

A&M Care 65 PLUS Plan

Updated June 2020



**THE TEXAS A&M
UNIVERSITY SYSTEM**

Table of Contents

A&M Care	1
65 PLUS Plan	1
.....	1
Updated June 2020	1
Welcome.....	1
Meeting Your Health Care Needs.....	1
Important Phone Numbers.....	1
Identification Cards	2
How to Request ID Cards.....	2
Website Features	3
How to register on MyEvide	3
How to Find Blue Access for Members	3
Blue Access for Members (requires registration).....	3
Your TAMUS Health Plan Benefits	3
Summary of Benefits - A&M Care 65 Plus	4
65 PLUS (Medicare Primary) - Medical	4
Medicare – Primary 65 PLUS - Pharmacy.....	5
Smart90 Network.....	6
Freedom of Choice.....	7
Network vs. Out-of-Network Providers	7
Use of Non-Contracting Providers.....	8
Allowable Amount.....	8
Predetermination of Benefits.....	9
Facility Fees	9
Continuity of Care	9
Transitional Benefits	9
Preauthorization Requirements	9
How to Preauthorize.....	10
Benefits Value Advisor (BVA)	11
Accessing the BlueCard Program for Health Care Outside Texas.....	11
What the A&M System Health Plan Covers	13
Acquired Brain Injury	13
Allergy Care	13
Ambulance Services.....	14
Breastfeeding Support, Services and Supplies.....	14
Certain Diagnostic Procedures	14
Chiropractic Care.....	14
Clinical Trials.....	14
Cosmetic, Reconstructive, or Plastic Surgery.....	15
Dental Services and Covered Oral Surgery	15
Emergency Care and Treatment of Accidental Injury.....	15

What is an emergency?.....	16
Hearing Aid Services	16
Home Health Care and Private Duty Nursing (preauthorization required)	16
Hospice Benefits (preauthorization required).....	17
Hospital Admission (preauthorization required).....	17
Lab and X-Ray Services	17
Maternity Care	18
Medical Supplies.....	18
Mental Health - Mental Illness/Serious Mental Illness/Chemical Dependency.....	18
Mental Health Care	18
Serious Mental Illness	19
Chemical Dependency Treatment (preauthorization required)	19
Organ and Tissue Transplants (preauthorization required)	19
Orthotics	20
Outpatient Facility Services.....	20
Preventive Care	20
Professional Services	22
Prosthetic Devices	23
Skilled Nursing Facility (preauthorization required) ..	23
What the A&M Care Plan Does Not Cover.....	24
Limitations and Exclusions	24
How Your A&M Care Plan Medicare Part D Prescription Drug Program Works.....	27
Prescription Drug Deductible.....	27
Purchasing Prescription Drugs.....	27
Here's how the Mandatory Drug Substitution program works:	27
Prior Authorization	28
Specialty Pharmacy.....	28
Coordination of Benefits.....	28
Smoking Cessation and Weight Loss	28
Medicare Part D.....	29
Prescription Drugs.....	29
Specialty pharmacy copay assistance program	30
A&M Care Plan Claims and Appeals.....	31
How to File a Medical Claim	31
To file a medical claim, follow these steps:	31
Receipt of Claims.....	32
Review of Claim Determinations	32
If a Claim Is Denied or Not Paid in Full	32
Timing of Required Notices and Extensions	33

Urgent Care Clinical Claims*	33
Pre-Service Claims	33
Post-Service Claims	34
Claim Appeal Procedures	34
Definitions	34
Expedited Clinical Appeals	34
How to Appeal an Adverse Benefit Determination	35
Timing of Appeal Determinations	36
Notice of Appeal Determination	36
If You Need Assistance	36
Standard External Review	37
Expedited External Review	38
Exhaustion	39
Interpretation of Employer's Plan Provisions	39
Prescription drug claims through Express Scripts	39
Summary of Express Scripts IRO Exchange of Information	40
Coordination of Benefits	41
Overpayments	42
Right of Subrogation	42
When Coverage Ends	43
When Coverage is Extended	43
Approved Leave of Absence	43
Family or Medical Leave	43
Total Disability	43
Retirement	44
Survivors	44
COBRA Continuation Coverage	44

TAMUS Health Plan Provisions	47
Retiree Eligibility	47
Dependent Eligibility	47
Qualifying Life Events	47
Definitions	49
Notices	53
Out-of-Area Services	53
BlueCard® Program	53
Negotiated (non-BlueCard Program) National Account Arrangements	53
Non-Participating Healthcare Providers Outside BCBSTX Service Area	53
BlueCard Worldwide® Program	54
Administrative and Privacy Information	55
Plan Name	55
Plan Sponsor	55
Plan Administrator	55
Type of Plan	55
Claims Administrator	55
Plan Funding	56
Plan Year	56
Employer Identification Number	56
Group Number	56
Agent for Service of Legal Process	56
Qualified Medical Child Support Orders	56
Privacy Information	56
Privacy Questions	57
Future of the Plan	57

Welcome

Meeting Your Health Care Needs

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

This booklet includes definitions of terms you should know and detailed information about your TAMUS plans. Tips on how to use the plan effectively, answers to frequently asked questions, and a comprehensive table of contents to help you locate information you need are also included. If you have questions, call Customer Service at 1-866-295-1212, refer to the website (www.bcbstx.com/tamus), or contact your campus or agency.

The terms “you” and “your” as used in this benefits booklet refer to the retiree. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise. **Underlined** words are defined terms or hyperlinks to additional information. Whenever these terms are used, the meaning is consistent with the definition given.

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.

You are responsible for carefully reading this booklet so you will be aware of all the benefits and requirements of the TAMUS plans, including definitions and limitations and exclusions.

The TAMUS plans are funded by the Texas A&M University System. Medical claims are administered by BlueCross and BlueShield of Texas, a division of Health Care Service Corporation, a mutual legal reserve company, an independent licensee of the BlueCross and BlueShield Association. Pharmacy claims are administered by Express Scripts.

TAMUS, 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.

Español

Para información sobre sus beneficios en español, llame 1 (866) 295-1212 (oprima “2” para español).



Important Phone Numbers

Customer Service (**Benefits Value Advisor/BVA**)

1-866-295-1212

8 a.m. - 8 p.m. (Central Time)

Monday through Friday

Preauthorization

1-800-441-9188

7:30 a.m. - 6 p.m. (Central Time)

Monday through Friday

Behavioral Health

1-800-528-7264

8 a.m. - 5 p.m. (Central Time)

Monday through Friday

24/7 Nurseline

1-800-581-0368

Websites

TAMUS and Online Provider Directory

www.tamus.myevive.com

www.bcbstx.com/tamus

Express Scripts, Inc.

Prescription Drug Program – Customer Service

1-855-895-4647 – www.express-scripts.com

The A&M Care Health Plan is administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. Blue

Cross and Blue Shield of Texas provides claims payment services only and does not assume any financial risk or obligation with respect to claims.

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Identification Cards

The ID card issued to you by Blue Cross and Blue Shield of Texas identifies you as a ***participant*** in one of the TAMUS health plans. (You and your spouse will receive a separate ID card from Express Scripts for your pharmacy benefits.) Your ID card contains important information about you, your employer group, and the benefits to which you are entitled.

Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.

Any change in family status may require a new ID card be issued to you.

Unauthorized, Fraudulent, Improper, or Abusive Use of ID cards

The unauthorized, fraudulent, improper, or abusive use of ID cards issued to you and your covered family members will include, but not be limited to:

- Use of the ID card prior to your ***effective date***
- Use of the ID card after your date of termination of coverage under one of the TAMUS plans.

