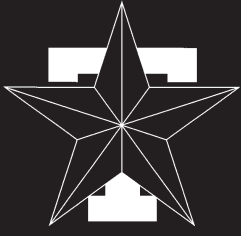




The Texas A&M University System

Your A&M System Health Plan

Updated September 2008



INTRODUCTION

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

Few things in life are as important as your health—and the health of your family. Staying healthy is the ideal for all of us, but sometimes that’s not possible. Whether it’s minor or major, an illness or an injury, we all have a need for health care at some point. And at that point, getting quality care at an affordable price is our biggest concern.

Your Texas A&M University System Health Plan can help ease your concerns. Your health coverage helps you pay the cost of medical care—whether that cost is modest or extreme. The plan helps ensure that you and your family have access to the help you need to protect your health.

The A&M Care plans are funded by The Texas A&M University System, and claims are administered by BlueCross BlueShield of Texas, Inc. (BCBSTX).

This booklet provides a summary of your medical coverage in everyday language. Most of your questions can be answered by referring to this booklet.

Terms that have a specific meaning or may be unfamiliar to you appear in italics. These are defined in the “Definitions” section at the end of this booklet.

This plan is governed by a plan document that includes the information in 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.

ESPAÑOL

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

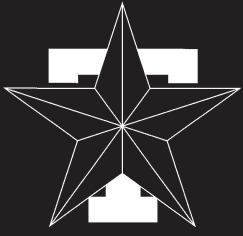
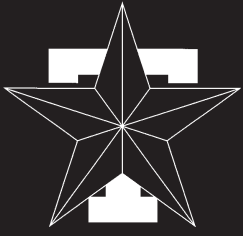


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PARTICIPATION

All full-time and many part-time employees and retirees and their eligible dependents are eligible for health coverage. Coverage can begin on your first day of work.

You and your dependents are eligible to participate in the A&M Care health plans if you:

- ☆ are eligible to participate in the Teacher Retirement System of Texas (TRS) or Optional Retirement Program (ORP), and
- ☆ work at least 50% time for at least 4½ months.

You and your dependents are also eligible if you are a graduate student employee who works at least 50% time for at least 4½ months, or if you are a postdoctoral fellow. To be eligible for coverage as a retiree, you must meet the criteria listed in the chart on the next page.

Eligibility for this plan is subject to change by the A&M System or the Texas Legislature.

ELIGIBLE DEPENDENTS

You may choose to cover any or all of your eligible dependents. Dependents eligible for coverage include:

- ☆ your spouse, and
- ☆ your unmarried, dependent children younger than 25.

Your spouse must be a spouse as defined by Texas law. 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 whom you have received a court order to provide health care coverage.

You may be asked to provide legal papers to verify your relationship to a child who is not your natural child (for example, court documentation of guardianship).

Coverage for a child may continue beyond age 25 only 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 25th birthday. This will allow time for you to obtain and complete the necessary forms for coverage to continue. Periodically, you may be required to provide evidence of the child's continuing disability and your support.

ENROLLING IN THE PLAN

The employer contribution will be applied toward your health premiums

beginning on your employer contribution eligibility date (the first of the month following your 90th day of employment or benefit eligibility). On this day, you will automatically be enrolled in employee-only coverage under A&M Care 350 unless during your 60-day enrollment period you:

- ☆ elect different coverage,
- ☆ elect coverage for your dependents, or
- ☆ waive coverage on yourself.

If you do not make any changes during your enrollment period, you must wait until you have a Change in Status (see page 6–7) or until the next Annual Enrollment period to enroll.

Likewise, if you gain a new dependent, you must enroll that dependent within 60 days or wait until the next Annual Enrollment period.

You can choose to have your health coverage take effect before your employer contribution eligibility date.

RETIREE ELIGIBILITY

If you were retired from or employed in a benefits-eligible position with the A&M System on Aug. 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 Sept. 1, 2003, but you met the above criteria as of Aug. 31, 2003, you qualify for retiree benefit coverage under these criteria.

If you are in TRS and you retire after Aug. 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 Aug. 31, 2003, or if you left A&M System employment before Aug. 31, 2003, and did not meet the criteria listed at left as of Aug. 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.

However, if you do, you must pay the full monthly premium yourself.

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

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

FORMER EMPLOYEES

You are eligible for coverage as a retiree if you are a former employee who meets the eligibility criteria listed on the previous page.

You may apply for coverage within 60 days of meeting this criteria or within 60 days of leaving a TRS-eligible position with another state employer after meeting the eligibility criteria. In these cases, you may choose to have your coverage become effective on the first of the month following the date the Human Resources office receives your application or on your employer contribution eligibility date (the first of the month that falls at least 90 days after the Human Resources office receives your application).

If you do not enroll on one of these dates, you may enroll during a later Annual Enrollment period. In that case, you can choose to have your coverage become effective on the next Sept. 1 or Dec. 1.

YOUR OPTIONS

You may choose either A&M Care 350 or A&M Care 1250. If you are retired and you (and your spouse if you wish to enroll him/her) are both on Medicare and working for the A&M System no more than six months of the plan year, you have the additional choice of the 65 PLUS plan.

You also have a choice of four levels of coverage:

- ☆ employee/retiree only,
- ☆ employee/retiree and spouse,
- ☆ employee/retiree and children, or
- ☆ employee/retiree and family (spouse and children).

If you enroll your dependents, you must enroll them in the same plan in which you enrolled yourself.

CHANGING YOUR COVERAGE

You can change your A&M Care plan choice, coverage level or dependents covered only during Annual Enrollment (changes effective Sept. 1) or within 60 days of a Change in Status.

Changes in Status include:

- ☆ employee's marriage or divorce or death of employee's spouse,
- ☆ birth, adoption or death of a dependent child,
- ☆ change in employee's, spouse's or dependent child's employment status that affects benefit eligibility,

- ☆ child becoming ineligible for coverage due to reaching age 25 or marrying,
- ☆ changes in the employee's, spouse's or a dependent child's residence that would affect eligibility for coverage,
- ☆ employee's receipt of a qualified medical child support order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) medical coverage for a child,
- ☆ changes made by a spouse or dependent child during his/her annual enrollment period with another employer,
- ☆ the employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid, or
- ☆ significant employer- or carrier-initiated changes in or cancellation of the employee's, spouse's or dependent child's coverage.

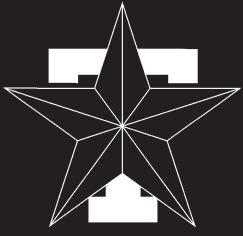
Changes in coverage must be consistent with the Change in Status. For example, if you have a baby, you may add that child to your coverage, but you may not drop your other children.

A divorce is considered official when the trial court announces its decision in open court or by written memorandum filed with the clerk. You must provide documentation to drop your divorced spouse.

NEWBORN CHILDREN

If you are covered by the plan, your newborn child or children are automatically covered from birth for 31 days.

