

**Group Health Insurance Contributions
and
Plan Summaries
*FY2015***

The Texas A&M University System
 FY 2015 Health Plans
 Full-time

Carrier	Category	Total Premium	Employer Contribution*	Employee Out-of-Pocket
A&M Care	E/O	513.15	503.15	10.00
	E/S	1,016.07	754.61	261.46
	E/C	865.21	679.18	186.03
	E/F	1,217.22	855.19	362.03
A&M Care 65+	E/O	459.26	459.26	0.00
	E/S	908.26	754.61	153.65
	E/C	773.58	679.18	94.40
	E/F	1,087.87	855.19	232.68
J Plan	E/O	547.58	503.15	44.43
	E/S	1,084.93	754.61	330.32
	E/C	923.74	679.18	244.56
	E/F	1,299.86	855.19	444.67

*Employer Contribution does not include the cost for Basic Life of \$4.23.

Certified Other Health Coverage 1/2 SGIP Maximum \$253.69
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The Texas A&M University System
 FY2015 Health Plans
 Part-time

Carrier	Category	Total Premium	Employer Contribution*	Employee Out-of-Pocket
A&M Care	E/O	513.15	249.46	263.69
	E/S	1,016.07	375.19	640.88
	E/C	865.21	337.48	527.73
	E/F	1,217.22	425.48	791.74
J Plan	E/O	547.58	249.46	298.12
	E/S	1084.93	375.19	709.74
	E/C	923.74	337.48	586.26
	E/F	1299.86	425.48	874.38
Graduate Student Plan*****	E/O	125.00	125.00	0.00
	E/S	373.00	373.00	0.00
	E/C	324.00	324.00	0.00
	E/F	435.00	425.48	9.52

*Employer Contribution does not include the cost for Basic Life of \$ 4.23

Certified Other Health Coverage 1/2 SGIP Maximum 126.85
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This chart outlines the major provisions of the health plans offered to A&M System employees and retirees. Remember, you cannot add or drop coverage for yourself or any dependents during the plan year unless you have certain Changes in Status.

The chart below shows your share of the cost of a service. For example, 20% means you pay 20% (coinsurance) of the cost after any applicable deductibles up to the out-of-pocket limit, and the plan pays 80%. \$30/visit means you pay a \$30 (copayment) for each office visit. **Retirees 65 and older, or otherwise eligible for Medicare-primary coverage, are not eligible for office visit copays.**

Provisions	A&M Care	A&M Care 65 PLUS
	Network/Out-of-Network benefits	
<i>Regions offered</i>	BlueCross BlueShield of Texas (BCBSTX) has networks in all 50 states	Available everywhere. All enrollees must be retired, enrolled in Medicare Parts A and B, and have Medicare as the primary payer.
<i>Pre-existing condition limitations</i>	None	None
<i>Emergency leave benefit</i>	Network benefit; must notify BCBSTX within 48 hours. Network: \$700/person/plan year, \$2,100/family/plan year	None
<i>Deductibles</i>	Out-of-Network: \$1,400/person/plan year; \$700/hospital	\$500/person/plan year
<i>Out-of-pocket maximum</i>	Network: \$5,000 (includes coinsurance and physician copayments) plus \$700 deductible/person/plan year, \$10,000 plus \$2,100 deductible/family/plan year Out-of-Network: \$10,000 plus \$1,400 deductible/family/plan year	\$1,400 plus \$500 deductible/person/plan year
<i>In-hospital care</i>	Network: 20% after deductible Out-of-Network: \$700/admission, then 50%	20% after deductible
<i>Emergency room</i>	Network: 20% after deductible Out-of-Network: 20% after deductible if emergency; otherwise 50%	20% after deductible
<i>Office visits</i>	Network: \$30/visit for Primary Care Physician (PCP) visits; \$45 for specialists; certain expensive surgeries—20% after deductible Out-of-Network: 50% after deductible No copays available for those with Medicare-primary coverage.	20% after deductible
<i>Lab/X-rays</i>	Network: Benefit depends on setting and procedure; see plan description book or call BCBSTX for details. Out-of-Network: 50% after deductible	20% after deductible
<i>Preventive Care</i>	Network: 100% covered; Out-of-Network: 50% after deductible	Network: 100% covered
<i>Surgery</i>	Network: 20% after deductible (inpatient and outpatient) Out-of-Network: 50% after deductible (inpatient and outpatient) Network and out-of-network: In physician's office, see office visit	Inpatient, Outpatient and in physician's office - 20% after deductible
<i>Chiropractic care</i>	Network: \$45/visit, 30 visits/plan year Out-of-Network: 50% after deductible, 30 visits/plan year	20% after deductible, 30 visits/plan year
<i>Vision/Hearing</i>	Vision - Network: \$45/visit, One routine preventive vision exam/per plan year; Vision - Out-of-Network: Routine preventive vision exams not covered; Hearing—Illness/accident coverage only	Vision – 20% after deductible, One routine preventive vision exam/per plan year; Hearing - Illness/accident coverage only
<i>Physical therapy</i>	Network: \$45/visit Out-of-Network: 50% after deductible	20% after deductible
<i>Durable medical equipment</i>	Network: 20% after deductible Out-of-Network: 50% after deductible	20% after deductible
<i>Home health care</i>	Network: 20% after deductible; 60 visits/person/plan year Out-of-Network: 50% after deductible; 60 visits/person/plan year	Network: 20% after deductible; 60 visits/person/plan year
<i>Skilled nursing facility (not including custodial care)</i>	Network: 20% after deductible; 60 days/person/plan year Out-of-Network: 50% after deductible; 60 days/person/plan year	Network: 20% after deductible; 60 days/person/plan year
<i>Mental health</i>	<i>Inpatient</i> Network: Inpatient—20% after deductible Out-of-Network: Inpatient—50% after deductible; 30 visits/person/plan year <i>Outpatient</i> Network: Outpatient—20% after deductible Out-of-Network: Outpatient—50% after deductible; 30 visits/person/plan year	<i>Inpatient</i> - 20% after deductible <i>Outpatient</i> - 20% after deductible
<i>Prescription drugs Coverage provided by Express Scripts</i>	After the \$50/person/plan year prescription drug deductible (three-person maximum): <ul style="list-style-type: none"> • 30-day supply: \$10/generic, \$35/brand-name formulary, \$60/brand-name nonformulary; brand-name copayment + difference between brand-name and generic when generic is available • 90-day supply: Two copayments required if purchased by mail-order; three if purchased through certain retail pharmacies. Express Scripts—(866) 544-6970; http://www.express-scripts.com	
<i>Member Services</i>	BlueCross BlueShield of Texas—(866) 295-1212; for information on networks outside Texas—(800) 810-BLUE (2583) http://www.bcbstx.com	