*The unauthorized, fraudulent, improper, or abusive use of ID cards by any ***participant*** can result in, but is not limited to, the following sanctions:*

- Denial of benefits
 - Recoupment from you or any of your covered family members of any benefit payments made
 - Notice to your institution Benefits Office of potential violations of law or professional ethics
-

How to Request ID Cards

Blue Cross and Blue Shield of Texas and Express Scripts will issue separate ID cards for the Medical and Prescription Drug plans. The cards will be mailed to your home address on file. There is no charge for ID cards. To request additional cards or to replace lost or damaged cards:

- **Medical:** Call Blue Cross and Blue Shield of Texas Customer Service at **1-866-295-1212**, or log onto Blue Access for Members through www.tamus.myevive.com to order Medical ID cards online or print a temporary ID card. A photo of your ID card can also be uploaded to the MyEvive app via your mobile phone.
- **Prescription Drug:** Call Express Scripts Medicare Part D customer service at **1-855-895-4647** or you can print one through the Express Scripts website, www.express-scripts.com. A photo of your ID card is also available through the new Express Scripts app (application) via your mobile phone.

Website Features

You can access helpful information and resource documents through your MyEvive portal. Go to www.tamus.myevive.com (requires registration) to:

- Connect seamlessly with Blue Access for Members and Express Scripts
- Complete a voluntary Health Assessment to receive personalized benefit recommendations
- Access to Resource Documentation
- Benefits Booklet
- Upload Virtual ID Cards for Medical and Pharmacy benefit plans
- Medical Policies
- Healthy Living Information
- Contact Information
- Frequently Asked Questions

How to register on MyEvive

- Click the “register” button at tamus.myevive.com
- Enter the following details:
- For your ID#, enter your employee UIN, which is the Unique Identification Number on your BCBSTX health insurance card. Note: Both employee and spouse will use the employee UIN to register.
- Select your status (Employee or Spouse)
- Enter your first name and last name, just as they appear on your BCBSTX health insurance card.
- Enter your birthday in the format MM/DD/YYYY.
- Select and confirm your preferred email address. Note: Your email address will serve as your username for future logins on MyEvive.
- Your password will need to contain at least: one capital letter, one number, and one special character.
- Provide your telephone number.
- Select how you would like to hear from MyEvive when a health or cost-saving opportunity is waiting for you
- Describe your status
- Log in and take a tour!

How to Find Blue Access for Members

- From tamus.myevive.com, click on the tile “Blue Access for Members”
- For your first time log in, you will need to register which requires your group number and ID# (employee UIN).
- Upon authentication, you will have direct access by clicking on the tile “Blue Access for Members”

Blue Access for Members (requires registration)

With Blue Access for Members you can:

- Check the status of a claim.
- Confirm who is covered under your plan.
- View and print detailed claim history and information (Explanation of Benefits/EOBs). **EOBs are available online. To receive copies by mail, you must log into Blue Access for Members through your MyEvive portal to elect to receive paper copies or call Customer Service for assistance.**
- Locate a physician or other provider in your network that meets your needs.
- Shop and compare provider costs for common procedures and treatments.
- Sign up to receive e-mail notifications of new claim activity.
- Request a new or replacement ID card or print a temporary ID card.

Your TAMUS Health Plan Benefits

Summary of Benefits - A&M Care 65 Plus

Payment for out-of-network (including **ParPlan**) services is limited to the **allowable amount** as determined by Blue Cross and Blue Shield of Texas. ParPlan providers accept the **allowable amount**. Any charges over the **allowable amount** for out-of-network services are the patient's responsibility and are in addition to **deductible, coinsurance** and **out-of-pocket maximums**. Annual deductibles, **out-of-pocket maximums** and annual limits are based on the plan year, which runs from September 1 through August 31. **Primary Care Physician** is abbreviated PCP. **Specialist** means any doctor or licensed practitioner physician's assistant who is not a general or family practitioner.

65 PLUS (Medicare Primary) - Medical	
Coverage	Benefit
Annual Plan Year Deductible (applicable when coinsurance is required)	\$400/person/plan year \$1,200/family/plan year
Annual Plan Year Out-of-Pocket Maximum Non-covered medical or prescription drug expenses, prescription drug penalties such as the mandatory generic substitute penalty and out-of-network hospital deductibles are not included in calculating the out-of-pocket maximum. BCBSTX and Express Scripts exchange out-of-pocket data so claims are processed correctly.	\$1,400/person/plan year \$2,800/family/plan year
Pre-existing Condition Limitation	None
Lifetime Maximum Benefit	No Limit
OFFICE SERVICES	
Preventive Care	Plan pays 100%
Diagnostic Office Visit	After deductible, plan pays 80%; you pay 20%
Diagnostic Lab and X-Ray	After deductible, plan pays 80%; you pay 20%
Other Diagnostic Tests	After deductible, plan pays 80%; you pay 20%
Allergy Testing	After deductible, plan pays 80%; you pay 20%
Allergy Serum/Injections	After deductible, plan pays 80%; you pay 20%
EMERGENCY CARE	
Ambulance Service	After deductible, plan pays 80%; you pay 20%
Hospital Emergency Room	After deductible, plan pays 80%; you pay 20%
Emergency Physician Services	After deductible, plan pays 80%; you pay 20%
OUTPATIENT CARE	
Observation	After deductible, plan pays 80%; you pay 20%
Surgery – Facility	After deductible, plan pays 80%; you pay 20%
Surgery – Physician	After deductible, plan pays 80%; you pay 20%
Diagnostic Lab and X-Ray	After deductible, plan pays 80%; you pay 20%
Other Diagnostic Tests	After deductible, plan pays 80%; you pay 20%
Outpatient Procedures	After deductible, plan pays 80%; you pay 20%
INPATIENT CARE	
Hospital – Semi-private Room and Board*	After deductible, plan pays 80%; you pay 20%
Hospital Inpatient Surgery*	After deductible, plan pays 80%; you pay 20%
Physician	After deductible, plan pays 80%; you pay 20%
Note: Newborn deductible waived for first 4 days of inpatient stay, including facility and physician services.	After deductible, plan pays 80%; you pay 20%
OBSTETRICAL CARE	
Prenatal and Postnatal Care Office Visits	After deductible, plan pays 80%; you pay 20%
Delivery – Facility/Inpatient Care*	After deductible, plan pays 80%; you pay 20%
Obstetrical Care and Delivery – Physician	After deductible, plan pays 80%; you pay 20%
THERAPY	
Chiropractic Care/Manipulations (max. 30 visits/person/plan year)	After deductible, plan pays 80%; you pay 20%
EXTENDED CARE	
Skilled Nursing/Convalescent Facility (max. 60 days/person/plan year)	After deductible, plan pays 80%; you pay 20%
Home Health Care Services and Private Duty Nursing (max. 60 visits/person/plan year)	After deductible, plan pays 80%; you pay 20%
Hospice Care Services ** (Limited to 6 months with possible extension for additional 6 months)	After deductible, plan pays 80%; you pay 20%
Bereavement Counseling (Limited to 15 visits)	After deductible, plan pays 80%; you pay 20%

65 PLUS (Medicare Primary) - Medical

Coverage	Benefit
BEHAVIORAL HEALTH	
Serious Mental Illness – Office Visit	After deductible, plan pays 80%; you pay 20%
Serious Mental Illness – Outpatient*	After deductible, plan pays 80%; you pay 20%
Serious Mental Illness – Inpatient*	After deductible, plan pays 80%; you pay 20%
Mental Illness – Office	After deductible, plan pays 80%; you pay 20%
Mental Illness – Outpatient*	After deductible, plan pays 80%; you pay 20%
Mental Illness – Inpatient*	After deductible, plan pays 80%; you pay 20%
Chemical Dependency – Office	After deductible, plan pays 80%; you pay 20%
Chemical Dependency – Outpatient Treatment*	After deductible, plan pays 80%; you pay 20%
Chemical Dependency – Inpatient Treatment*	After deductible, plan pays 80%; you pay 20%
OTHER SERVICES	
Durable Medical Equipment	After deductible, plan pays 80%; you pay 20%
Prosthetic Devices	After deductible, plan pays 80%; you pay 20%
Eye Examination	After deductible, plan pays 80%; you pay 20%
Hearing Aid	No deductible, plan pays 80% up to \$1000 per ear, you pay 20%

* For services provided out-of-network and out-of-area, any charges over the allowable amount are the patient's responsibility.