However, to keep coverage, you *must* notify your Human Resources office of the addition within 60 days of the child's birth. Otherwise, coverage for that child will end after 31 days. You must then wait until the next Annual Enrollment period or until you have a Change in Status if you later want to enroll the child.



COVERAGE COST

You and the System share the cost of health coverage. You can pay your share on a before-tax basis.

Each month, beginning with the month after your 90th day of employment, your employer makes a contribution toward your health coverage. In some cases, this is enough to cover the entire premium. In other cases, you must pay part of the cost yourself.

If coverage for you or your dependents begins in the middle of a month, you must pay your share of the premium for the entire month.

Through the Pretax Premiums Plan, your share of any premium is automatically deducted from your paycheck on a before-tax basis. This means you never pay federal income tax or Social Security tax on the money you pay for your health coverage.

When you pay premiums on a before-tax basis, your taxable income is reduced. This may mean that your eventual Social Security benefit could be reduced. However, the reduction is quite small. Your base pay, for purposes of pay increases and benefits based on pay, is not reduced.

If you participate, your spouse's premiums will be deducted on a pretax

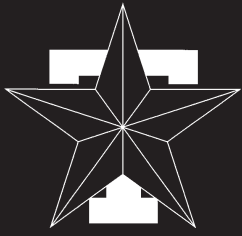
basis as well. Your dependent children's premiums can also be deducted pretax if you certify each year that at least one of your covered dependent children meets one of the following criteria:

- ☆ The child is 18 or younger on Dec. 31 of that year.
- ☆ If the child is older than 18 but younger than 24 on Dec. 31 of that year and is a full-time student, he/she must provide less than half of his/her own financial support. You or someone else provides the rest.
- ☆ If the child is older than 18 on Dec. 31 of that year and not a student, or if the child is age 24 and a full-time student, he/she must receive more than half of his/her financial support from you.

If you would prefer to have your contributions paid after taxes have been deducted, contact your Human Resources office for the correct form.

You may change to or from before-tax premiums only during Annual Enrollment each year (effective Sept. 1) or when you have a Change in Status, as described on pages 6-7.

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



HOW HEALTH COVERAGE WORKS

You choose between A&M Care 350 and A&M Care 1250.

All employees and retirees can choose between A&M Care 350 and A&M Care 1250. The two plans cover the same services but have different deductibles, cost-sharing percentages, out-of-pocket maximums and monthly premiums, as shown in the charts on pages 18–21.

Retirees have the additional choice of the 65 PLUS plan if the retiree and spouse, if covered, are both enrolled in Medicare Parts A and B and working for the A&M System no more than six months of the plan year.

Whichever plan you choose, whether you receive network or non-network benefits depends on where you live, unless you are retired and eligible for Medicare (see “If You Are Retired,” page 10).

You or your dependents choose which health care providers to use. BCBSTX does not provide services or supplies but only pays benefits for eligible expenses. BCBSTX is not liable for any act or omission by any health care provider and has no responsibility for a health care provider’s failure or refusal to provide services or supplies to you or your dependents. The health care provider determines the care and treatment you or your

dependents receive. BCBSTX does not control, influence or participate in health care treatment decisions made by your health care providers.

The health care providers, their employees, their agents and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX. They are independent contractors.

When you enroll, you will receive a plan ID card that you present when you access services. Your ID card will include an ID number that is not your Social Security number. You will receive a separate drug plan ID card from Caremark (see “Prescription Drugs,” page 38).

NETWORK AND NON-NETWORK

For active employees and retirees for whom Medicare is not primary, how benefits are paid under either plan depends on whether you live in a network service area or a non-network service area. This is determined by your home ZIP code.

All Texas counties except Donley, Hansford, Lipscomb, Ochiltree and Wheeler are network areas. If you live outside of Texas but within the United States, you are in a network area. You may call your Human Resources office or BCBSTX Customer Service, (866) 295-1212, to find out if you live in a network service area.

If you live in a Texas non-network area and are not eligible for Medicare, you will receive network benefits if you travel to a network area and use a network *doctor* or *hospital*.

NETWORK AND OUT-OF-NETWORK

If you live in a network service area, whether you receive network or out-of-network benefits depends on which *doctors* and *hospitals* you choose.

If you live in a network area, each time you need medical care, you can choose to use a *network* or *out-of-network doctor* or *hospital*. You will receive higher benefits from the plan if you use a network provider.

If you live in a network area in Texas, the BlueChoice network is available. If you live or are traveling anywhere outside Texas, the BlueCard network is available.

You may call BCBSTX Customer Service at (866) 295-1212 to find out if a specific *doctor* or *hospital* is in the network or to request a directory for your area. You may also search for doctors on the BCBSTX web page (www.bcbstx.com).

If you are outside Texas, you may call the toll-free number on the back of your ID card, (800) 810-2583, to locate a BlueCard network *doctor* or facility in your area.

Other Blue Cross and Blue Shield Plans outside of Texas, called Host Blue, may have contracts with certain health care providers in their service areas. When you receive health care services through BlueCard (network providers outside of Texas) from a provider who does not have a contract with BCBSTX, the amount you pay for covered services is based on the lower of the billed charges or the negotiated price that the Host Blue passes on to BCBSTX.

In general, the next few pages show how each of the types of benefits work. More specific information is shown in the comparison chart on pages 18–21.

IF YOU ARE RETIRED

If you are a retiree for whom Medicare is not primary and you live in a network area, you receive network benefits if you use a network provider and out-of-network benefits if you use a provider not in the network. Your spouse will receive the same benefits if Medicare is not primary for him/her.

All retirees and their spouses for whom Medicare is primary receive non-network benefits no matter where they live or what providers they use. Retirees and spouses for whom Medicare is primary are not eligible for network benefits because of the need to coordinate with Medicare.

For more information about coordination with Medicare, see page 50.

When this plan coordinates with Medicare, benefits are calculated as if you are enrolled in Medicare parts A and B, even if you do not enroll in both parts. For this reason, you should enroll in Medicare parts A and B as soon as you become eligible.

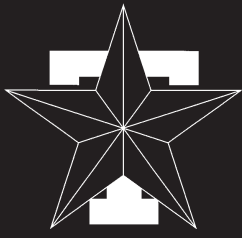
NONREPRESENTED SPECIALTIES

If you need to see a specialist and no network *doctor* with that specialty is in your area, you may be able to see a local specialist not in the network for a \$45 copayment. You or your *doctor* must call BCBSTX in advance to discuss the situation and seek approval. If you need to travel to a larger city for a specialist, you must use a network specialist if one is available in order to receive network benefits, including the \$45 copayment.

