2015-2016

Annual Enrollment for Active Employees

Get Ready for Plan Year 2015-16

General Change
Beginning September 1, 2015, eligible dependent children, married or unmarried, up to age 26 may be enrolled in optional coverages, including dental, vision and dependent life, as well as medical coverage. Dependents previously covered and dropped will not be automatically re-added. Dependents may be added during annual enrollment – July 1 through July 31.

Health Plan Changes
- Office visit and prescription drug copays will be included in the annual out-of-pocket maximum.
- Total premiums are increasing in all health plans due to medical trends. Because of an increase in state contributions, and funds made available from health plan reserves for the A&M Care plans, the employee-only premium for A&M Care plan participants will remain the same and the other tiers will have modest increases.
- Employees, who work 75% time, will get full SGIP after September 1st, 2015.
- The Graduate Student Employee Plan total cost will increase as well.

New Benefits

2ND.MD
- If you are enrolled in the A&M Care plan, you have the services of 2nd.MD available to you. As a 2ND.MD member, you and your covered dependents can speak via video or phone to medical specialists at top institutions like the Mayo Clinic or Boston Children's Hospital, *at no cost to you*.
- Most people use 2ND.MD to get second opinions. When you want expert advice about an important medical decision, contact us to speak to a world-class specialist in about 3 days. *All consults are confidential*.
- If you were recently diagnosed with an illness, considering surgery or recently had a change in medication, simply go to 2ND.MD to speak to a world-class specialist in about 3 days.
- For information, **check here**.

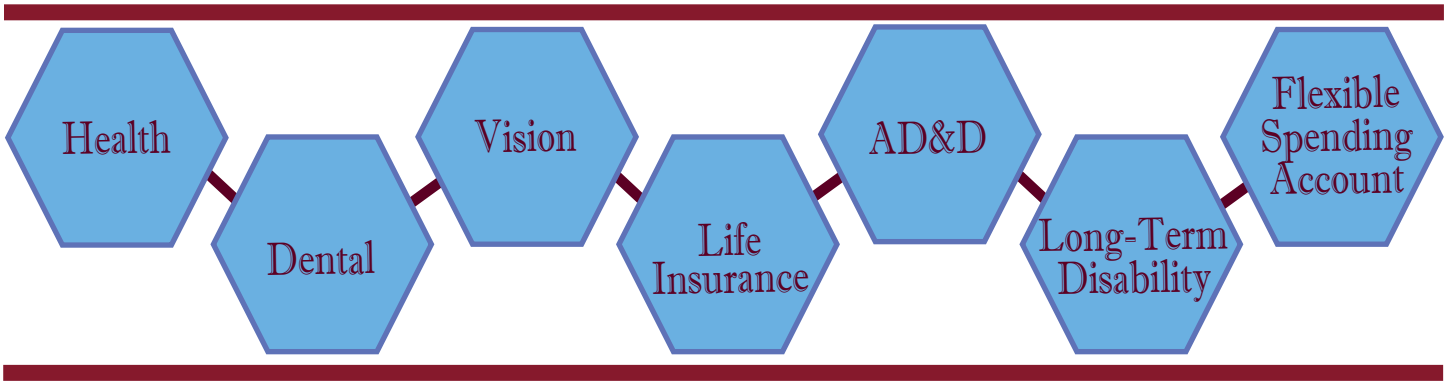
The Word on Wellness
The A&M System recognizes the importance of fostering employee wellness. The Chancellor's Wellness Initiative includes a two-pronged approach: incenting employees to have an annual wellness exam with their physician and engaging employees in healthy behaviors through campus- and agency-based programs encouraging wellness.

Click on **http://www.tamus.edu/business/benefits-administration/wellness/** to find information about the wellness initiatives on your campus to find other wellness resources.

Naturally Slim
A pilot program, Naturally Slim®, will be offered to employees and retirees in the A&M Care and J plans. To qualify, a member must have a risk factor related to Metabolic Syndrome. For our pilot, this normally means BMI over 30 or BMI over 25 plus an additional risk factor. For eligible, accepted participants, the program will be provided at no cost. After acceptance, participants watch weekly videos instructing them on the Naturally Slim® program principles. The program will be offered to System members in "waves" through the summer and fall. Contact your Human Resources office for more information.

Optional Insurance Plan Changes
- The EyeMed Vision program will increase slightly this year.

Your Options . . .



Click on any of the above hexagons to read more about your benefits!

- ✔ Review/make changes to your benefits for 2015 – 2016 by logging on to ***i*Benefits** through Single Sign-On. Be sure to submit any changes before August 1, 2015. You can make additional changes once you submit our online document by using the "recall" button in ***i*Benefits**. Be sure to **resubmit** your document.