**These services require preauthorization to establish medical necessity; see [Preauthorization Requirements](#).

What is a ParPlan provider?

ParPlan providers have agreed to accept the Blue Cross and Blue Shield of Texas allowable amount and/or negotiated rates for covered services. When using ParPlan providers, benefits for covered services are reimbursed at the lower (out-of-network) level. In most cases, ParPlan providers will file the member's claims and preauthorize necessary services. The member is not responsible for costs exceeding the Blue Cross and Blue Shield of Texas allowable amount for covered services when ParPlan providers are used.

What happens if care is not available from a network provider?

If care is not available from a network provider as determined by Blue Cross and Blue Shield of Texas, and Blue Cross and Blue Shield of Texas preauthorizes your visit to a out-of-network provider prior to the visit, network benefits will be paid. Otherwise, out-of-network benefits will be paid, and the claim will have to be resubmitted for review and adjustment, if appropriate.

Medicare – Primary 65 PLUS - Pharmacy

Coverage	Express Scripts Network	Express Scripts Out-of-Network
Drug Deductible	\$0/per/plan year	\$0/person/plan year
Retail Short-Term (up to a 30-day supply) <ul style="list-style-type: none"> • Generic • Brand-name preferred drug • Brand-name non-preferred drug 	<ul style="list-style-type: none"> • \$10 Copay • \$35 Copay • \$60 Copay 	You will be reimbursed for 75% of the reasonable and customary charges after the deductible and copayment. You must file a claim for reimbursement with Express Scripts, Inc. within 12 months of service date.
Mail Order Pharmacy Service (up to a 90-day supply) <ul style="list-style-type: none"> • Generic • Brand-name preferred drug • Non-preferred drug 	<ul style="list-style-type: none"> • \$20 Copay • \$70 Copay • \$120 Copay, 	N/A
Retail-Plus Network (32- to 90-day supply at Retail-Plus participating pharmacies) <ul style="list-style-type: none"> • Generic • Brand-name preferred drug • Brand-name non-preferred drug 	<ul style="list-style-type: none"> • \$30 Copay • \$105 Copay • \$180 Copay 	You will be reimbursed for 75% of the reasonable and customary charges after the deductible and copayment. You must file a claim for reimbursement with Express Scripts, Inc. within 12 months of service date.

* For services provided out-of-network and out-of-area, any charges over the allowable amount are the patient's responsibility.

**These services require preauthorization to establish medical necessity; see [Preauthorization Requirements](#).

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.

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 preferred drug or non-preferred drug *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 preferred drug or non-preferred drug *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 brand-name preferred drug or brand-name non-preferred drug *copayment*.

Smart90 Network

The Smart90 Network is part of the nExpress Scripts Medicare Part D prescription plan, managed by Express Scripts. You do not have to get a 90-day supply of your maintenance medications. But to get a 90-day supply, you must either:

- fill those prescriptions through Walgreens,
- use home delivery from the Express Scripts PharmacySM.
- use an independent retail pharmacy in the Smart90 network.

If you were participating in the Diabetes Care Value Program, you can continue to receive your 90-day supply from the same location. To find out more information or to locate a pharmacy in the Smart90 network, contact Express Scripts Medicare customer service at 1-855-895-4647.

Freedom of Choice

Each time you need medical care, you can choose to:

See a Network Provider	See an Out-of-Network Provider <i>Par Plan</i> Provider	Out-of-Network Provider that is not a contracting provider
<ul style="list-style-type: none"> You receive the highest level of benefits (network benefits) You are not required to file claim forms You are not balance billed; network providers will not bill for costs exceeding the BCBSTX allowable amount for covered services Your provider will preauthorize necessary services 	<ul style="list-style-type: none"> You receive the lower level of benefits (non-network benefits) You are not required to file claim forms in most cases; ParPlan providers will usually file claims for you You are not balance billed; ParPlan providers will not bill for costs exceeding the BCBSTX allowable amount for covered services In most cases, ParPlan providers will preauthorize necessary services 	<ul style="list-style-type: none"> You receive out-of-network benefits (the lowest level of benefits) You are required to file your own claim forms You may be billed for charges exceeding the BCBSTX allowable amount for covered services You must preauthorize necessary services

Network vs. Out-of-Network Providers

Network	Out-of-Network (Including <i>ParPlan</i>)
<p>You pay lower out-of-pocket costs if you choose network care</p>	<p>Payment for out-of-network services is limited to the allowable amount as determined by BCBSTX. ParPlan providers accept the allowable amount. You are responsible for all charges billed by non-ParPlan providers which exceed the allowable amount.</p>
<p>If you need to...</p>	
<p>Visit a doctor or specialist <i>A “specialist” is any physician other than a family practitioner, internist, OB/GYN or pediatrician</i></p>	<ul style="list-style-type: none"> Visit any network doctor or specialist Pay the office visit copayment Pay any deductible and coinsurance Your doctor or other provider cannot charge more than the allowable amounts for covered services
<p>Receive preventive care</p>	<ul style="list-style-type: none"> Visit any licensed doctor or specialist Pay for the office visit File a claim and get reimbursed for the visit minus any deductible and coinsurance Your costs will be based on allowable amounts; the out-of-network doctor from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
<p>Receive emergency care</p>	<ul style="list-style-type: none"> Visit any licensed doctor or specialist Pay for the preventive care visit Your costs will be based on allowable amounts; the out-of-network doctor from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX.
<p>Be admitted to the hospital</p>	<ul style="list-style-type: none"> Call 911 or go to any hospital or doctor immediately; you will receive network benefits for <u>Emergency Care</u> as defined by the plan Pay any deductible and coinsurance (if admitted) (see <u>Emergency Care</u>)
<p>Be admitted to the hospital</p>	<ul style="list-style-type: none"> Your network doctor will preauthorize your admission You, a family member, your doctor or the hospital must preauthorize your admission

	Network	Out-of-Network (Including <i>ParPlan</i>)
	You pay lower out-of-pocket costs if you choose network care	Payment for out-of-network services is limited to the allowable amount as determined by BCBSTX. <i>ParPlan</i> providers accept the allowable amount. You are responsible for all charges billed by non- <i>ParPlan</i> providers which exceed the allowable amount.
If you need to...		
	<ul style="list-style-type: none"> • Go to the network hospital • Pay any applicable copayment, deductible and coinsurance 	<ul style="list-style-type: none"> • Go to any licensed hospital • Pay any deductible and coinsurance each time you are admitted • Your costs will be based on allowable amounts; the out-of-network doctor/facility from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
Receive behavioral health or chemical dependency services	<ul style="list-style-type: none"> • Call the behavioral health number on your ID card first to authorize all inpatient and certain outpatient care • See any licensed doctor or other provider, or go to any network hospital or facility • Pay any applicable copayment, deductible and coinsurance 	<ul style="list-style-type: none"> • Call the behavioral health number on your ID card first to authorize all inpatient and certain outpatient care • See any licensed doctor or other provider, or go to any licensed hospital or facility • Pay any deductible and coinsurance • Your costs will be based on allowable amounts; the out-of-network doctor or other provider from whom you receive services may require you to pay any charges over the allowable amounts determined by BCBSTX
File a claim	Claims will be filed for you	You may need to file the claim yourself

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a ***provider*** that does not contract with Blue Cross and Blue Shield of Texas (a non-contracting ***provider***), you receive out-of-network benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the Blue Cross and Blue Shield of Texas non-contracting ***allowable amount***, which in most cases is less than the ***allowable amount*** applicable for Blue Cross and Blue Shield of Texas contracted ***providers***. The non-contracted ***provider*** is not required to accept the Blue Cross and Blue Shield of Texas non-contracting ***allowable amount*** as payment in full and may balance bill you for the difference between the Blue Cross and Blue Shield of Texas non-contracting ***allowable amount*** and the non-contracting ***provider's*** billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies and procedures limited or not covered under your TAMUS medical plan and any applicable deductibles, ***coinsurance*** amounts, and ***copayment*** amounts.