REFERRALS

While you are not required to obtain a referral from your network *doctor* to see a specialist, in some cases you may wish to do so. Ideally, your network *doctor* will refer you only to other network *doctors*. *However, it is your responsibility to check to be sure any doctor you see is in the network if you wish to receive network benefits.*

Physicians have individual contracts with BCBSTX. If you go to a doctor in a group practice, be sure the doctor treating you is in the network. If you go to an out-of-network *doctor* on referral from your network *doctor*, you will receive out-of-network benefits. You may contact BCBSTX if you believe that you must see a particular out-of-network specialist. BCBSTX will evaluate the situation and determine whether to allow network benefits.



NETWORK BENEFITS

If you live in a network area and use a BlueChoice or BlueCard network doctor or hospital, you receive network benefits.

If you go to a *primary care physician* (*PCP*) who participates in the BlueChoice or BlueCard networks, you pay \$25 for an office visit and most related services. Related services include most lab tests and X-rays performed in conjunction with the office visit even if they are done later. The plan pays all other eligible costs. If you go to a *specialist*, you pay \$45 per visit. See pages 59–60 for definitions of PCP and specialist.

For most other services, including inpatient and outpatient *hospital* services and in-office surgeries costing \$500 or more, you must first meet your annual deductible. Then you pay 20% under the A&M Care 350 plan or 30% under the A&M Care 1250 plan and the plan pays the remaining 80% or

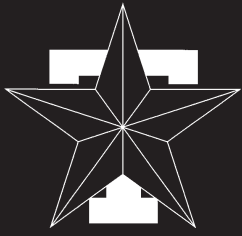
70% until you reach your out-of-pocket maximum. After that, the plan pays 100% of most remaining eligible expenses, excluding copayments, for the rest of that plan year.

Using network *doctors* and *hospitals* has many advantages, including:

- ☆ no claim forms,
- ☆ no *reasonable and customary* limits,
- ☆ the *doctor* is responsible for pre-authorizing coverage (except BlueCard network *doctors* outside Texas; see “Pre-authorization and Reviews,” pages 28–29),
- ☆ you pay only \$25 for most *PCP* services related to a pregnancy and only 20% (A&M Care 350) or 30% (A&M Care 1250) up to the out-of-pocket maximum after you meet your annual deductible for pregnancy-related *hospital* services, and
- ☆ full coverage for most preventive care—you pay only the office visit copayment. See page 26 for a list of covered office services.

BENEFITS AT A GLANCE

DOCTOR'S OFFICE VISITS	OTHER SERVICES	
You pay \$25 for PCP visits; \$45 for specialist visits	You pay your annual deductible	
The plan pays 100% of remaining costs	You pay: A&M Care 350: 20% A&M Care 1250: 30%	The plan pays: A&M Care 350: 80% A&M Care 1250: 70%
	Once you reach the out-of-pocket maximum, the plan pays 100% of remaining eligible expenses, excluding office visit and prescription drug copayments and prescription drug deductibles.	



OUT-OF-NETWORK BENEFITS

If you live in a BlueChoice or BlueCard network area and choose to use doctors and hospitals that are not members of the network, you receive out-of-network benefits.

Then you pay 50% and the plan pays 50% of *most* remaining eligible expenses up to the out-of-pocket maximum. Then the plan pays 100% of most remaining expenses.

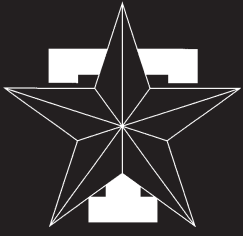
For most out-of-network *doctor* or *hospital* services, you must first meet your annual deductible. For hospitalization, you must also pay a deductible each time you or a family member is hospitalized. The hospital deductible is \$350 for the A&M Care 350 plan and \$500 for the A&M Care 1250 plan. You are also responsible for pre-authorizing hospitalizations.

BENEFITS AT A GLANCE

You pay your annual deductible (twice the network deductible).

You pay 50%	The plan pays 50%	For each hospitalization, you also pay a <i>hospital</i> deductible.	
		You pay 50%	The plan pays 50%

Once you reach the out-of-pocket maximum, the plan pays 100% of remaining eligible expenses, excluding office visit and prescription drug copayments and prescription drug deductibles.



NON-NETWORK AND 65 PLUS BENEFITS

If you live in a non-network area, or if you are eligible for Medicare as your primary carrier and are not working, or if you enroll in 65 PLUS, your benefits will be the same no matter which doctors and hospitals you use.

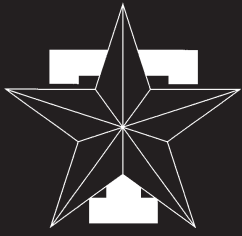
For most non-network and 65 PLUS doctor or hospital services, you must first meet your annual deductible.

Then under the A&M Care 350 plan or 65 PLUS, you pay 20% and the plan pays 80% of most remaining eligible expenses up to the out-of-pocket maximum. Under the A&M Care 1250 plan, you pay 30% and the plan pays 70% of most remaining eligible expenses up to the out-of-pocket maximum. After that, under all plans, the

plan pays 100% of remaining eligible expenses except prescription drug copayments and prescription drug deductibles.

If you are younger than age 65 and are willing to drive to an area where network providers are available, you have the option of using network providers and receiving network benefits, as explained on pages 9 and 10.

Non-working retirees and dependents with Medicare parts A and B do not have to pre-authorize the services listed on pages 28 and 29.



PLAN BENEFITS

All of the plans pay benefits based on deductibles, copayments, cost sharing, and plan maximums and limits.

Understanding the terms defined in this section is important to knowing how your plan works—no matter which plan you choose.

ANNUAL DEDUCTIBLE

For some health care services, you must first pay an annual plan year deductible before you receive benefits for those services.

If you have dependent coverage, your maximum deductible for all family members is three times the individual deductible. All expenses incurred by any combination of three or more family members go toward meeting the family deductible.

If you live in a BlueChoice or BlueCard network area and Medicare is not primary, you have separate deductibles for network services and out-of-network services. If you get some care in-network and some out-of-network, your network expenses apply only to the network deductible. However, your out-of-network expenses apply to both the network and out-of-network deductibles.

Doctor's office visit and drug copayments and drug and hospital deductibles do not count toward meeting this deductible. You must continue to pay these expenses even after you have met your annual deductible.

HOSPITAL DEDUCTIBLE

If you live in a BlueChoice or BlueCard network area and go to an out-of-network *hospital*, you must pay a *hospital deductible* each time you or a covered dependent is admitted to the *hospital*. This deductible is in addition to the annual deductible.

You pay no *hospital deductible* for network or non-network hospitalizations. However, you must meet your annual deductible before benefits will be paid.

COPAYMENTS

A copayment is a set dollar amount you pay for a service. The plan pays all other costs for that service. If the amount the *doctor* charges for a service is less than your copayment, you pay only what the *doctor* charges.

If you go to a network *doctor* for an office visit, you pay one copayment for most services performed during that visit (see “Certain Diagnostic Procedures,” page 24, and “Surgery Expenses,” pages 33-34, for exceptions). The plan pays the rest.