- ✔ Make sure your address is correct in HR Connect. Log into HRConnect through **Single Sign-On** and click on the Personal Data tab to update, if necessary.

- ✔ Flexible Spending Accounts, Health Care and/or Dependent Daycare do **not** automatically continue. You must enroll for the new plan year and (re-)elect the debit card to enroll in or continue those options. If you have a debit card, the card is good through the "valid thru" date on the card, but you must re-elect this option to use the card after September 1, 2015.

- ✔ Remember, you cannot add or drop coverage for yourself or any dependents during the plan year unless you have certain Changes in Status.

- ✔ Update your beneficiary designations in ***i*Benefits**. Entering your beneficiaries into the database will make it easier to update them online, anytime.

- ✔ When you make any benefit changes, you will receive an email confirmation. If you do not have an email address in HRConnect, you will receive a confirmation letter in the mail. ***Be sure these are the benefits you intended to elect for 2015-2016.***

For more information:
- click here to see the **Employee Benefits Guide**
- review your plan description booklets at **http://www.tamus.edu/business/benefits-administration/booklets-brochures-forms/**
- contact your Human Resources office if you still have questions.

2015-2016 Annual Enrollment Meeting Schedule

City	2015	Time	System Member	Location	For
College Station	7/8	9 am - noon	AgriLife, HSC, TEES/ COE, TTI	Brazos Center	Retirees
College Station	7/8	1:00 - 3:00 pm	TEES/COE	Mechanical Engineering Office Building (MEOB), Room 301	Active Employees
College Station	7/9	**Benefits Fair** - 10 am - 2 pm **Presentations** - 9 am - 1 pm	TAMU, System Offices	**General Services Complex (GSC)** Vendor tables Assembly Room 101A Presentations Assembly Room 101 B/C	All
College Station	7/10	**Benefits Fair -** 10 am - 2 pm **Presentations** - 8:30 am - noon	TAMU, System Offices	**General Services Complex (GSC)** Vendor tables Assembly Room 101A Presentations Assembly Room 101 B/C	All
Killeen	7/13	9 am - noon	TAMU-Central Texas	Warrior Hall-Mutipurpose Room 1001 Leadership Place	All
Texarkana	7/13	10 am - 2 pm	TAMU-Texarkana	University Center/Lounge Area 7101 University Avenue	All
Dallas	7/13	11 am - 1 pm	HSC/BCD - Dallas	3302 Gaston Ave. BCD - 6th floor	All
Canyon	7/14	10:00 am - Retirees 2 pm - Employees	TAMU-West Texas	ANS Building Room 101	All
Stephenville	7/14	8:30 am - Retirees 10:30 am - 1:30 pm - Employees	TAMU-Tarleton	Tarleton Student Center - Ballrooms	All
Commerce	7/14	10 am - noon	TAMU-Commerce	McDowell Business Administration Building Room 343 2600 S. Neal	All
Corpus Christi	7/15	9 am - 4 pm	TAMU-Corpus Christi	Anchor Ballroom 147 B,C, & D	All
Kingsville	7/16	10 am - 2 pm	TAMU-Kingsville HSC/Pharmacy	Javelina Dining Hall Banquet Room 200	All
Weslaco	7/17	10:30 am	TAMU-Kingsville	Citrus Center - Conference Center 1	All
College Station *TTVN	7/17	9 am - 11:30 am	AgriLife	Centeq Plaza 1500 Research Parkway, Suite 120A	
Prairie View	7/20	9 am - 11:00 am 2 pm - 4 pm	PVAMU	John B.Coleman Library Rm 108 130 L.W. Minor Street	All
Lufkin	7/20	9 am - noon	TFS	Angelina Cooperative Extension 2201 South Medford Drive	All
Bryan	7/21	9 am - noon	Health Science Center	Health Professions Education Building Building 1000, Room LL38 8447 State Hwy 47	Active Employees
Galveston	7/22	10 am - 2 pm	TAMU-Galveston	CLB (Building 3007, Room 103)	All
Laredo	7/22	9 am & 2 pm	TAMIU-Laredo	5201 University Boulevard Student Center Room 231	All
Houston	7/23	**Benefits Fair** - 9 am - 11:30 am **Presentations** -10am - 11 am	HSC/IBT-Houston	2121 W. Holcombe Boulevard	All
San Antonio	7/23	10 am - 3 pm	TAMU-San Antonio	Central Academic Building (CAB) Room 101 A, 1st Floor Rotunda One University Way	All

**AgriLife - TTVN meetings will be broadcast at various AgriLife locations throughout the state. These meetings are hosted by AgriLife, but employees & retirees of all System Members are welcome to participate at the connected TTVN sites. The originating site will be at Centeq Research Plaza (CTQ) building in College Station.*

2015-2016 Plan: A&M Care Information

Vendor: BlueCross BlueShield of Texas (BCBSTX)
This is a preferred provider organization (PPO). Cost are higher if non-network providers are used.

