. See the chart on "COBRA Qualifying Events & Continuation Periods". 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 may 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.

In some cases, you are responsible for notifying the A&M 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. Failure to meet notification 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 COBRA vendor 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 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 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 COBRA vendor 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 the COBRA vendor 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.

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 Qualifying Events & 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...	Then...
<p>You divorce, or</p> <p>Your child becomes ineligible for coverage</p>	<p>You and/or your dependents have 60 days after the event to notify Human Resources of the event.</p> <p>The COBRA Vendor has 14 days to send you and/or your dependents a COBRA enrollment form.</p> <p>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.</p> <p>You and/or your dependents have 45 days after making your election to pay premiums.</p>
If...	Then...
<p>You leave employment, Your hours are reduced, You go on leave without pay, or You die</p>	<p>The COBRA Vendor has 14 days after your notification to send you and/or your dependents a COBRA enrollment form.</p> <p>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.</p> <p>You and/or your dependents have 45 days after making your election to pay premiums.</p>

COBRA Information

P&A Group
 17 Court Street Suite 500
 Buffalo, NY 14202
 Phone: 1 (800) 688-2611

Federal Marketplace

Conversion to an individual health insurance policy is not available when your coverage under this plan ends. However, you are eligible to go to the Federal Marketplace for coverage at [HealthCare.gov](https://www.healthcare.gov).

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 bold 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.

Allowable Amount means the maximum amount determined by the Claim Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claim Administrator in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, Professional Other Providers, and any other provider not contracting with the Claim Administrator in Texas*** - The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated on a periodic basis.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claim Administrator does not have any claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the Provider's billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.

- ***For multiple surgeries*** - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed. Form No. PPO-GROUP#12345-0116 Page 46
- ***For procedures, services, or supplies provided to Medicare recipients*** - The Allowable Amount will not exceed Medicare's limiting charge.
- ***For Covered Drugs as applied to Participating and non-Participating Pharmacies*** - The Allowable Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between the Claim Administrator and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service. The Allowable Amount for non-Participating Pharmacies will be based on the Average, Wholesale Price.

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care

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.

Life Threatening Disease or Condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Negotiated National Account Arrangement means an agreement negotiated between one or more Blue Cross and Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

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.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

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 a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for Mental Health Care and/or for treatment of Chemical Dependency. BCBSTX requires that any facility providing Mental Health Care and/or a Chemical Dependency Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by BCBSTX as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

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 Blue Choice or BlueCard network or if you are referred to one of these providers by a doctor. See "Professional Services" for additional provider information.

Specialty Drug means drugs which can be given by any route of administration and are typically used to treat chronic, complex conditions, are defined as having one or more of several key characteristics, including:

- the requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes,
- the need for intensive patient training and compliance assistance to facilitate therapeutic goals,
- limited or exclusive specialty pharmacy distribution, or
- specialized product handling and/or administration requirements.

Value Based Program means an outcome-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Administrative and Privacy Information

Here are some additional 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, J Plan and 65 PLUS.

Plan Sponsor

Executive Director of Risk Management and
Benefits Administration
The Texas A&M University System Moore/Connally Building
301 Tarrow Dr., 5th Floor College Station, TX 77840 Mail Stop: 1117 TAMU
1 (979) 458-6330

Plan Administrator

The plan administrator is the Executive 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. Express Scripts, in accordance with an administrative agreement between Express Scripts 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:
Express Scripts
P. O. Box 2872
Clinton, IA 52733-2872 1 (608) 741-5471 (fax)

Mail-order drug claims should be sent to:
Express Scripts
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 September 1 and runs through the next August 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 Express Scripts 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 Express Scripts gathers information about you from your applications, claims and other forms. They also have personal health information that comes in from your claims, your healthcare 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, Express Scripts 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, administrators, 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 <http://assets.system.tamus.edu/files/benefits/pdf/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 Kevin McGinnis, the Privacy Official at 1 (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

Moore/Connally Building

The Texas A&M University System 301 Tarrow Dr., 5th Floor
College Station, TX 77840

Notice

Other Blue Cross and Blue Shield Plans and Separate Financial Arrangements with Providers

Out-of-Area Services

Blue Cross and Blue Shield of Texas (BCBSTX) has a variety of relationships with other Blue Cross and BlueShield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of BCBSTX service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program, and may include **negotiated National Account arrangements** available between BCBSTX and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare providers. Our payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside BCBSTX's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over-or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a **negotiated National Account arrangement** with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

For nonparticipating healthcare providers outside our Plan Service Area please refer to the **Allowable Amount** definition in the “Definitions” section of this Benefit Booklet.

D. BlueCard Worldwide® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or **hospital**) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, **hospitals** will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the **hospital** will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact the Plan to obtain precertification for nonemergency inpatient services.

Outpatient Services

Outpatient Services are available for Emergency Care. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service

Submitting a BlueCard Worldwide Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider’s itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970。

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970

번으로 전화해 주십시오.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970

(رقم هاتف الصم والبكم:

Urdu

لاک - سیہ بای تسد سیہ تفم تامدخ یک ددم یک نابز وک پآ وت، سیہ ے تلوب ودر پآ رگا: رادربخ

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970

ک

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa
BCBSTX: 1-866-295-1212
Express Scripts: 1-866-544-6970

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le:
BCBSTX: 1-866-295-1212
Express Scripts: 1-866-544-6970

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
BCBSTX: 1-866-295-1212
Express Scripts: 1-866-544-6970

Persian

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
BCBSTX: 1-866-295-1212
Express Scripts: 1-866-544-6970

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:
BCBSTX: 1-866-295-1212
Express Scripts: 1-866-544-6970

Gujarati

◆યુ ના: જો તમે◆જરાતી બોલતા હો, તો િન:◆લુ ભાષા સહાય સેવાઓ તમારા માટે◆ઉપલબ્ધ છે. ફોન કરો
BCBSTX: 1-866-295-1212
Express Scripts: 1-866-544-6970

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970

まで、お電話にてご連絡ください。

Laotian

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ

BCBSTX: 1-866-295-1212

Express Scripts: 1-866-544-6970