If you have a routine office visit with a network *specialist* and the contracted amount for that *specialist* is less than the \$45 office visit copayment, you will pay only the contracted amount. If the bill for that visit also includes charges for lab work and/or x-rays, you will still pay only the contracted office visit amount. However, if the bill includes charges for other services

(such as office surgery), you will pay the remaining copayment amount.

COST SHARING

You and the plan share many costs on a percentage basis. For these expenses, after you meet your deductible, you pay 20% under A&M Care 350 and 65 PLUS or 30% under A&M Care 1250, and the plan pays the remaining percentage.

COPAYMENTS

- Network doctor office visits (all plans except 65 Plus): \$25 for *primary care physician (PCP)*; \$45 for *specialist*.
- Caremark drug card (all plans): \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary for a 30-day supply.
- Caremark mail-order drugs (all plans): \$20 for generic, \$50 for brand-name formulary and \$100 for brand-name nonformulary for a 90-day supply.

See “Prescription Drugs,” pages 39-40, for additional costs related to the use of brand-name drugs when a generic drug is available.

DEDUCTIBLES (PER PERSON/PLAN YEAR)

	<i>Network</i>	<i>Non-network</i>	<i>Out-of-network</i>
<i>A&M Care 350</i>	\$350	\$350	\$700
<i>A&M Care 1250</i>	\$1,250	\$1,250	\$2,500
<i>65 PLUS</i>	\$500		
<i>Caremark prescription drug deductible</i>	All A&M Care plans include a \$50/person annual deductible (with a 3-person maximum) on prescription drug purchases.		

COST SHARING (AFTER DEDUCTIBLE)

	<i>Network</i>	<i>Non-network</i>	<i>Out-of-network</i>
<i>A&M Care 350</i>	Plan pays 80%/ You pay 20%	Plan pays 80%/ You pay 20%	Plan pays 50%/ You pay 50%
<i>A&M Care 1250</i>	Plan pays 70%/ You pay 30%	Plan pays 70%/ You pay 30%	Plan pays 50%/ You pay 50%
<i>65 PLUS</i>	Plan pays 80%/You pay 20%		

OUT-OF-POCKET MAXIMUMS

A&M Care 350: network and non-network: \$3,000; out-of-network: \$6,000

A&M Care 1250: network and non-network: \$3,500; out-of-network: \$7,000

65 PLUS: \$1,400

If you live in a network area and use out-of-network *doctors, hospitals* or other providers, you and the plan each pay 50%.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is generally the most you will have to spend each plan year on each family member for the annual deductible and your share of expenses. Once you've met the out-of-pocket maximum, the plan pays 100% of *most* remaining expenses for that family member for the rest of that plan year.

If you have dependent coverage, your maximum out-of-pocket expenses for all family members is three times the limits individual maximum. All expenses you pay for the annual deductible and share with the plan for any combination of three or more family members will go toward meeting the family out-of-pocket maximum.

Office visit copayments, prescription drug copayments, prescription drug

deductibles and out-of-network *hospital* deductibles do not count toward the out-of-pocket maximum. Likewise, you must continue to pay these expenses out of your pocket after you have met the out-of-pocket maximum.

If you live in a network area, you have a separate out-of-pocket maximum for network and out-of-network benefits. Network expenses apply only to the network maximum, but out-of-network expenses apply to both the out-of-network and network maximums.

Lifetime Maximum

With the exception of certain specified limits for services such as chiropractic care, mental health services, home healthcare and skilled nursing facility care, there is no lifetime benefit maximum.

Comparison Chart

The charts shown on the following pages give you more information on how the plans work and how they compare.

HEALTH PLAN PROVISION	A&M CARE 350 (NETWORK)	A&M CARE 350 (OUT-OF-NETWORK)
<i>Deductible</i>	\$350 per person per plan year. \$50 per person per plan year for prescription drugs.	\$700 per person per plan year, plus \$350 per person per hospitalization. \$50 per person per plan year for prescription drugs.
<i>Out-of-pocket maximum</i>	\$3,000 per person per plan year, including annual deductible, excluding drug deductible and office visit and drug copayments.	\$6,000 per person per plan year, including annual deductible, excluding hospital and drug deductibles and office visit and drug copayments.
<i>Office visits</i>	You pay \$25/visit (\$45/visit if visiting a specialist); the plan pays the rest. This does not apply to office surgeries that are performed in a doctor's office and cost at least \$500.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. Then the plan pays 100%.
<i>Hospital services (Includes inpatient, outpatient and diagnostic procedures performed by a hospital provider)</i>	After you meet your annual deductible, the plan pays 80% and you pay 20% up to the out-of-pocket maximum. Then the plan pays 100%.	After you meet your annual and hospital deductibles, the plan pays 50% and you pay 50% up to the out-of-pocket maximum. Then the plan pays 100%.
<i>Preventive care</i>	Your office visit copayment covers related tests and shots.	Routine physicals and other preventive care are not covered.
<i>Maternity care and well-baby care</i>	You pay \$25 for your first office visit. The plan pays 100% of all other doctor's charges. After you pay your annual deductible, the plan pays 80% and you pay 20% of hospital charges up to your out-of-pocket maximum. Then the plan pays 100%. The deductible is waived for the first four days of well-baby care for the newborn.	After you pay your annual and hospital deductibles, the plan pays 50% and you pay 50% for doctor and hospital charges up to your out-of-pocket maximum. Then the plan pays 100%. The deductible is waived for the first four days of well-baby hospital care for the newborn.
<i>Home health care and private duty nursing</i>	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays up to \$8,000 in benefits per person per plan year and up to \$40,000 for each person's lifetime.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. The plan pays up to \$8,000 in benefits per person per plan year and up to \$40,000 for each person's lifetime.
<i>Skilled nursing facility</i>	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays up to \$35,000 in benefits for each person's lifetime.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. The plan pays up to \$35,000 in benefits for each person's lifetime.
<i>Inpatient mental health</i>	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays for up to 30 days per person per plan year.	After you meet your annual and hospital deductibles, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. The plan pays for up to 30 days per person per plan year.
<i>Outpatient mental health</i>	You pay \$45 per visit. The plan covers up to 40 visits per person per plan year.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. The plan covers up to 40 visits per person per plan year.
<i>Prescription drugs (These copayments apply after you meet the \$50 prescription drug deductible.)</i>	With your prescription card, for a 30-day supply, you pay \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.	With your prescription card, for a 30-day supply, you pay \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.