Member Services Contact Information:
BlueCross BlueShield of Texas: (866) 295-1212; Information About Networks Outside Texas: (800) 810-BLUE (2583)
Website: http://www.bcbstx.com

	Network:	Non-Network:
Limitations and Restrictions		
Pre-existing condition limitations:	None	
Benefit Maximum:	None	
Out-of-service-area restrictions:	Emergency care - must notify BCBSTX within 48 hours.	Emergency care
Maximums & Deductibles		
Deductibles:	$700 Medical/$50 Rx	$1,400 Medical/$700 hospitalization
Out-of-pocket maximum:	$5,000 + the medical deductible above $10,000 + $2,100 family	$10,000 + $1,400 deductible per person
Benefit maximum:	No annual/lifetime maximums except those listed below	
Hospital Benefits		
In-hospital care:	20% after deductible	$700/admission, then 50%
Emergency room:	20% after deductible	20% after deductible if emergency; otherwise 50% after deductible
Surgery:	20% after deductible In physician's office, see office visit	50% after deductible 50% after deductible
Non-Hospital Visits		
Office visits:	$30/visit for Primary Care Physican $45/visit for specialists; Certain surgeries—20% after deductible	50% after deductible
Preventive exam:	100% covered	Not covered
Lab/X-rays:	Benefit depends on setting and procedure; See plan book or call BCBSTX	50% after deductible
Skilled nursing facility (not including custodial care):	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Home health care:	20% after deductible; 60 visits/plan year	50% after deductible; 60 visits/plan year
Other Healthcare Benefits		
Chiropractic care:	$45/visit, 30 visits/plan year	50% after deductible, 30 visits/plan year
Durable medical equipment:	20% after deductible	50% after deductible
Maternity care:	Hospital - 20% after deductible; Doctor - $30 initial visit only	Hospital - 50% after deductible; Doctor - 50% after deductible
Mental health:	Inpatient - 20% after deductible Outpatient - $30/visit	Inpatient - 50% after deductible Outpatient - 50% after deductible
Physical therapy:	$45/visit	50% after deductible
Vision:	$45/visit	Routine preventive exams not covered
Hearing:	Illness/accident coverage only	

Prescription drugs: After you meet the $50/person/plan year prescription drug deductible (three-person maximum):

- 30-day supply: $10/generic, $35/brand-name formulary, $60/brand-name nonformulary; brand-name copayment + difference between brand-name and generic when available
- 90-day supply: Two copayments required if purchased by mail-order; three if purchased through most retail pharmacies.

Member Services Contact Information ExpressScripts: (800) 544-6970; **Website:** http://www.express-scripts.com

2015-2016 Plan: Graduate Student Health Plan

Vendor: BlueCross BlueShield of Texas (BCBSTX)

This plan is designed for Graduate Student Employees in eligible graduate student positions. It is a preferred provider organization (PPO). Costs are higher if non-network providers are used. This plan may also be available to students eligible for benefits due to the Affordable Care Act. For international students, this plan satisfies the health coverage requirement for International Students and meets grad student J-1 visa holder requirements.

Member Services Contact Information:

Academic HealthPlans (AHP): (877) 624-7911;
Website: **https://tamus.myahpcare.com/**

	Network:	Non-Network:
Limitations and Restrictions		
Pre-existing condition limitations:	None	
Benefit Maximum:	None	
Out-of-service-area restrictions:	None	
Maximums & Deductibles		
Deductibles:	$350 Medical/waived student health center	$750; waived student health center
Out-of-pocket maximum:	$6,600/person (includes all copayments)	$12,700/person (includes all copayments)
Benefit maximum:	No annual/lifetime maximums	
Hospital Benefits		
In-hospital care:	20% after deductible	40% after deductible
Emergency room: Emergency Services	$150 copay; 20% after deductible 20% after deductible	 40% after deductible
Surgery:	20% after deductible In physician's office, See office visit	40% after deductible
Non-Hospital Visits		
Office visits:	$35 copay	
Preventive exam:	100% covered	40% after deductible
Lab/X-rays:	20% after deductible	40% after deductible
Skilled nursing facility (not including custodial care):	20% after deductible; 25 days/plan year	40% after deductible; 25 days/plan year
Home health care:	20% after deductible; 60 visits/plan year	40% after deductible; 60 visits/plan year
Other Healthcare Benefits		
Chiropractic care:	$35/visit	40% after $35 copay; 35 visits/person
Durable medical equipment:	20% after deductible	
Mental health:	Inpatient - 20% after deductible Outpatient - $35/visit	40% after deductible 40% after $35 copay
Physical therapy:	$35/visit; 35 visits/person	40% after $35 copay; 35 visits/person
Vision/Hearing/Speech:	20% after deductible One preventive vision exam/per plan year	40% after deductible (must be within 60 days of rehabilitation release)