Allowable Amount

The ***allowable amount*** is the maximum amount of benefits Blue Cross and Blue Shield of Texas will pay for eligible expenses you incur under your TAMUS medical plan. Blue Cross and Blue Shield of Texas has established an ***allowable amount*** for medically necessary services, supplies and procedures provided by ***providers*** that have contracted with Blue Cross and Blue Shield of Texas or any other Blue Cross and/or Blue Shield Plan and ***providers*** that have not contracted with Blue Cross and Blue Shield of Texas or any other Blue Cross and/or Blue Shield Plan. When you receive services, supplies, or care from a ***provider*** that does not contract with Blue Cross and Blue Shield of Texas, you will be responsible for any difference between the Blue Cross and Blue Shield of Texas ***allowable amount*** and the amount charged by the non-contracting ***provider***. You will also be responsible for charges for services, supplies and procedures limited or not covered under TAMUS medical plans, ***copayment*** amounts, ***deductibles***, any applicable ***coinsurance***, and ***out-of-pocket maximum*** amounts.

Predetermination of Benefits

As participants in one of the TAMUS Medical plans, you and your covered dependents are entitled to a review by the Blue Cross and Blue Shield of Texas medical Division to determine the medical necessity of any proposed medical procedure. It will inform you in advance if Blue Cross and Blue Shield of Texas considers the service to be medically necessary and, therefore, eligible for benefits. To have a predetermination conducted, have your physician provide a letter of medical necessity and any pertinent medical records supporting this position to Blue Cross and Blue Shield of Texas. After a decision is reached, you and your physician will be notified in writing. **Predetermination is not a guarantee of payment.**

Facility Fees

Some medical centers charge a separate facility fee for doctor visits or other procedures and services performed in an outpatient or inpatient facility. If your services take place at a medical center that charges a facility fee, you may be charged for outpatient or inpatient services. These fees can be up to a few hundred dollars for each visit—even if the provider is in the network. When making an appointment, always ask your provider's office if a separate facility fee will be charged for your visit.

Continuity of Care

In the event a participant is under the care of a network provider at the time such provider stops participating in the network and at the time of the network provider's termination, the participant has *special circumstances* such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, Blue Cross and Blue Shield of Texas will continue providing coverage for that provider's services at the in-network benefit level.

Special circumstances means a condition such that the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the participant. *Special circumstances* shall be identified by the treating physician or health care provider, who must request that the participant be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the participant of any amounts for which the participant would not be responsible if the physician or provider were still a network provider.

The continuity of coverage will not extend for more than ninety (90) days, or more than nine (9) months if the participant has been diagnosed with a terminal illness, beyond the date the provider's termination from the network takes effect. However, for participants past the 24th week of pregnancy at the time the provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care and the follow-up check-up within the first six (6) weeks of delivery.

Transitional Benefits

If you or a covered dependent are undergoing a course of medical treatment at the time of enrolling in A&M Care Health Plans and your provider is **not** in the PPO network, ongoing care with the current provider may be requested for a period of time. Transitional care benefits may be available if being treated for any of the following conditions by a non-network provider.

- Pregnancy (third trimester or high risk)
- Newly diagnosed cancer
- Terminal illness
- Recent heart attack
- Other ongoing acute care

Preauthorization Requirements

TAMUS requires advance approval (preauthorization) by Blue Cross and Blue Shield of Texas for certain services. Preauthorization establishes in advance the medical necessity of certain care and services covered under TAMUS. Preauthorization ensures that care and services will not be denied on the basis of medical necessity. However, preauthorization does not guarantee payment of benefits. Benefits are always subject to other applicable requirements, such as limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

The following types of services require preauthorization:

- All inpatient hospital admissions
- Skilled nursing care in a skilled nursing facility
- Home health care

- Hospice care
- Home infusion therapy (in a home setting)
- Motorized and customized wheelchairs and certain other durable medical equipment totaling over \$5,000
- Transplants
- All inpatient treatment of mental health care, chemical dependency and serious mental illness; and (See ***Serious Mental Illness***)
- The following outpatient treatment of mental health care, chemical dependency and serious mental illness:
 - Electroconvulsive therapy
 - Repetitive transcranial magnetic stimulation, and
 - Intensive outpatient program.

Intensive outpatient program means a freestanding or ***hospital***-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions that are unlikely to benefit from treatment programs that focus solely on mental illness conditions.

Care should also be preauthorized if you or your ***doctor*** wants to:

- Extend your ***hospital*** stay beyond the approved days (you or your ***doctor*** must call for an extension before your approved stay ends); or
- Transfer you to another facility or to or from a specialty unit within the facility.

Note: You must request preauthorization to use an out-of-network ***provider*** to receive the network level of benefits.

Preauthorization for *medical necessity* of services does not guarantee the network level of benefits. Even if approved by Blue Cross and Blue Shield of Texas, out-of-network ***providers*** paid at the network level may bill for charges exceeding the Blue Cross and Blue Shield of Texas ***allowable amount*** for covered services. You are responsible for these charges, which can be significant.

What happens if services are not preauthorized?

Blue Cross and Blue Shield of Texas will review the ***medical necessity*** of your treatment prior to the final benefit determination. If Blue Cross and Blue Shield of Texas determines the treatment or service is not medically necessary, benefits will be denied.

How to Preauthorize

To satisfy preauthorization requirements, you, your physician or other ***provider*** of services, or a family member must call the toll-free number (1-800-441-9188) on the back of your Medical ID Card. The call for preauthorization should be made between 7:30 a.m. and 6:00 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management ***nurse*** will follow up with your ***provider's*** office.

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.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient ***hospital admission***, the call for preauthorization should be made at least two working days before you are admitted unless it would delay ***emergency*** care. In an ***emergency***, preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

When an inpatient ***hospital admission*** is preauthorized, a length of stay is assigned. Your TAMUS medical ***plan*** is required to provide a minimum length of stay in a ***hospital*** facility for the following:

- Maternity Care
- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by Caesarean section
- Treatment of Breast Cancer
- 48 hours following a mastectomy
- 24 hours following a lymph node dissection

If you require a longer stay than was first preauthorized, your **provider** may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Note: Your **provider** will not be required to obtain preauthorization from Blue Cross and Blue Shield of Texas for prescribing a length of stay less than 48 hours (or 96 hours) for **maternity care**. If you require a longer stay, your **provider** must seek an extension for the additional days by obtaining preauthorization from Blue Cross and Blue Shield of Texas.

Preauthorization for Extended Care Expense and Home Infusion Therapy

Preauthorization for **extended care expense** and home infusion therapy (in a home setting) may be obtained by having the agency or facility providing the services contact Blue Cross and Blue Shield of Texas to request preauthorization. The request should be made:

- Prior to initiating **extended care expense** or home infusion therapy
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

Blue Cross and Blue Shield of Texas will review the information submitted prior to the start of **extended care expense** or home infusion therapy and will send a letter to you and the agency or facility confirming preauthorization or denying benefits. If **extended care expense** or home infusion therapy is to take place in less than one week, the agency or facility should call the preauthorization telephone number shown on your ID card (1-800-441-9188). If Blue Cross and Blue Shield of Texas has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Chemical Dependency, Serious Mental Illness, Mental Health Care

- All inpatient and certain outpatient treatment of chemical dependency, serious mental illness and mental health care should be preauthorized by calling the toll-free number on your ID card (1-800-528-7264).