**A&M CARE 350
(NON-NETWORK)**

**HEALTH PLAN
PROVISION**

<p>\$350 per person per plan year. \$50 per person per plan year for prescription drugs.</p>	<p><i>Deductible</i></p>
<p>\$3,000 per person per plan year, including annual deductible, excluding drug deductible and office visit and drug copayments.</p>	<p><i>Out-of-pocket maximum</i></p>
<p>After you meet your annual deductible, the plan pays 80% and you pay 20% up to the out-of-pocket maximum. Then the plan pays 100%.</p>	<p><i>Office visits</i></p>
<p>After you meet your annual deductible, the plan pays 80% and you pay 20% up to the out-of-pocket maximum. Then the plan pays 100%.</p>	<p><i>Hospital services (Includes inpatient, outpatient and diagnostic procedures performed by a hospital provider)</i></p>
<p>The plan pays 100% up to \$200 per plan year for routine tests and routine immunizations.</p>	<p><i>Preventive care</i></p>
<p>After you pay your annual deductible, the plan pays 80% and you pay 20% for doctor and hospital charges up to your out-of-pocket maximum. Then the plan pays 100%. The deductible is waived for the first four days of well-baby hospital care for the newborn.</p>	<p><i>Maternity care and well-baby care</i></p>
<p>After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays up to \$8,000 in benefits per person per plan year and up to \$40,000 for each person's lifetime.</p>	<p><i>Home health care and private duty nursing</i></p>
<p>After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays up to \$35,000 in benefits for each person's lifetime.</p>	<p><i>Skilled nursing facility</i></p>
<p>After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays for up to 30 days per person per plan year.</p>	<p><i>Inpatient mental health</i></p>
<p>After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan covers up to 40 visits per person per plan year.</p>	<p><i>Outpatient mental health</i></p>
<p>With your prescription card, for a 30-day supply, you pay \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.</p>	<p><i>Prescription drugs (These copayments apply after you meet the \$50 prescription drug deductible.)</i></p>

HEALTH PLAN PROVISION	A&M CARE 1250 (NETWORK)	A&M CARE 1250 (OUT-OF-NETWORK)
<i>Deductible</i>	\$1,250 per person per plan year. \$50 per person per plan year for prescription drugs.	\$2,500 per person per plan year, \$500 per person per hospitalization. \$50 per person per plan year for prescription drugs.
<i>Out-of-pocket maximum</i>	\$3,500 per person per plan year, including annual deductible, excluding drug deductible and office visit and drug copayments.	\$7,000 per person per plan year, including annual deductible, excluding hospital and drug deductibles and office visit and drug copayments.
<i>Office visits</i>	You pay \$25/visit (\$45/visit if visiting a specialist); the plan pays the rest. This does not apply to office surgeries that are performed in a doctor's office and cost at least \$500.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to the out-of-pocket maximum. Then the plan pays 100%.
<i>Hospital services (Includes inpatient, outpatient and diagnostic procedures performed by a hospital provider)</i>	After you meet your annual deductible, the plan pays 70% and you pay 30% up to the out-of-pocket maximum. Then the plan pays 100%.	After you meet your annual and hospital deductibles, the plan pays 50% and you pay 50% up to the out-of-pocket maximum. Then the plan pays 100%.
<i>Preventive care</i>	Your office visit copayment covers related tests and shots.	Routine physicals and other preventive care are not covered.
<i>Maternity care and well-baby care</i>	You pay \$25 for your first office visit. The plan pays 100% of all other doctor's charges. After you pay your annual deductible, the plan pays 70% and you pay 30% of hospital charges up to your out-of-pocket maximum. Then the plan pays 100%. The deductible is waived for the first four days of well-baby care for the newborn.	After you pay your annual and hospital deductibles, the plan pays 50% and you pay 50% for doctor and hospital charges up to your out-of-pocket maximum. Then the plan pays 100%. The deductible is waived for the first four days of well-baby hospital care for the newborn.
<i>Home health care and private duty nursing</i>	After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. The plan pays up to \$8,000 in benefits per person per plan year and up to \$40,000 for each person's lifetime.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. The plan pays up to \$8,000 in benefits per person per plan year and up to \$40,000 for each person's lifetime.
<i>Skilled nursing facility</i>	After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. The plan pays up to \$35,000 in benefits for each person's lifetime.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. The plan pays up to \$35,000 in benefits for each person's lifetime.
<i>Inpatient mental health</i>	After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. The plan pays for up to 30 days per person per plan year.	After you meet your annual and hospital deductibles, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. The plan pays for up to 30 days per person per plan year.
<i>Outpatient mental health</i>	You pay \$45 per visit. The plan covers up to 40 visits per person per plan year.	After you meet your annual deductible, the plan pays 50% and you pay 50% up to your out-of-pocket maximum. The plan covers up to 40 visits per person per plan year.
<i>Prescription drugs (These copayments apply after you meet the \$50 prescription drug deductible.)</i>	With your prescription card, for a 30-day supply, you pay \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.	With your prescription card, for a 30-day supply, you pay \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.

A&M CARE 1250 (NON-NETWORK)	A&M CARE 65 PLUS	HEALTH PLAN PROVISION
\$1,250 per person per plan year. \$50 per person per plan year for prescription drugs.	\$500 per person per plan year. \$50 per person per plan year for prescription drugs.	<i>Deductible</i>
\$3,500 per person per plan year, including annual deductible, excluding drug deductible and office visit and drug copayments.	\$1,400 per person per plan year, including annual deductible, excluding drug deductible and office visit and drug copayments.	<i>Out-of-pocket maximum</i>
After you meet your annual deductible, the plan pays 70% and you pay 30% up to the out-of-pocket maximum. Then the plan pays 100%.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to the out-of-pocket maximum. Then the plan pays 100%.	<i>Office visits</i>
After you meet your annual deductible, the plan pays 70% and you pay 30% up to the out-of-pocket maximum. Then the plan pays 100%.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to the out-of-pocket maximum. Then the plan pays 100%.	<i>Hospital services (Includes inpatient, outpatient and diagnostic procedures performed by a hospital provider)</i>
The plan pays 100% up to \$200 per plan year for routine tests and immunizations.	The plan pays 100% up to \$200 per plan year for routine tests and immunizations.	<i>Preventive care</i>
After you pay your annual deductible, the plan pays 70% and you pay 30% for doctor and hospital charges up to your out-of-pocket maximum. Then the plan pays 100%. The deductible is waived for the first four days of well-baby hospital care for the newborn.	Maternity care is not applicable.	<i>Maternity care and well-baby care</i>
After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. The plan pays up to \$8,000 in benefits per person per plan year and up to \$40,000 for each person's lifetime.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays up to \$8,000 in benefits per person per plan year and up to \$40,000 for each person's lifetime.	<i>Home health care and private duty nursing</i>
After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. The plan pays up to \$35,000 in benefits for each person's lifetime.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays up to \$35,000 in benefits for each person's lifetime.	<i>Skilled nursing facility</i>
After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. The plan pays for up to 30 days per person per plan year.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan pays for up to 30 days per person per plan year.	<i>Inpatient mental health</i>
After you meet your annual deductible, the plan pays 70% and you pay 30% up to your out-of-pocket maximum. The plan covers up to 40 visits per person per plan year.	After you meet your annual deductible, the plan pays 80% and you pay 20% up to your out-of-pocket maximum. The plan covers up to 40 visits per person per plan year.	<i>Outpatient mental health</i>
With your prescription card, for a 30-day supply, you pay \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.	With your prescription card, for a 30-day supply, you pay \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary drugs. You can buy a 90-day supply of maintenance drugs at certain pharmacies by paying three copayments. For a 90-day supply by mail order, you pay two copayments. Generic substitution is required in most cases.	<i>Prescription drugs (These copayments apply after you meet the \$50 prescription drug deductible.)</i>

OTHER PLAN LIMITS

The plan limits benefits for some services.