Prescription drugs: $15 at student health center;
Prime Therapeutics RX drug card $15/generic, $30/preferred brand-name, $40/non-preferred brand-name - no maximum
Generic Drug –A medication duplicated by another company once the patent expires
Brand Name Drug –A medication developed by a pharmaceutical company

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com or by calling 1-866-295-1212.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$700** Person/**$2,100** Family Out-of-Network **$1,400** Person /**$4,200** Family Doesn't apply to services that charge a copay, prescription drugs, and In-Network diagnostic tests and preventive care. Copays and per occurrence deductibles do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Out-of-Network $**500** per hospital admission. **$50** RX deductible for In- and Out-of-Network. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network **$5,000** Person + **$700** Medical Deductible/ **$10,000** Family + **$2,100** Medical Deductible Out-of-Network **$10,000** Person + **$1,400** Medical Deductible/ **$20,000** Family + **$4,200** Medical Deductible	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of In-Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-295-1212 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an Out-of-Network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an Out-of-Network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit no deductible	50% coinsurance after deductible	---none---
	Specialist visit	$45 copay/visit no deductible	50% coinsurance after deductible	
	Other practitioner office visit	$45 copay/visit no deductible	50% coinsurance after deductible	Chiropractic services are limited to 30 visits per calendar year for In- and Out-of-Network.
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance after deductible	Deductible waived In-Network. Certain Diagnostic Procedures only. See your policy or plan document for a list of procedures.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Generic drugs	Retail: $10 copay/ prescription after $50 deductible Mail: $20 copay/ prescription after $50 deductible	Total cost of prescription at the time of service. 75% of allowable,charges are reimbursed after applicable copayment	Retail: one copay per 30 day supply Mail: two copays up to 90 day supply
	Preferred brand drugs	Retail: $35 copay/ prescription after $50 deductible Mail: $70 copay/ prescription after $50 deductible	Total cost of prescription at the time of service. 75% of allowable,charges are reimbursed after applicable copayment	Retail: one copay per 30 day supply Mail: two copays up to 90 day supply
	Non-preferred brand drugs	Retail: $60 copay/ prescription after $50 deductible Mail: $120 copay/ prescription after $50 deductible	Total cost of prescription at the time of service. 75% of allowable,charges are reimbursed after applicable copayment	Retail: one copay per 30 day supply Mail: two copays up to 90 day supply
	Specialty drugs	Generic $10 copay Preferred $35 copay Non-preferred $60 copay/ after $50 deductible	Total cost of prescription at the time of service. 75% of allowable,charges are reimbursed after applicable copayment	Beginning with second fill specialty medication must be filled through Specialty Pharmacy: one copayment per 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	---none---
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	20% coinsurance after deductible	---none---
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	
	Urgent care	$30/$45 copay/visit no deductible	50% coinsurance after deductible	Specialist has higher copay.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. $500 penalty for failure to preauthorize Out-of-Network.
	Physician/surgeon fee	20% coinsurance after deductible	50% coinsurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit no deductible	50% coinsurance after deductible	Certain services must be preauthorized; refer to plan document.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. $500 penalty for failure to preauthorize Out-of-Network.
	Substance use disorder outpatient services	$30 copay/visit no deductible	50% coinsurance after deductible	Certain services must be preauthorized; refer to plan document.
	Substance use disorder inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. $500 penalty for failure to preauthorize Out-of-Network.
If you are pregnant	Prenatal and postnatal care	$30/$45 copay/ initial visit no deductible	50% coinsurance after deductible	Specialist has higher copay. No charge after initial copay. For physician services only.
	Delivery and all inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. $500 penalty for failure to preauthorize Out-of-Network.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. Limited to 60 visits per plan year.
	Rehabilitation services	$45 copay/visit no deductible	50% coinsurance after deductible	---none---
	Habilitation services	$45 copay/visit no deductible	50% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. Limited to 60 days per plan year.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	---none---
	Hospice service	20% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. No plan maximums.
If your child needs dental or eye care	Eye exam	$30/$45 copay/visit no deductible	50% coinsurance after deductible	---none---
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care (covered only with diagnosis of diabetes)
- Weight loss programs (except Naturally Slim Program)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limitations may apply)
- Bariatric surgery (limitations may apply)
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult Vision Screening)