Preauthorization for Applied Behavioral Analysis (ABA) Therapy

- TAMUS requires advance approval (preauthorization) by Blue Cross and Blue Shield of Texas for certain services. Preauthorization establishes in advance the **medical necessity** of certain care and services covered under TAMUS. Preauthorization ensures that care and services will not be denied on the basis of medical necessity. However, preauthorization does not guarantee payment of benefits. Benefits are always subject to other applicable requirements, such as limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

Benefits Value Advisor (BVA)

You have a choice when selecting where to go for health care. Many times you can choose between different **providers** or facilities and receive the same procedure at a lower cost. This is where Benefits Value Advisor (BVA) comes in. You can call a BVA and get cost comparison information from **providers** in your area or assistance with:

- MRIs, CAT/CT scans
- Knee, hip and spine surgery
- Maternity services
- Colonoscopies
- Find in-network **providers**
- Schedule visits for you
- Request preauthorization
- Access online educational tools

Accessing the BlueCard Program for Health Care Outside Texas



Your benefits travel with you. Your TAMUS Medical ID Card features the Blue Cross and Blue Shield symbols and the PPO-in-a-suitcase logo telling **providers** that you are part of the BlueCard program. This means that you and your covered dependents may use Blue Cross and Blue Shield network **providers** throughout the United States. Follow these steps to receive the network (highest) level of benefits offered under your **plan** while traveling or away from home:

1. If you are outside of Texas and need health care, call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest network **doctors** and **hospitals**.
2. Although network **providers** outside of Texas may preauthorize those services that require preauthorization (such as a **hospital admission**), it is ultimately your responsibility to obtain preauthorization by calling 1-800-441-9188.

3. When you arrive at the doctor's office or hospital, present your TAMUS Medical ID Card, and the doctor or hospital will verify eligibility and coverage information.
4. After you receive medical attention, the network provider will file claims for you.
5. You will be responsible for paying any applicable copayment, deductible, or coinsurance amounts, as well as any charges for non-covered services. BlueCard providers have agreed to accept the Blue Cross and Blue Shield Plan's allowable amount for covered services and will not bill you for any costs exceeding the allowable amount.

For more information, see the notice regarding other Blue Cross and Blue Shield's separate financial arrangements with providers.

Does TAMUS provide benefits for medical services outside the United States?

Yes. Through the BlueCard Worldwide program, you have access to hospitals on almost every continent and to a broad range of medical assistance services when you travel or live outside the United States. BlueCard Worldwide provides the following services:

- Provider location
- Referral information
- Medical monitoring
- Wire transfers/overseas mailing
- Translation
- Coverage verification
- Currency conversion

If you need to locate a doctor, other provider or hospital, or need medical assistance, call BlueCard Access at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. A medical assistance coordinator, in conjunction with a medical professional, will arrange hospitalization, if necessary. Network benefits will apply for inpatient care at BlueCard Worldwide hospitals.

In an emergency, go directly to the nearest hospital.

Call Blue Cross and Blue Shield of Texas for preauthorization, if necessary call 1-800-441-9188. The preauthorization phone number is different than the BlueCard Access number.)

In most cases, you will not need to pay for inpatient care at BlueCard Worldwide hospitals in advance. The hospital should submit your claim. You will, however, be responsible for the usual out-of-pocket expenses (non-covered services, copayment, deductible, and coinsurance amounts).

If you do not use a BlueCard Worldwide provider for care, you must pay the provider or hospital at the time of service and obtain proof of payment (itemized receipt). Then, you will need to complete and submit an international claim form, along with your proof of payment and send it to the BlueCard Worldwide Service Center to receive any applicable reimbursement for covered expenses. The claim form is available online at www.bcbstx.com/tamus.

Remember that bills from foreign providers differ from billing in the United States. The bills may be missing the provider's name and address, in addition to other critical information. It is very important that you fill out the BlueCard Worldwide claim form completely and attach your bills from the foreign provider. Missing information will delay claims processing.

What the A&M System Health Plan Covers

The following medical expenses are covered by the A&M System. The descriptions have been alphabetized for quick reference. Covered services may be subject to other plan limitations.

Refer to the Benefits Summaries for A&M System health plans of this booklet for more detailed information, including the applicable copayment, deductible and coinsurance.

What does medical necessity or medically necessary mean?

Supplies and services are covered only if they are medically necessary. This means that the services and supplies must be:

- Essential to, consistent with, and provided for diagnosis or the direct care or treatment of the condition, sickness, disease, injury, or bodily malfunction
- Within the standards of generally accepted health care practice as determined by Blue Cross and Blue Shield of Texas
- Not primarily for the convenience of the participant, his physician, the hospital or other provider
- The most economical supplies or levels of service appropriate for safe and effective treatment. When applied to hospitalization, this further means that the participant requires acute care as a bed patient due to the nature of the services provided or the participant's condition and the participant cannot receive safe or adequate care as an outpatient.

Medical necessity is determined by Blue Cross and Blue Shield of Texas, considering the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a physician may have prescribed treatment, such treatment may not be medically necessary within this definition. A determination of medical necessity does not guarantee payment unless the service is covered by the TAMUS medical plans.

Acquired Brain Injury

Benefits for medically necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an acquired brain injury.

To ensure that appropriate post-acute care treatment is provided, TAMUS includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Note: *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.

Allergy Care

Coverage is provided for testing and treatment for medically necessary allergy care. Allergy injections are not considered immunizations for purposes of the TAMUS preventive care benefit.

Ambulance Services

Reasonable and customary charges, as determined by BCBSTX, for transportation by professional ambulance to or from the nearest hospital or facility 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 1-866-295-1212.

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

Chiropractic Care

TAMUS plans cover manual manipulation and modalities of the spinal skeleton system and surround tissue to render proper alignment of bones and proper functions of nerves and joints. Treatment is limited to 30 visits per person each plan year for chiropractic care, physical therapy and occupational modalities in conjunction with physical therapy when performed in conjunction with modalities of the spine.

Clinical Trials

Benefits are available for services 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 a life-threatening disease or condition and is approved by:

- Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- National Institutes of Health;
- United States Food and Drug Administration;
- United States Department of Defense;
- United States Department of Veterans Affairs; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Benefits are not available for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

Cosmetic, Reconstructive, or Plastic Surgery

Cosmetic, reconstructive and/or plastic surgery is surgery which can be expected or is intended to improve the physical appearance of a participant, or is performed for psychological purposes; or restores form but does not correct or materially restore a bodily function. For cosmetic, reconstructive or plastic surgery, TAMUS covers only the following services if medically necessary:

- Treatment for correction of defects due to accidental injury while covered under TAMUS.
- Reconstructive surgery following cancer surgery.
- Surgery performed on a newborn child for the treatment or correction of a congenital defect, if continuously covered under TAMUS from date of birth.
- Reconstruction of the breast on which a mastectomy has been performed while covered under a health care plan offered by TAMUS; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses (two per plan year) and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

Benefits for eligible expenses will be the same as for the treatment of any other sickness as shown on the Benefits Summary. No other cosmetic, reconstructive or plastic surgery is covered unless particularly specified in this benefits booklet.

Dental Services and Covered Oral Surgery

General dental services are not covered by TAMUS. When medically necessary as determined by Blue Cross and Blue Shield of Texas and prescribed by your doctor, covered oral surgery is limited to:

- Covered oral surgery, including removal of complete/partial bony impacted teeth (soft tissue wisdom tooth removal is not a covered benefit);
- Services provided to a newborn for treatment or correction of a congenital defect;
- Correction of damage caused solely by external violent accidental injury to healthy, un-restored natural teeth and supporting tissues, if the accident occurs while the participant is covered by TAMUS. Services must be received within 24 months of the date of the accident or to the termination date of the TAMUS plan, whichever occurs first. (An injury sustained as a result of biting or chewing is not considered to be an accidental injury); and
- Orthognathic surgery (to age 19)

Facility and related services, when medically necessary, are covered for participants who are unable to undergo treatment in a dental office or under local anesthesia due to a documented physical, mental, or medical reason. Preauthorization is required. **The specific dental procedure is not covered under the TAMUS plan; only the facility and related services are covered.**

What is covered oral surgery?

Covered oral surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms, including benign tumors and cysts, and all malignant and premalignant lesions and growths;
 - Incision and drainage of facial abscess;
 - Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses;
 - Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) due to accident, trauma, congenital defects and developmental defects or a pathology.
-

Emergency Care and Treatment of Accidental Injury

Your TAMUS plan covers medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

In case of emergency, call 911 or go to the nearest emergency room. Whether you require hospitalization or not, you should notify your network physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

All emergency care, whether provided by a network provider or an out-of-network provider, will be eligible for the network level of benefits. If you continue to be treated by an out-of-network provider after you receive emergency care and you can safely be transferred to the care of a network provider, only out-of-network benefits will be available. Out-of-network providers may bill you for any charges exceeding the non-contracting allowable amount.

