

A&M Care Plan

Vendor: Blue Cross Blue Shield of Texas (BxBSTX)

Member Services Contact Information:

Blue Cross and Blue Shield of Texas: 1 (866) 295-1212

Information about networks outside of Texas: 1 (800) 810-BLUE (2583)

Website: bcbstx.com/tamus

This is a Preferred Provider Organization (PPO). Costs are higher if non-network providers are used.

* Retirees age 65 and older are not eligible for copays.

	Network Provider	Brazos Valley Network (BVN)	Baylor Scott & White Health (Brazos Valley)	Non-Network
Limitations and Restrictions				
Pre-existing condition limitations:	None	None	None	None
Benefit Maximum:	None	None	None	None
Out-of-service area restrictions:	Emergency care - must notify BCBSTX within 48 hours	Emergency care - must notify BCBSTX within 48 hours	Emergency care - must notify BCBSTX within 48 hours	Emergency Care
Maximums and Deductibles				
Deductibles:	\$400 Medical/\$50 Rx	\$400 Medical/\$50 Rx	\$400 Medical/\$50 Rx	\$800 Medical/\$400 Hospital
Out-of-pocket maximum:	\$5,000 + the \$400 medical deductible above \$10,000 + \$1,200 family deductible	\$5,000 + the \$400 medical deductible above \$10,000 + \$1,200 family deductible	\$5,000 + the \$400 medical deductible above \$10,000 + \$1,200 family deductible	\$10,000 + \$800 deductible per person \$20,000 + \$2,400 family deductible
Benefit maximum:	No annual/lifetime maximums, except those listed below			
Hospital Benefits				
In-Hospital care:	20% after deductible	10% after deductible	10% after deductible	\$400/admission + deductible, then 50%
Emergency Room:	\$200 copay (waived if admitted to the hospital) + 20% after deductible	\$200 copay (waived if admitted to the hospital) +10% after deductible	\$200 copay (waived if admitted to the hospital) +10% after deductible	\$200 copay (waived if admitted to the hospital) +20% after deductible if emergency; otherwise 50% after deductible
Surgery:	20% after deductible; In-physician's office, See office visit	10% after deductible	10% after deductible	50% after deductible 50% after deductible
Non-Hospital Visits				
*Office visits:	Primary Care: \$20/visit Specialist: \$30/visit Certain surgeries: 20% after deductible	Primary Care: \$5/visit Specialist: \$15/visit	Primary Care: \$20/visit Specialist: \$15/visit	50% after deductible

	Network Provider	Brazos Valley Network (BVN)	Baylor Scott & White Health (Brazos Valley)	Non-Network
A&M Care Plan Information (cont)				
Preventive exam:	100% covered	100% covered	100% covered	Not covered
Lab/X-rays:	Benefit depends on setting & procedure	Benefit depends on setting & procedure	Benefit depends on setting & procedure	50% after deductible
Skilled nursing facility (not custodial care):	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Home health care:	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Other Healthcare Benefits				
*Chiropractic care:	\$30/visit; 30 visits/plan year	\$15/visit; 30 visits/plan year	\$15/visit; 30 visits/plan year	50% after deductible; 30 visits/plan year
Durable medical equipment:	20% after deductible	10% after deductible	10% after deductible	50% after deductible
*Maternity care:	Hospital: 20% after deductible; Doctor: \$20 initial visit only	Hospital: 10% after deductible; Doctor: \$5 initial visit only	Hospital: 10% after deductible; Doctor: \$20 initial visit only	Hospital: 50% after deductible; Doctor: 50% after deductible
*Mental health:	Inpatient: 20% after deductible; Outpatient: \$20/visit	Inpatient: 10% after deductible; Outpatient: \$5/visit	Inpatient: 10% after deductible; Outpatient: \$20/visit	Inpatient: 50% after deductible; Outpatient: 50% after deductible
*Physical therapy:	\$30/visit	\$15/visit	\$15/visit	50% after deductible
*Vision:	\$30/visit	\$15/visit	\$15/visit	Routine preventive eye exams not covered
Hearing:	Illness/accident coverage; 20% coinsurance, one hearing aid per ear, every 36 months	Illness/accident coverage; 20% coinsurance, one hearing aid per ear, every 36 months	Illness/accident coverage; 20% coinsurance, one hearing aid per ear, every 36 months	Illness/accident coverage; 20% coinsurance
Prescription Drug Vendor: Express Scripts				
Member Services Contact Information: 1 (866) 544-6970 express-scripts.com/				
After you meet the \$50/person/plan year prescription drug deductible (three-person maximum):				
<ul style="list-style-type: none"> 30-day supply: \$10/generic, \$35/brand-name formulary, \$60/brand-name non-formulary; brand-name copayment + difference between brand name and generic when available 90-day supply: Two copayments required if purchased by mail-order; three if purchased through most retail pharmacies 				

For more information

Medical Summary Plan Description Booklet:

assets.system.tamus.edu/files/benefits/website/SPDs/SPDHealth.pdf