Home health care and private duty nursing are limited to \$8,000 per person per plan year and \$40,000 for each person's lifetime. See pages 24–25 for more information on home health care and private duty nursing.

Skilled nursing facility care is limited to \$35,000 for each person's lifetime. See page 33 for more information on skilled nursing facility care.

The plan covers up to 30 days per person each plan year for inpatient mental health treatment. Outpatient mental health treatment is limited to 40 visits per plan year. See pages 31–32 for more information.

Preventive care is covered after the copayment at network *doctors*. Preventive care is not covered if provided by out-of-network *doctors*. If you live in a non-network area, preventive care is limited to \$200 per person each plan year at a doctor who is not in the network. If you travel to a network doctor, preventive care is covered after the copayment. See page 32 for more information on preventive care.

Spinal skeletal system treatment is limited to 30 visits per person each

plan year. See page 33 for more information.

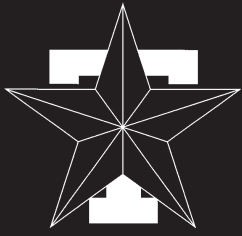
Hospice care is limited to six months with possible extension for an additional six months. Bereavement counseling is limited to 15 visits. See page 25 for more information on hospice care.

PRESCRIPTION DRUGS

The A&M Care plans' prescription drug program, administered by Caremark, has a separate annual deductible. After you meet the deductible, you pay a copayment for each drug purchase. In most cases, the plan pays the rest. For more information on this program, see "Prescription Drugs," pages 38–43.

PLAN YEAR

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



COVERED EXPENSES

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

All of the health plans cover medically necessary services for the treatment of injuries or illnesses, including alcoholism, chemical dependency and certain serious mental illnesses. In addition, preventive care is covered under some circumstances.

For non-network and out-of-network providers, the plan covers up to the *reasonable and customary* fee for services and supplies.

While each of the plans pays benefits a little differently, as described in the “How Health Coverage Works”

section of this booklet (pages 9–11), the services and supplies covered are identical, except for preventive care.

This section lists the expenses covered by the plan. For information on prescription drug coverage, see “Prescription Drugs” on page 38. Expenses that are not covered are listed beginning on page 35. If you cannot find a service or supply in either section, call BCBSTX Customer Service, (866) 295-1212, or Caremark Customer Service, (866) 935-5433, to find out if the expense is covered.

AMBULANCE SERVICE

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

CATEGORIES OF EXPENSES COVERED IN THIS SECTION:

- ☆ Ambulance Service
- ☆ Certain Diagnostic Procedures
- ☆ Doctor's Office Visits
- ☆ Emergency Care
- ☆ Home Health Care and Private Duty Nursing
- ☆ Hospice Benefits
- ☆ Hospitalization
- ☆ Laboratory Services
- ☆ Maternity Care
- ☆ Medical Supplies
- ☆ Mental Health
- ☆ Preventive Care
- ☆ Professional Services
- ☆ Skilled Nursing Facility
- ☆ Spinal Skeletal System Treatment
- ☆ Substance Abuse
- ☆ Surgery Expenses
- ☆ Transplants and Replacements

This section also addresses pre-authorization and receiving care while traveling.

CERTAIN DIAGNOSTIC PROCEDURES

No matter where you receive services, benefits for some procedures are paid on a cost-sharing basis (see page 16), even at a network provider, after you meet the necessary deductible(s).

These include, but are not limited to:

- ☆ arthroscopy
- ☆ bone scan
- ☆ cardiac stress test
- ☆ CT scan
- ☆ endoscopic procedures, which include:
 - esophagoscopy
 - endoscopy, UGI
 - colonoscopy
 - cystourethroscopy
 - laparoscopy
 - flexible sigmoidoscopy
- ☆ MRI
- ☆ myelogram
- ☆ PET scan
- ☆ ultrasound

DOCTOR'S OFFICE VISITS

You pay \$25 for a *doctor's* office visit to a network *doctor* for the types of care shown on page 26, and you pay \$45 for a *specialist's* office visit.

Only medically necessary treatment is covered from doctors not in the network, except the preventive care services listed in the chart on page 30 are covered if you live in a non-network area. You receive benefits based on your annual deductible and your share of costs.

EMERGENCY CARE

If you need emergency care, you should go to the nearest emergency facility. If you live in a network area, benefits will be paid at the network level. If you live in a non-network area, you will receive regular non-network benefits.

An emergency is a condition that would result in permanent disability or death if the condition were to go untreated.

Examples of emergencies are unconsciousness, severe bleeding, heart attack, serious burns and serious breathing difficulties.

HOME HEALTH CARE AND PRIVATE DUTY NURSING

The plan covers *home health care* and private duty nursing for up to \$40,000 in benefits for each person's lifetime. The plan will pay up to \$8,000 in benefits per person each plan year.

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; see page 30),
- ☆ 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; see below and pages 27 and 33).

Benefits for *home health care* and private duty nursing will be covered only if:

- ☆ the care is medically necessary for a totally disabled person who would otherwise be hospitalized, and
- ☆ the services are provided by a home health agency, although the private duty nursing may be provided by a *nurse* who is not employed by the home health agency.

Other requirements for coverage are that:

- ☆ the patient be under the direct care of a *doctor*,

- ☆ the *doctor* write a treatment plan before treatment begins,
- ☆ the treatment plan be reviewed by BCBSTX before treatment begins, and
- ☆ the treatment plan be certified by the *doctor* and BCBSTX at least once a month during treatment.

HOSPICE BENEFITS

Hospice benefits are covered when the *doctor* certifies that the patient is terminally ill and expected to live six months or less. Benefits may be extended for a second six months, but will not be paid for more than 12 months.

Covered hospice expenses are:

- ☆ room and board,
- ☆ services and supplies while confined in a hospice,
- ☆ part-time nursing care by or under the supervision of a registered *nurse*,
- ☆ home health aide services,
- ☆ physical, speech and respiratory therapy by persons licensed to provide these services,
- ☆ counseling services by a licensed social worker or pastoral counselor,
- ☆ bereavement counseling by a licensed social worker or pastoral counselor for the family for up to 15 visits, and
- ☆ any *doctor*-ordered service including *custodial care*.