Questions: Call 1-866-295-1212 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-295-1212. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact BlueCross BlueShield of Texas at 1-866-295-1212 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Texas Department of Insurance's Consumer Health Assistance Program at (855) 839-2427 or visit www.texashealthoptions.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-295-1212.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-295-1212.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-295-1212.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-295-1212.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,460
- **Patient pays** $2,080

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$720
Copays	$0
Coinsurance	$1,210
Limits or exclusions	$150
Total	**$2,080**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,780
- **Patient pays** $1,620

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$750
Copays	$580
Coinsurance	$210
Limits or exclusions	$80
Total	**$1,620**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from Out-of-Network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-866-295-1212 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com or by calling 1-866-295-1212.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$500** Person/**$1,500** Family Out-of-Network **$1,000** Person /**$3,000** Family Doesn't apply to services that charge a copay, prescription drugs, and In-Network diagnostic tests and preventive care. Copays and per occurrence deductibles do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Out-of-Network $**500** per hospital admission. **$50** RX deductible for In- and Out-of-Network. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network **$5,000** Person + **$500** Medical Deductible/ **$10,000** Family + **$1,500** Medical Deductible Out-of-Network **$10,000** Person + **$1,000** Medical Deductible/ **$20,000** Family + **$3,000** Medical Deductible	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of In-Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-295-1212 or visit us at www.bcbstx.com.
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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an Out-of-Network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an Out-of-Network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit no deductible	50% coinsurance after deductible	---none---
	Specialist visit	$45 copay/visit no deductible	50% coinsurance after deductible	
	Other practitioner office visit	$45 copay/visit no deductible	50% coinsurance after deductible	Chiropractic services are limited to 30 visits per calendar year for In- and Out-of-Network.
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance after deductible	Deductible waived In-Network. Certain Diagnostic Procedures only. See your policy or plan document for a list of procedures.
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Generic drugs	Retail: $10 copay/ prescription after $50 deductible Mail: $20 copay/ prescription after $50 deductible	Total cost of prescription at the time of service. 75% of allowable,charges are reimbursed after applicable copayment	Retail: one copay per 30 day supply Mail: two copays up to 90 day supply
	Preferred brand drugs	Retail: $35 copay/ prescription after $50 deductible Mail: $70 copay/ prescription after $50 deductible	Total cost of prescription at the time of service. 75% of allowable,charges are reimbursed after applicable copayment	Retail: one copay per 30 day supply Mail: two copays up to 90 day supply
	Non-preferred brand drugs	Retail: $60 copay/ prescription after $50 deductible Mail: $120 copay/ prescription after $50 deductible	Total cost of prescription at the time of service. 75% of allowable,charges are reimbursed after applicable copayment	Retail: one copay per 30 day supply Mail: two copays up to 90 day supply
	Specialty drugs	Generic $10 copay Preferred $35 copay Non-preferred $60 copay/ after $50 deductible	Total cost of prescription at the time of service. 75% of allowable,charges are reimbursed after applicable copayment	Beginning with second fill specialty medication must be filled through Specialty Pharmacy: one copayment per 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	50% coinsurance after deductible	---none---
	Physician/surgeon fees	25% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	25% coinsurance after deductible	25% coinsurance after deductible	---none---
	Emergency medical transportation	25% coinsurance after deductible	25% coinsurance after deductible	
	Urgent care	$30/$45 copay/visit no deductible	50% coinsurance after deductible	Specialist has higher copay.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. $500 penalty for failure to preauthorize Out-of-Network.
	Physician/surgeon fee	25% coinsurance after deductible	50% coinsurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit no deductible	50% coinsurance after deductible	Certain services must be preauthorized; refer to plan document.
	Mental/Behavioral health inpatient services	25% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. $500 penalty for failure to preauthorize Out-of-Network.
	Substance use disorder outpatient services	$30 copay/visit no deductible	50% coinsurance after deductible	Certain services must be preauthorized; refer to plan document.
	Substance use disorder inpatient services	25% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. $500 penalty for failure to preauthorize Out-of-Network.
If you are pregnant	Prenatal and postnatal care	$30/$45 copay/ initial visit no deductible	50% coinsurance after deductible	Specialist has higher copay. No charge after initial copay. For physician services only.
	Delivery and all inpatient services	25% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. $500 penalty for failure to preauthorize Out-of-Network.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. Limited to 60 visits per plan year.
	Rehabilitation services	$45 copay/visit no deductible	50% coinsurance after deductible	---none---
	Habilitation services	$45 copay/visit no deductible	50% coinsurance after deductible	
	Skilled nursing care	25% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. Limited to 60 days per plan year.
	Durable medical equipment	25% coinsurance after deductible	50% coinsurance after deductible	---none---
	Hospice service	25% coinsurance after deductible	50% coinsurance after deductible	All services must be preauthorized. No plan maximums.
If your child needs dental or eye care	Eye exam	$30/$45 copay/visit no deductible	50% coinsurance after deductible	---none---
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care (covered only with diagnosis of diabetes)
- Weight loss programs (except Naturally Slim Program)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limitations may apply)
- Bariatric surgery (limitations may apply)
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult Vision Screening)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-295-1212. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact BlueCross BlueShield of Texas at 1-866-295-1212 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Texas Department of Insurance's Consumer Health Assistance Program at (855) 839-2427 or visit www.texashealthoptions.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-295-1212.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-295-1212.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-295-1212.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-295-1212.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,310
- **Patient pays** $2,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$520
Copays	$0
Coinsurance	$1,560
Limits or exclusions	$150
Total	**$2,230**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,900
- **Patient pays** $1,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$550
Copays	$610
Coinsurance	$260
Limits or exclusions	$80
Total	**$1,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from Out-of-Network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com or by calling 1-855-267-0214.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network providers **$350** Individual/**$1,050** Family For Out-of-Network providers **$700** Individual/**$2,100** Family Services that charge a copay, prescription drugs, and In-Network preventive care do not apply to the overall deductible. Copays do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For In-Network providers **$6,350** Individual/**$12,700** Family For Out-of-Network providers **$12,700** Individual/**$25,400** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, preauthorization penalties and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbstx.com or call 1-855-267-0214 for a list of In-Network providers.	If you use an In-Network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your In-Network doctor or hospital may use an Out-of-Network **provider** for some services. Plans use the term In-Network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an Out-of-Network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an Out-of-Network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	---none---
	Specialist visit	$35 copay/visit	40% coinsurance	---none---
	Other practitioner office visit	20% coinsurance	40% coinsurance	Chiropractic and Osteopathic services are limited to 35 visits combined for all therapies per plan year. Includes, but is not limited to, physical and occupational therapy.
	Preventive care/screening/immunization	No Charge	40% coinsurance	Deductible waived In-Network. No charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	---none---