What is an *emergency*?

Emergency care means health care services provided in a hospital emergency facility (emergency room), freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement, or

In the case of a pregnant woman, serious jeopardy to the health of the fetus.

24/7 Nurseline

Available 24 hours a day, seven days a week; bilingual nurses available.

The 24/7 Nurseline can help:

- Decide if a situation is an emergency
- Answer health-related questions.
- Understand your condition

Hearing Aid Services

A Hearing Aid benefit is payable after certification by a licensed medical or osteopathic doctor that an eligible person has a hearing loss that may be lessened by the use of a hearing aid. The benefit is 80% of the expenses, up to a maximum of \$1,000.00 per ear (\$2,000.00 if a hearing aid is required for both ears). The deductible is not applicable to this benefit. In general, the benefit is payable only once in a three year period. This benefit amount may be adjusted periodically. Included in the benefit are:

- the cost of the hearing aid, the cost of batteries and other ancillary equipment provided at the time the hearing aid is purchased
- the doctor's hearing examination charges if such charges are not otherwise covered and the cost of service or repairs to the hearing aid.

A hearing aid purchased for either ear will be covered provided at least three years have elapsed since a prior claim. Any unused portion of the benefit may not be carried forward to a future benefit period.

Home Health Care and Private Duty Nursing (preauthorization required)

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 (preauthorization required)

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..

Hospital Admission (preauthorization required)

TAMUS covers room and board (up to the hospital's semiprivate room rate; a private-room rate is allowed only when medically necessary), general nursing care, and other hospital services and supplies. It does not cover personal items such as telephones and television rental.

Lab and X-Ray Services

Medically necessary laboratory and radiographic procedures, services and materials, including diagnostic X-rays, X-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services are covered when ordered by a provider.

Network providers are responsible for referring patients to network labs, imaging centers or an outpatient department of a network hospital for medically necessary lab and X-ray services that are not available in a provider's office. However, you should always remind your provider that you will receive a higher level of benefits offered under your plan when using network providers.

If care is not available from a network provider as determined by Blue Cross and Blue Shield of Texas, and Blue Cross and Blue Shield of Texas preauthorizes your visit to an out-of-network provider prior to the visit, network benefits will be paid. If an out-of-network provider is used, the participant will be responsible for any expenses exceeding the allowable amount.

In some situations, a provider or facility will refer the results of lab tests and X-rays to a radiologist or pathologist for a professional interpretation of the results. If an out-of-network provider is used, the participant will be responsible for any expenses exceeding the allowable amount.

Lab and X-ray services, including interpretations, performed outside the doctor's office at a free-standing network facility are paid at 100% of the allowable amount. Lab and X-ray services performed in conjunction with an outpatient procedure or inpatient at an in-network facility will be subject to deductible and coinsurance.

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 ***Primary Care Physician (PCP)*** or OB/GYN, you pay your ***PCP*** copay 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 an office visit ***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 - Mental Illness/Serious Mental Illness/Chemical Dependency

Mental Health Care

TAMUS covers charges for inpatient and outpatient mental health care for:

- Diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system used by Blue Cross and Blue Shield of Texas, whether or not the cause of the disease, disorder or condition is physical, chemical or mental in nature or origin
- Diagnosis or treatment of any symptom, condition, disease or disorder by a ***provider***, or any person working under the direction or supervision of a ***provider***, when the eligible expense is:

- Individual conjoint psychotherapy
- Individual, Group or Family Counseling
- Psychoanalysis
- Psychological testing and assessment
- For administering or monitoring of psychotropic drugs
- ***Hospital*** visits or consultations in a facility providing such care
- Electroconvulsive treatment
- Psychotropic drugs

All inpatient and some outpatient treatment for mental health should be preauthorized by calling **1-800-528-7264**.

Medically necessary mental health care in a ***psychiatric day treatment facility***, a ***crisis stabilization unit*** or facility, or a ***residential treatment center***, in lieu of hospitalization, will be considered inpatient ***hospital*** expense at a mental health facility. Each full day of mental health care in a ***psychiatric day treatment facility***, ***crisis stabilization unit*** or facility, or ***residential treatment center*** will count as a half day of inpatient care when calculating ***plan year*** limitations. ***Residential treatment centers*** are generally not covered for adults.

Serious Mental Illness

Benefits for the treatment of serious mental illness will be provided on the same basis as any other illness. Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*:

- Bipolar disorders (hypomanic, manic, depressive, and mixed)
- Depression in childhood and adolescence
- Major depressive disorders (single episode or recurrent)
- Obsessive-compulsive disorders
- Paranoid and other psychotic disorders
- Schizo-affective disorders (bipolar or depressive)
- Schizophrenia
- Applied Behavioral Analysis (ABA)

All inpatient and some outpatient treatment for serious mental illness should be preauthorized by calling 1-800-528-7264.

Chemical Dependency Treatment (preauthorization required)

Chemical dependency is the abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance. All inpatient and certain outpatient treatment for chemical dependency should be preauthorized by calling **1-800-528-7264**.

A series of treatments is a planned, structured, and organized program to promote chemical-free status. A program may include different facilities or modalities, such as inpatient detoxification, inpatient rehabilitation/ treatment, partial hospitalization or intensive outpatient treatment or a series of these levels of treatments without a lapse in treatment. A series is complete when a ***participant*** is discharged on medical advice or when a ***participant*** fails to materially comply with the treatment program.

Inpatient treatment of chemical dependency must be provided in a chemical dependency treatment center. Benefits for the medical management of acute, life-threatening intoxication (toxicity) in a ***hospital*** will be available on the same basis as any other illness.

Organ and Tissue Transplants (preauthorization required)

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung) and related services and supplies are covered if the:

- Transplant is not ***experimental/investigational*** in nature
- Donated human organs or tissue or an FDA-approved artificial device are used
- Recipient or donor is a ***participant*** under TAMUS (Benefits are also available to the donor who is not a ***participant*** under TAMUS)
- Transplant procedure is preauthorized
- Recipient meets all of the criteria established by Blue Cross and Blue Shield of Texas in its written medical policy guidelines, and
- Recipient meets all of the protocols established by the ***hospital*** in which the transplant is performed

Covered services and supplies include:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches
- Donor search and acceptability testing of potential live donors
- Removal of organs or tissues from deceased donors
- Transportation and storage of donated organs and tissues

Covered services and supplies related to an organ or tissue transplant include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, and complications arising from such transplant.

Services and supplies **not** covered by TAMUS include:

- Living and/or travel expenses of the recipient or live donor
- Expenses related to maintenance of life for purposes of organ or tissue donation
- Purchase of the organ or tissue
- Organs or tissue (xenograft) obtained from another species

Orthotics

TAMUS covers orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold body parts in a correct position) and crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom-designed for the purpose of assisting the function of a joint.

Non-covered items include, but are not limited to, splints or bandages available for purchase over the counter for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot; or foot alignment, arch supports, elastic stockings and garter belts.

Note: Foot orthotics are covered for the treatment of diabetes.

Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the participant's responsibility.

Outpatient Facility Services

TAMUS covers the following services provided through a hospital outpatient department or a free-standing facility when medically necessary:

- Radiation therapy
- Chemotherapy
- Dialysis
- Rehabilitation services
- Outpatient surgery

Preauthorization for outpatient procedures is not required, but calling customer service to confirm benefits before services are performed is recommended.

Preventive Care

TAMUS encourages preventive care and maintenance of good health. Covered services under this benefit must be billed by the provider as “preventive care.” Preventive care benefits will be provided for the following covered services and when using network providers, the services will not be subject to copayment, deductible, coinsurance or dollar maximums:

- 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;
- Evidenced-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
- Additional preventive care and screenings for women, not described 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 described above may change as USPSTF, CDC and HRSA guidelines are modified. For the most recent list of recommended services, check with your **doctor** or visit www.healthcare.gov.