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

DOCTOR OFFICE SERVICES (Network Only)

One copayment is taken per *doctor*, per day

OFFICE SETTING SERVICES	A&M CARE
1. Office visit	100% after copayment
2. Consultation	100% after copayment
3. Chemotherapy and radiation	100% after copayment
4. Injections (except allergy injections)	100% after copayment
5. Allergy injections when billed separately	100%
6. Lab—office	100% after copayment
7. Independent lab	100%
8. X-ray—office (including mammograms)	100% after copayment
9. Radiologist	100% outpatient or <i>doctor's</i> office
10. Maternity –initial visit	100% after copayment
–remaining visits	100%
11. Office surgery –less than \$500	100% after copayment
–\$500 or more	80% /70% after deductible
12. Medical supplies and equipment	80%/70% after plan-year deductible
13. Allergy test	100% after copayment
14. Speech therapy	100% after copayment
15. Chiropractic care/physical therapy*	100% after copayment
16. Occupational modalities in conjunction w/physical therapy*	100% after copayment
17. Mental health/substance abuse	100% after copayment
18. Routine physical exam/office visit charge	100% after copayment
19. Well-baby exam/office visit charge	100% after copayment
20. Preventive hearing exam	100% after copayment
21. Treatment of eye diseases	100% after copayment
22. Routine immunizations, flu shots, lab, X-ray & hearing test	100% after copayment

**These services combined are limited to 30 visits per person each plan year, when performed in conjunction with modalities of the spine.*

HOSPITALIZATION

The plans cover:

- ☆ semiprivate room and board,
- ☆ medical services and supplies,
- ☆ intensive nursing care,
- ☆ outpatient services, and
- ☆ medical treatment given by or in the presence of a *doctor*.

You must pre-authorize all hospitalizations, including those for mental health, serious mental illness and substance abuse; see pages 28–29.

LABORATORY SERVICES

The plan covers:

- ☆ X-ray exams (except for dental), lab tests and other diagnostic services,
- ☆ X-ray and radiation therapy,
- ☆ skin testing for allergies and RAST testing up to the cost of skin testing, and
- ☆ low-dose mammography screening on an annual basis for women age 35 and older to detect breast cancer (see “Preventive Care,” page 32).

MATERNITY CARE

The plan covers prenatal, delivery and postnatal expenses related to pregnancy. See page 44 for information about the Mother/Baby Program.

If you go to a network *PCP*, you pay \$25 for your first office visit and the plan pays all other *PCP* charges related to your pregnancy. Network *hospital* charges and all out-of-network and non-network maternity expenses are subject to the deductible and cost sharing.

If the pregnancy results in a miscarriage and is not completed, the plan requires a \$25 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 spouses and covered dependent daughters.

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 pre-authorize your delivery expenses before you are four months pregnant; please see the “Mother/Baby Program” on page 44. You must pre-authorize 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.

PRE-AUTHORIZATION AND REVIEWS

Certain services must be reviewed and approved in advance by BCBSTX before you can receive benefits. This is done to ensure that you receive appropriate care in a cost-effective setting. *If you use a Texas BlueChoice network doctor, your doctor will take care of this for you. If you use a non-network or out-of-network doctor or a BlueCard (outside Texas) network doctor, you are responsible for calling or having your doctor call BCBSTX. You pay a \$500 penalty if you do not pre-authorize services. If you are hospitalized outside Texas, you or a family member must pre-authorize your hospitalization with BCBSTX.*

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

You must call BCBSTX at (800) 441-9188 before you use these services:

- ☆ Hospitalization: You or your *doctor* must call BCBSTX before you or a covered dependent is hospitalized. BCBSTX will review the medical necessity of hospitalization and either tell you the number of days of hospitalization that will be covered or suggest an alternative to hospitalization, such as outpatient surgery. For an emergency hospitalization, you, your *doctor* or a family member must call BCBSTX within 48 hours after admission. Emergency means care is needed immediately.
- ☆ Extended Care Services: You or your *doctor* must call BCBSTX to pre-authorize home health care, *skilled nursing facility* admissions, physical, occupational and speech therapy, and hospice services.
- ☆ Mental Health Care and Serious Mental Illness: All services and supplies for inpatient and day treatment facility admissions for mental health care must be pre-authorized *before* you receive them. The telephone number for pre-authorizing mental health services is (800) 528-7264. If you use a BlueChoice network *doctor*, your mental health care will be pre-authorized for you. Otherwise, it will be up to you to pre-authorize the services. (You must pre-authorize if you are using a BlueCard network doctor, which is a network doctor in another state or country.)
- ☆ Home Infusion Therapy: Home infusion therapy is intravenous infusion or injection of fluids done in the home setting. You or your *doctor* must pre-authorize home infusion therapy treatment before you receive the services or supplies. Your *doctor*

PRE-AUTHORIZATION AND REVIEWS (CONTINUED)

must submit a treatment plan to BCBSTX, and it must be approved every 30 days for the therapy to continue.

If you do not pre-authorize, you must pay a \$500 penalty in addition to any deductibles or shared costs you otherwise pay. 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.

In addition to pre-authorization, BCBSTX will perform these reviews:

- ☆ **Concurrent Review and Discharge Planning:** While you are hospitalized, BCBSTX will evaluate your progress and, if necessary, adjust the number of days of approved hospitalization. BCBSTX will notify you and your *doctor* of any change in the number of days that will be covered. BCBSTX also will work with you and your *doctor* to find alternatives to hospitalization, such as home health care, that will allow you to leave the *hospital* sooner and receive the care you need.
- ☆ **Retrospective Review:** BCBSTX also will review hospitalizations and surgeries once treatment is finalized. Any treatment previously not authorized that appears to have been medically necessary will be considered for benefits.

If BCBSTX decides not to pre-authorize a service, you will receive a notification letter from BCBSTX. If you or your *doctor* disagrees with the decision, you may request a review of that decision by having your *doctor* call the contact person indicated in the notification letter or by submitting a written request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044.

During the 30 days after you request the review, you can submit additional information and comments to BCBSTX regarding your claim, and you may review any relevant documents held by BCBSTX.

Within 30 days of receiving your review request, BCBSTX will send you its decision regarding the claim. In some cases, an additional 15 days may be needed for the review. If so, you will be notified of this during the initial 30-day period.

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 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 BlueChoice or BlueCard medical equipment supplier.

NON-NETWORK PREVENTIVE BENEFITS UP TO \$200 WITH NO DEDUCTIBLE

TEST	FREQUENCY
Pap smear, occult blood, tonometry, audiometry, flu immunizations, blood sugar, CBC, urinalysis	Once per plan year
Nutritional analysis, cholesterol	Twice per plan year
Blood pressure	No limit
Prostate exam: blood test, digital test, PSA	Once per plan year after age 40
Routine mammogram	Once per plan year
Routine immunizations	As needed
Pneumonia shot	Once per lifetime

MENTAL HEALTH

The plan covers inpatient and outpatient treatment of mental health.