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	$15 retail / $45 mail order copay/ prescription	$15 copay/ prescription plus 40% coinsurance	One copay per 30 day supply. For Non-Participating pharmacy, member must file claim. Mail order is covered.
	Preferred brand drugs	$30 retail / $90 mail order copay/ prescription	$30 copay/ prescription plus 40% coinsurance	
	Non-preferred brand drugs	$40 retail / $120 mail order copay/ prescription	$40 copay/ prescription plus 40% coinsurance	
	Specialty drugs	$15/$30/$40 copay/prescription	$15/$30/$40 copay/prescription plus 40% coinsurance	Coverage based on group policy. Specialty retail is limited to 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
If you need immediate medical attention	Emergency room services	$150 copay/visit plus 20% coinsurance	$150 copay/visit plus 20% coinsurance	OON Non-Emergency services are covered at 40% after copay and plan year deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	$35 copay/visit	40% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/visit	40% coinsurance	Certain services must be preauthorized; refer to benefits booklet for details.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	All services must be preauthorized; $250 penalty if services are not preauthorized Out-of-Network.
	Substance use disorder outpatient services	$35 copay/visit	40% coinsurance	Certain services must be preauthorized; refer to benefits booklet for details.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	All services must be preauthorized; $250 penalty if services are not preauthorized Out-of-Network.
If you are pregnant	Prenatal and postnatal care	$35 copay/visit	40% coinsurance	Copay applies to first prenatal visit (per pregnancy).
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. Limited to 60 visits maximum per plan year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to 35 visits combined for all therapies per plan year. Includes, but is not limited to, physical and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required. Limited to 25 days maximum per plan year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice service	20% coinsurance	40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Eye exam	Covered	Covered	Refer to benefit booklet.
	Glasses	Covered	Covered	
	Dental check-up	Covered	Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for extended care services)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids (Limited to 1 per ear per 36 month period)
- Routine eye care (Adult)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-267-0214. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact BlueCross BlueShield of Texas at 1-855-267-0214 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Texas Department of Insurance's Consumer Health Assistance Program at (855) 839-2427 or visit www.texashealthoptions.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-267-0214.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-267-0214.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-855-267-0214.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-267-0214.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,760
- **Patient pays** $1,780