Examples of covered services included are routine annual physicals; routine gynecological examinations, pap smears, mammograms; immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; routine bone density test; screening for prostate cancer and colorectal cancer (including routine colonoscopies); tobacco cessation counseling services; healthy diet counseling; and obesity screening/counseling. Examples of covered services for women with reproductive capacity are female sterilization procedures and specified FDA-approved contraception methods with a written prescription by a **health care practitioner**, including cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. Prescription contraceptives for women are covered under the pharmacy benefits administered by Express Scripts. To determine if a specific contraceptive drug or device is included in this benefit, contact customer service at the toll-free number on your identification card. The list of contraceptive drugs and devices covered under this benefit may change as FDA guidelines, medical management and medical policies are modified. NOTE: If religious employer exemption/eligible organization accommodation applies, ACA federal mandates pertaining to coverage of certain FDA-approved women's contraception methods and counseling with no cost sharing, may not be required.

Covered preventive care services not included in the description above may be subject to applicable **copayment**, **deductible**, and **coinsurance**. Examples include hearing screenings and early detection tests for cardiovascular disease.

You may find more information about covered preventive care services by visiting healthcare.gov or by contacting customer service at 1-866-295-1212. Please be aware that you may incur some cost if the preventive service is not the primary purpose of the visit or if your **doctor** bills for services that are not preventive.

More about Your Preventive Care Benefits

Benefits for the Prevention and Detection of Osteoporosis

If a **participant** is a *qualified individual*, as defined below, benefits will be determined on the same basis as for any other illness as shown on the *Benefits Summary*. Benefits are provided for medically accepted bone mass measurement for the detection of low bone mass and/or to determine the **participant's** risk of osteoporosis and fractures associated with osteoporosis.

Qualified individual means a **participant** who is:

- Postmenopausal and not receiving estrogen replacement therapy
- An individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or effectiveness of approved osteoporosis drug therapy

Benefits for Certain Tests for Detection of Prostate Cancer

If a male **participant** incurs medical-surgical expenses for diagnostic medical procedures incurred in conducting a medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided for:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test used for the detection of prostate cancer for each covered male who is at least 50 years of age and asymptomatic, or 40 years of age with a family history of prostate cancer or another prostate risk factor.

Benefits for Colorectal Cancer Screening

Benefits will be provided for colorectal cancer screening as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are provided as a surgical benefit as referenced in the *Benefits Summary*.

Benefits for Speech and Hearing Services

Benefits as shown on the *Benefits Summary* are available for the services of a physician or other professional **provider** to restore loss of or correct an impaired speech or hearing function. Any benefit payments made by Blue Cross and Blue Shield of Texas for hearing aids will apply toward the benefit maximum amount indicated on the *Benefits Summary*.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for a covered dependent child for a screening test for hearing loss from birth through the date the child is 30 days old and for necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits will be determined on the same basis as for other preventive care services as shown on the *Benefits Summary*, for each woman enrolled in a TAMUS plan for eligible expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus. **Note:** TAMUS provides coverage for the HPV vaccine.

Benefits for Certain Tests for Detection of Breast Cancer

Benefits will be determined on the same basis as for other preventive care services as shown on the *Benefits Summary*, for each woman enrolled in a TAMUS plan, for eligible expenses incurred for an annual medically recognized diagnostic examination for the early detection of breast cancer, including diagnostic mammograms.

Childhood Immunizations

Benefits for childhood immunizations will be determined at 100% of the **allowable amount**. Any **copayment**, **deductible**, and **coinsurance** and amounts will not be applicable. Benefits are available for:

- Diphtheria
- Hemophilus influenzae type B
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Varicella
- Any other immunization that is required by law for the child

Doses, recommended ages, and recommended populations vary. See the Advisory Committee on Immunization Practices' website for more information: www.cdc.gov/vaccines/recs/acip/default.htm. Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher. Covered services not included in the description above may be subject to applicable **copayment**, **deductible**, and **coinsurance**.

Professional Services

Covered services must be **medically necessary** as determined by Blue Cross and Blue Shield of Texas and provided by a licensed **doctor** or by other covered health **providers** as listed below. Benefits for services for diagnosis and treatment of illness or injury are available on an inpatient or an outpatient basis or in a **provider's** office.

This includes the following but is not an exclusive list?

- Certified Registered Nurse Anesthesia
 - Licensed Nurse Practitioner
 - Advanced Practice Nurse (APN)
 - Nurse Midwives Certified by the AMBCE (American Midwifery Certification Board Examination) and ACNM (American College of Nurse Midwives)
 - Licensed Physician Assistant
 - Licensed Physical Therapist
-

Prosthetic Devices

TAMUS provides coverage for prosthetic appliances, including replacements necessitated by growth to maturity of the **participant**. Coverage is provided for **medically necessary** artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of:

- An absent body organ (including contiguous tissue), or
- The function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses)

For purposes of this definition, a wig or hairpiece is **not** considered a prosthetic appliance.

Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the **participant**'s responsibility.

Skilled Nursing Facility (preauthorization required)

TAMUS covers care in a **skilled nursing facility** and pays benefits for:

- Room and board
- Routine medical services, supplies, and equipment provided by the **skilled nursing facility**
- General nursing care by a registered **nurse** (RN), advanced practice nurse (APN) or licensed vocational nurse (LVN)
- Physical, occupational, speech therapy, and respiratory therapy services by a licensed therapist

What is a skilled nursing facility?

A skilled nursing facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services. A skilled nursing facility is licensed in accordance with state law (where the state law provides for licensing of such facility) and is Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care. Skilled nursing facilities are not for individuals convalescing.

Care must be recertified every 30-days. **Custodial care** is not covered.

What the A&M Care Plan Does Not Cover

Limitations and Exclusions

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 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).

How Your A&M Care Plan Medicare Part D Prescription Drug Program Works

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 and you spouse 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 (855) 895-4647.

Prescription Drug Deductible

The plan has no annual deductible. You only pay the applicable copayments (see next section) for any remaining eligible drug purchases through the end of the plan year., 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 Mandatory Drug Substitution 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.

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 (855) 895-4647. 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 deter- mined 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 (855) 895-4647. 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 a 30-day, 60-day, 90-day supply of medication to the individual's home or physician's office. Supply is based on written prescription from a physician.
- 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, in most cases, all prescriptions 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. When you, your spouse or other dependents become eligible for Medicare (by turning age 65 or by approval from Social Security to receive disability benefits), it is important to investigate enrollment in Medicare Parts A and B. In most cases, if you do not enroll in Medicare when you're first eligible, you will have to pay a late enrollment penalty to Medicare for as long as you have Part B. For more information on Medicare Eligibility and Enrollment refer to the A&M System Benefits Administration website (<https://www.tamus.edu/business/benefits-administration/medicare-information/>), Medicare.gov or call 1-800-Medicare (800) 633-4227)

Medicare Part D is available if you qualify for Medicare Part A and/or Part B. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some offer more coverage for a higher premium. The Texas A&M University System has determined that the prescription drug coverage offered by the A&M Care Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a separate Medicare drug plan when you are eligible.

You can join when you first become eligible for Medicare, and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable drug coverage through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current A&M System coverage will be affected. You cannot be enrolled in both the 65+ plan and a Non-A&M System Medicare Part D plan. You can stay in the A&M Care plan if you must enroll in a Non-A&M System Medicare Part D plan. You will not receive a drug benefit from your System health plan, but your System health premiums will not decrease. If you decide to join a Medicare drug plan and drop your current coverage, which would mean your medical and drug coverage, you and your dependents will be able to get this coverage back during annual enrollment unless you are a "survivor".

If you drop or lose your current coverage with the A&M System and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. Your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information, visit www.medicare.gov; call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help OR call (800) MEDICARE ((800) 633-4227). TTY users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit Social Security on the web at www.socialsecurity.gov, or call them at (800) 772-1213 (TTY (800) 325-0778).

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 in “*Smoking Cessation and Weight Loss*”),
- anorectics or those used for weight control (except as covered under the weight loss program),
 - 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.