J Plan

The J plan is only available to employees on a J-1 or J-2 visa and their family members. If you fall into this group, your visa requires you to have a plan with a maximum deductible of \$500 and a maximum coinsurance amount of 25%. The benefits are essentially the same as those in the A&M Care plan, including the BlueCross BlueShield in-network and out-of-network benefits, with the following differences:

In-network services	Non-network services
\$500 Deductible per person/plan year	\$1,000 deductible per person/plan year; \$500 hospital deductible for non-emergency services
\$1,500 Maximum family deductible	\$3,000 maximum family deductible
25% Coinsurance percentage for network services	50% coinsurance for non-network services

Since this coverage is a requirement of employment, if you are working for the A&M System on a J-1 or J-2 visa, the J plan will be your default plan.

Reminder About Repatriation and Medical Evacuation

Repatriation of remains of at least \$7,500 and medical evacuation coverage of at least \$10,000 are also required of those on a J-1 or J-2 visa. The student insurance plan for graduate and international students exceeds this federal requirement.

The J plan does not provide these benefits; however, the Basic Life coverage from Minnesota Life, provided with the J plan as a package, does provide the following required coverage:

- Evacuation/Repatriation: \$150,000
- Repatriation of Remains: \$15,000
- Visit of Family Member or Friend: \$5,000
- Return of Dependent Children: \$5,000
- Vehicle Return: \$2,500

With a combined single limit of \$150,000 per person.

The health plan chart below shows your share of the cost of a service. For example, 20% means you pay 20% (co-insurance) of the cost up to the out-of-pocket limit and the plan pays 80% after applicable deductibles. \$35/visit means you pay \$35 (copayment) for each office visit.

Graduate Student Health Plan

Provisions	
<i>Regions offered</i>	Available worldwide; outside U.S. benefits paid at 80%
<i>Pre-existing condition limitations</i>	No waiting period
<i>Benefit maximum</i>	Unlimited per person/year
<i>Out-of-service-area restrictions</i>	None
<i>Deductibles</i>	\$350/person; in or out-of-network; waived at student health center;
<i>Out-of-pocket maximum</i>	\$6,350 (includes medical and prescription copayments)
<i>In-hospital care</i>	Network: 20% after deductible, Out-of-Network: 40% after deductible
<i>Emergency room</i>	\$150 copay; after deductible, Network: 20%, Out-of-Network: 40% emergency
<i>Office visits</i>	\$35 copay
Preventive Services	Network: 100%, Out-of-Network: 40%, deductible and co-pay does not apply when in network.
<i>Diagnostic Lab/X-rays</i>	Network: 20%, Out-of-Network: 40% after deductible
<i>Surgery</i>	Network: 20% after deductible, Out-of-Network: 40% after deductible
<i>Chiropractic care</i>	Network: \$35/visit plus 20% after deductible, Out-of-Network: 40%, when medically necessary due to accident or illness
<i>Vision/Hearing/Speech</i>	Network: 20% after deductible, Out-of-Network: 40% after deductible. must be within 60 days of being released for rehabilitation
<i>Physical therapy</i>	Network: \$35/visit, 20% after deductible, Out-of-Network: 40% after deductible
<i>Durable medical equipment</i>	Network: 20% after deductible, Out-of-Network: 40% after deductible
<i>Home health care</i>	Network: 20% after deductible, Out-of-Network: 40% after deductible; limited to 60 visits
<i>Skilled nursing facility (not including custodial care)</i>	Network: 20% after deductible, Out-of-Network: 40% after deductible; limited to 25 days
<i>Mental health</i>	Network: Inpatient - 20% after deductible, Out-of-Network: 40% after deductible Network: Outpatient - \$35/visit, Out-of-Network: 40% after deductible
<i>Prescription drugs</i>	\$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
<i>How does this health plan work?</i>	This plan is for graduate student employees only. Students must be taking at least six credit hours or otherwise be working toward a degree. It is a preferred provider organization (PPO). You may choose any provider in the BlueCross BlueShield network to receive the highest level of coverage. You receive benefits for services provided by an out-of-network provider, but your cost will be higher. You will be reimbursed 100% for services you receive at an A&M student health center.
<i>Member Services phone number/website</i>	(877) 624-7911 or http://www.ahpcare.com/tamus/

Bold type indicates items that will change for the new plan year.