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$350
Copays	$0
Coinsurance	$1,280
Limits or exclusions	$150
Total	**$1,780**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,150
- **Patient pays** $1,250

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$350
Copays	$0
Coinsurance	$820
Limits or exclusions	$80
Total	**$1,250**

Note: These examples are based on individual coverage only.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from Out-of-Network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-855-267-0214 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

Monthly Premiums

Effective September 1, 2015

Basic Life

The premium for this plan is usually paid by the employer contribution.
Basic Life $4.23 Alternate Basic Life $.564 per $1,000

Health

The following chart applies to you if you are a ***full-time employee*** (work at least 30 hours per week):

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	***Your Cost***	*Total Cost*	***Your Cost***	*Total Cost*	***Your Cost***	*Total Cost*	***Your Cost***
A&M Care	$553.48	$ 10.00	$1,095.93	$281.22	$933.22	$199.87	$1,312.89	$389.70
J Plan	$590.62	$ 47.14	$1,170.21	$355.50	$996.35	$263.00	$1,402.03	$478.84

The following chart applies to you if you are a ***part-time employee*** (work 20 to 29 hours per week):

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	***Your Cost***	*Total Cost*	***Your Cost***	*Total Cost*	***Your Cost***	*Total Cost*	***Your Cost***
A&M Care	$553.48	$283.85	$1,095.93	$690.69	$933.22	$568.66	$1,312.89	$853.41
Graduate Student Health Plan	$141.00	$ 0.00	$ 422.00	$ 16.76	$366.00	$ 1.44	$ 492.00	$ 32.52
J Plan	$590.62	$320.99	$1,170.21	$764.97	$996.35	$631.79	$1,402.03	$942.55

Dental

Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
A&M Dental PPO	$29.41	$58.82	$61.76	$94.11
DeltaCare USA Dental HMO	$21.23	$37.76	$38.05	$59.12

Vision

Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
$ 6.70	$14.25	$11.00	$19.61

Optional Life

If your birthday falls between 9-1-15 and 2-28-16 and you will move to a higher cost category, you must pay the higher premium for the entire year. *Monthly rate per $1,000:*

Age	No-tobacco rate	Tobacco rate	Age	No-tobacco rate	Tobacco rate
under 25	$.04	$.08	50–54	$.16	$.32
25–29	.04	.08	55–59	.29	.58
30–34	.04	.08	60–64	.45	.90
35–39	.05	.10	65–69	.61	1.22
40–44	.06	.12	70–74	1.15	2.30
45–49	.10	.20	75+	1.61	3.22

Dependent Life

Plan A: Spouse Age-based rate per $1,000 of coverage; Child: $.06 per 1,000 of coverage
Plan B: $1.37/month (flat rate)
Plan C: ½ Alternate Basic Life premium; (1/10 if no spouse is covered)

Age	Non-tobacco rate	Tobacco rate	Age	Non-tobacco rate	Tobacco rate
under 25	$.05	$.06	50–54	$.23	$.276
25–29	.06	.072	55–59	.43	.516
30–34	.08	.096	60–64	.66	.792
35–39	.09	.108	65–69	1.27	1.524
40–44	.10	.120	70–74	2.06	2.472
45–49	.15	.180	75+	2.06	2.472

AD&D

Monthly rate per $10,000: Employee Only $ .14 Employee & Family $ .24

Long-Term Disability

Monthly rate per $100/monthly pay: Non-tobacco rate $ .202 Tobacco rate $ .261

Flexible Spending Account Debit Card (Health Care Account only)

$9.00/year

Premium Worksheet

1. Health: Enter premium amount. The employer contribution has already been deducted. Add $30 each if you, your spouse, or any dependent children use tobacco products, up to a possible additional $90 per month. Add $30 each if your A&M System Medical coverage began prior to September 1, 2014 and if you or your spouse have not had a preventive wellness exam processed through BlueCross BlueShield. This does not apply to retirees or those enrolled in the J or Graduate Student Health Plans. $ _____

2. Dental: Enter premium amount. $ _____

3. Vision: Enter premium amount. $ _____

4. Optional Life: Take your annualized salary, multiply by your coverage amount (½, 1, 2, 3, 4, 5 or 6), and round down to the nearest thousand (maximum is $1,000,000). Divide by 1,000: _____ × your age-based premium of _____ = $ _____

5. Alternate Basic Life: Divide your coverage amount by 1,000: _____ × .564 = $ _____ *

6. Dependent Life:
   Plan A Premium: Your spouse's age-based premium of _____ × (spouse coverage amt/1000) + $ _____
   (child coverage amt/1000 X.06) = _____ $ _____ *
   Plan B Premium: $1.37/month (flat rate)
   Plan C Premium: Your Alternate Basic Life premium (see #5)_____ × .5 (.1 if covering children only) = $ _____

7. Accidental Death and Dismemberment: Choose your coverage amount and divide by 10,000: _____ × your premium of _____= $ _____
   (Maximum coverage is the greater of $250,000 or 10 times your annual salary, not to exceed coverage of $800,000.)