Specialty pharmacy copay assistance program

Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum. Although the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant, and copays for certain specialty medications may be set to the max of the current plan design or any available manufacturer-funded copay assistance.

A&M Care Plan Claims and Appeals

How to File a Medical Claim

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 medical claim, follow these steps:

1 Get a claim form	Claim forms are available from your institution or agency Human Resources office, or you can download a claim form from the website by logging onto www.bcbstx.com/tamus . Use a separate claim form for each individual; do not combine expenses for family members on one claim form.
2 Complete the claim form	Complete all information requested on the claim form. Any missing information, especially the items listed below, will cause a delay in processing your claim. <ul style="list-style-type: none">• Patient's name• Subscriber number, including the alpha prefix (ex. TXW)• Correct address• Diagnosis (preferably indicated by your provider on an itemized bill)• Date of injury, illness, or pregnancy• Whether the patient has other group health insurance coverage
3 Attach an itemized bill	Attach an itemized bill to the completed claim form. An itemized bill includes the following information that is critical to prompt processing of your claim: <ul style="list-style-type: none">• Name and address of the provider providing the services or supplies• Date of service• Type of service• Charges for each service• Patient's name• Diagnosis
4 Mail the claim form and itemized bills <i>Keep a copy of the claim form and itemized bills for your records.</i>	Send the claim form and itemized bills to: BCBSTX, P.O. Box 660044, Dallas, TX 75266-0044. (The address also appears on the form.) Do not send the claim form to the A&M System. This will only delay processing. Note: Foreign claims must be translated. If no translation is attached, processing may be delayed. <i>You must file and Blue Cross and Blue Shield of Texas must receive claims for expenses within 12 months after the date of service.</i>
5 Review your Explanation of Benefits (EOB) statement after the claim is processed	The EOB will confirm if the expense is covered by A&M CARE HEALTH PLAN and is eligible for payment. If so, you or the provider will receive a check. If your claim is denied, the EOB will state the reasons why. Note: EOBs are available online through Blue Access for Members at www.bcbstx.com/tamus ; you must log in and elect to receive paper copies by mail.

To assist providers in filing your claims, you should always carry your A&M CARE HEALTH PLAN ID card with you. 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.

Receipt of Claims

A claim will not be considered received for processing until Blue Cross and Blue Shield of Texas actually receives the claim at the proper address and with all of the required information. If the claim is not complete, Blue Cross and Blue Shield of Texas will return it. On claims that need further information for proper processing, Blue Cross and Blue Shield of Texas may contact either you or the ***provider*** for the additional information. The claim will be processed when Blue Cross and Blue Shield of Texas receives all the requested information. After processing the claim, BCBSTX will notify the ***participant*** by way of an Explanation of Benefits summary.

Review of Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion to interpret and determine benefits in accordance with A&M CARE HEALTH PLAN plan provisions. BCBSTX will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between BCBSTX and the A&M System.

You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your A&M CARE HEALTH PLAN medical plan.

If a Claim Is Denied or Not Paid in Full

On occasion, BCBSTX 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 BCBSTX; then review this Benefits 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 BCBSTX and request a review of the decision.

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

- The reasons for the determination;
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, 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 BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of claim denial 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 BCBSTX;
- 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 on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claim. An urgent care/expedited claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- 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:

- A reason for the determination;
- A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
- 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;
- 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;
- 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);
- 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, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision;
- 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.
- 5. 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.
- 6. **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).

You can review the fact sheets on the System Benefits Administration website at:

<http://www.tamus.edu/business/benefits-administration/medicare-information/> for more 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 65 + 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

65 PLUS Plan: FY19 \$400 deductible; Medicare Part B Deductible: CY19 \$183

*Because A&M Care 65+'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 65 + 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 Open Enrollment not to continue coverage,
- the last day of the month in which you elect to terminate coverage due to a Life Event, 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 Open Enrollment not to continue dependent coverage,
- the last day of the month in which you elect to drop dependent coverage due to a Life Event, 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 (unless coverage was dropped for nonpayment), 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 (unless coverage was dropped for nonpayment), 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 under Eligibility 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 O Enrollment or due to a Life Event, 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 P&A Group 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...
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Coverage for you and/or your covered family members can be extended for up to 18 months.
<ul style="list-style-type: none"> • You die, or • You divorce or legally separate, or • Your covered child no longer qualifies for coverage 	<ul style="list-style-type: none"> • Coverage for your covered family members can be extended for up to 36 months • Coverage for the child can be extended for up to 36 months
<p>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.</p>	<p>Coverage for the disabled person and all covered family members can be extended for up to 29 months.</p>

COBRA Timeline	
If...	Then...
<ul style="list-style-type: none"> • You divorce, or • Your child becomes ineligible for coverage 	<ul style="list-style-type: none"> • You and/or your dependents have 60 days after the event to notify Human Resources of the event. • The COBRA Vendor has 14 days to send you and/or your dependents a COBRA enrollment form. • You and/or your dependents have 60 days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form. • You and/or your dependents have 45 days after making your election to pay premiums.

If..	Then...
<ul style="list-style-type: none"> • You leave employment, • Your hours are reduced, • You go on leave without pay, or • You die 	<ul style="list-style-type: none"> • The COBRA Vendor has 14 days after your notification to send you and/or your dependents a COBRA enrollment form. • You and/or your dependents have 60 days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form. • You and/or your dependents have 45 days after making your election to pay premiums.

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.

TAMUS Health Plan Provisions

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.

Dependent Eligibility

You may choose to cover any or all of your eligible dependents. If you enroll your dependents, you must enroll them in the same plan in which you enrolled yourself.

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.

Qualifying Life Events

You can change dependent coverage during Open Enrollment (changes effective September 1) or

within 60-days of a Qualifying Life Event. Life Events 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 open 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 Life Event. 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 Open Enrollment period or your next Life Event.

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
- **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.

Clinical Ecology, means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

- Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);

- Urine auto injection (injecting one's own urine into the tissue of the body);
- Skin irritation by Rinkel method;
- Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

The A&M System does not provide coverage for clinical ecology; the definition is included for clarification purposes only.

Coinsurance is A participant's share of covered services and supplies, not counting the deductible or copays. It is usually a percentage of the allowable amount. For example, if the coinsurance amount is "80/20" that means that the A&M Care Plan pays 80% and you pay 20% of the allowable amount for the eligible charges.

Copayment (Copay): The set amount you pay for certain medical services and prescription drugs at the time of service. The \$30 amount a participant must pay for an FCP office visit when using network physicians is an example of a copay amount. **Creditable Coverage:** Prior health coverage under various plans including, but not limited to, group health plans, individual health policies, Medicare, and Medicaid.

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 per-form 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.

Deductible is the amount of out-of-pocket expense that must be paid for health care services by the covered individual before becoming payable by the A&M System Health Plan. The family deductible means three individuals in the family must each meet a plan year deductible under one A&M System Health Plan subscriber identification number

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

Effective Date: The date the participant's coverage begins under A&M System Health Plan or any portion for which the participant has enrolled.

Eligibility Date: The date the participant satisfies the definition of a(n) employee, retiree, or dependent and is in a class eligible for coverage under the A&M Care Plans or Graduate Student Employee Health Plan.

Emergency: An emergency is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate care could result in:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

The A&M Care Plan covers medical emergencies wherever they occur. In case of emergency, call 911 or go to the nearest emergency room.

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.).

Out-of-Pocket Maximum means your share of eligible expenses incurred during a plan year. After you reach the out-of-pocket maximum, the A&M Care Plan pays 100% of the allowable amount for covered charges for the rest of the plan year. *Preauthorization penalties and billed charges exceeding the Blue Cross and Blue Shield of Texas allowable amount do not apply to the out-of-pocket maximum.*

Participant: An employee, or retiree or a dependent whose coverage has become effective according to the requirements of The A&M System Health Plans.

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.

Notices

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.

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.

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.

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.

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.

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 A&M Care 65 Plus Plan (65 + Plan).

Plan Sponsor

Director of 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 Director of 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 Ellen Gerescher, 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