8. Long-Term Disability: Divide your annual salary by 12. Divide the lesser of that number or $12,307 by 100: _____ × your premium of_____ = $ _____ *

9. Spending Accounts: Enter Health Care Account monthly contribution $_____ + $ _____
   Dependent Day Care Account monthly contribution _____ = $ _____

10. YOUR TOTAL MONTHLY COST (Add 1 through 9) = $ _____

Complete items 11 and 12 if you do not have A&M System health coverage but certify that you have other health coverage:

11. Employer Contribution: Enter the total of your premiums shown above for Dental (line 2), Vision (line 3), Alternate Basic Life (line 5), AD&D (line 7) and Long-Term Disability (line 8)† or $273.86 ($136.93 if part-time), whichever is less. – $ _____

12. YOUR TOTAL MONTHLY OUT-OF-POCKET COST (Subtract line 11 from line 10)= $ _____

* *The premiums may increase based on your salary.*
† *Include only premiums you choose to pay using the employer contribution.*

Age 65 and Still Working

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

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial (877) KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as your employer's plan, your employer must allow you to enroll in your employer's plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer's plan, contact the Department of Labor at www.askebsa.dol.gov or call (866) 444-EBSA (3272).

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
(866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323, Ext. 61565

Campus Human Resources Contact Information

Texas A&M University	(979) 862-1718	benefits@tamu.edu
Texas A&M Health Science Center	(979) 436-9207	benefits@tamhsc.edu
Prairie View A&M University	(936) 261-1720	benefitsteam@pvamu.edu
Tarleton State University	(254) 968-9129	barrett@tarleton.edu
Texas A&M University-Central Texas	(254) 519-8015	t.flores@ct.tamus.edu
Texas A&M International University	(956) 326-2365	hr@tamiu.edu
Texas A&M University-Commerce	(903) 886-5049	Cynthia.Todhunter@tamu-commerce.edu
Texas A&M University-Corpus Christi	(361) 825-2630	human.resources@tamucc.edu
Texas A&M University at Galveston	(409) 740-4534	penningt@tamug.edu
Texas A&M University-Kingsville	(361) 593-4998	kuadf008@tamuk.edu
Texas A&M University-Texarkana	(903) 223-3113	Tina.Tindal@tamut.edu
Texas A&M Transportation Institute	(979) 845-9668	ttihr@ttimail.tamu.edu
Texas A&M University-San Antonio	(210) 784-2059	kgilbert@tamusa.tamus.edu
Texas A&M Forest Service	(979) 845-9337	dorithie.thomas@ag.tamu.edu
Texas A&M AgriLife	(979) 845-2423	Dana.dewveall@ag.tamu.edu
Texas A&M Engineering Experiment Station	(979) 458-7696	teeshr@tamu.edu
Texas A&M Engineering Extension Service	(979) 458-6818	martha.alexander@teex.tamu.edu
West Texas A&M University	(806) 651-2117	personnel@mail.wtamu.edu
System Offices	(979) 862-1718	benefits@tamu.edu

Carrier Phone Numbers and Websites

Academic HealthPlan	(877) 624-7911	http://www.ahpcare.com/
Graduate Student Health Plan		http://www.bcbstx.com/
BlueCross BlueShield A&M Care	(866) 295-1212	
Delta Dental - A&M Dental	(800) 336-8264	http://www.deltadentalins.com/tamus/
DeltaCare USA Dental HMO	(800) 422-4234	http://www.deltadentalins.com/tamus/
Cigna Insurance - Long-Term Disability	(800)362-4462	http://www.cigna.com
EyeMed Vision Care	(855) 862-4300	http://www.eyemed.com
Express Scripts - A&M Care Drug Program	(866) 544-6970	http://www.express-scripts.com/
Minnesota Life Insurance	(877) 443-5854	http://www.lifebenefits.com/
PayFlex - Flexible Spending Accounts	(800) 284-4885	http://www.healthhub.com/