Inpatient treatment is paid the same as any other illness, but treatment is limited to 30 days per person each plan year. Benefits must be precertified.

Outpatient treatment is also paid the same as any other illness. Benefits are

limited to 40 visits per person each year.

Treatment for a dependent child in a *crisis stabilization unit* or *residential treatment center* will be considered an eligible expense if the child has a serious mental illness that impairs thought, reality perception, emotional process, judgment or behavior. The center is

CARE WHILE TRAVELING

If you are traveling within the United States and you need urgent but nonemergency care, you should call the BlueCard toll-free number on your ID card for assistance in locating a network *doctor* in your area. Benefits will be paid at the network level if you use a network *doctor* and at the out-of-network level if you use a *doctor* not in the network, unless you are overseas in an area where there is no network coverage. In this case, you will still receive network benefits.

If you or a family member has an emergency while away from home, you should seek care immediately at the nearest emergency facility. If you or a family member is hospitalized, you must pre-authorize with BCBSTX (see “Pre-authorization,” pages 28–29). After you file a claim, the plan will pay network benefits for those expenses.

If you are traveling outside the United States, several plan provisions apply:

- ☆ BlueCross BlueShield has a worldwide *hospital* network in which participating *hospitals* can file claims electronically. You can get a list of these hospitals from your Human Resources office, by calling BCBSTX customer service at (800) 810-BLUE, or by visiting BCBSTX online at www.bcbstx.com.
- ☆ All billing must be submitted in English or with a translation and must include details of the services received.
- ☆ Charges must be converted into American currency at the exchange rate in effect at the time the claim is processed.
- ☆ Pre-authorization is not necessary.
- ☆ Treatments not normally covered or that are not recognized forms of treatment in the U.S. will not be covered.
- ☆ Transportation costs are covered only when treatment cannot be provided at your location and only to the nearest place where treatment is available.

If you plan to travel, contact your Human Resources office or visit System Benefits Administration online at tamus.edu/benefits/publications/brochures/travel.pdf for *A Guide to Using Your Benefits While Traveling*.

covered only if the child would otherwise require *hospital* care and services are provided according to a treatment plan through providers who are licensed or operated by a state agency or board.

Certain serious mental illnesses are covered the same as other illnesses with the normal plan benefits and limits. These are:

- ☆ schizophrenia,
- ☆ paranoid and other psychotic disorders,
- ☆ bipolar disorders (mixed, manic, hypomanic and depressive),
- ☆ major depressive disorders (single episode or recurrent),
- ☆ schizo-affective disorders (bipolar or depressive),
- ☆ pervasive developmental disorders up to age six (medical and mental health maximums will apply after age six),
- ☆ obsessive-compulsive disorders, and
- ☆ depression in childhood or adolescence.

PREVENTIVE CARE

Whether you receive benefits for routine physicals and well-baby care depends on whether you live in a network or non-network area and, if in a network area, whether you go to a network or out-of-network *doctor*.

You pay \$25 for all *PCP*'s office visits (\$45 if you see a specialist) and related tests if you go to a network *PCP*. This includes preventive tests performed at network stand-alone facilities or outpatient network *hospi-*

tals except those outpatient diagnostic procedures listed on page 24.

You pay \$25 for well-baby visits to a network *PCP*, including any immunizations received during the visit.

If you live in a network area and go to an out-of-network *doctor*, you receive *no* benefits for routine physical exams, well-baby care or other preventive care.

If you live in a non-network area, you can receive up to \$200 per person per plan year in preventive care benefits. Only the tests shown in the chart on page 30 are covered. You can receive 100% reimbursement, with no deductible, up to the \$200 maximum each plan year.

Your *doctor* must code preventive care expenses correctly on the bill so BCBSTX will know they are preventive benefits. If the tests result in a diagnosis of an illness, they will not be considered preventive and will be paid under the normal plan benefits—80% after you meet your deductible.

Non-network well-baby care is covered at 80% after you meet your annual deductible.

PROFESSIONAL SERVICES

The plan covers:

- ☆ *doctor's* services,
- ☆ services of a certified registered nurse anesthetist, licensed nurse practitioner, advanced nurse practitioner, licensed midwife or licensed physician's assistant, and
- ☆ licensed physiotherapist's services, if a reasonable chance of improvement is likely.

The services of a psychological associate are covered only under the clinical supervision of a licensed psychologist/psychiatrist who is employed by the System and meets the guidelines of the Texas State Board of Examiners of Psychologists. In addition, the services must be part of a treatment plan that is reviewed and approved by the psychologist every three months.

SKILLED NURSING FACILITY

The plan covers care in a *skilled nursing facility* up to a lifetime maximum of \$35,000 in facility charges. To be covered, the *skilled nursing facility* care must:

- ☆ be precertified before care is received,
- ☆ be part of a treatment plan submitted by your *doctor* and approved by BCBSTX before care is received,
- ☆ be recertified every 30 days, and
- ☆ not be *custodial*.

SPINAL SKELETAL SYSTEM TREATMENT

The plan covers manual manipulation and modalities of the spinal skeletal system and surrounding tissue to restore proper alignment of bones and proper function of nerves and joints. Treatment is limited to 30 visits during any plan year. You may not have more than one visit in a single day.

X-rays are paid as a separate expense under the normal plan benefits.

SUBSTANCE ABUSE

The plan covers inpatient and outpatient treatment of substance abuse (chemical dependency) the same as other illnesses.

SURGERY EXPENSES

Surgeries costing less than \$500 and performed in a *doctor's* office are covered for a \$25 copayment if you use a network *PCP* (\$45 if you use a *specialist*). Surgeries performed inpatient or outpatient at a *hospital* or surgeries costing \$500 or more performed in a doctor's office will be covered at the appropriate cost-sharing level after you meet your annual deductible (and *hospital* deductible if out-of-network). The \$500 surgery cost is based on the contracted amount set by BCBSTX, rather than the billed amount submitted by the doctor.

The plan covers:

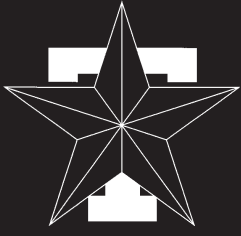
- ☆ anesthetics and their administration,
- ☆ surgeon's fees, and
- ☆ donation and storage charges of your own blood for use during your own surgery.

If you have a mastectomy, the plan will cover the surgery as well as reconstruction of the affected breast and the other breast to provide symmetry. The plan will also cover prostheses and services in connection with other complications resulting from the mastectomy, including lymphedemas. Expenses for these services are covered in the same manner as most other surgery-related expenses and are subject to normal plan limits. This means you may be required to pay part of the cost through copayments, annual and/or hospital deductibles and cost sharing (see pages 15–17).

TRANSPLANTS AND REPLACEMENTS

When the recipient is covered by the plan, the plan covers the donor and recipient for the following organ and tissue transplants and replacements:

- ☆ cornea,
- ☆ artery or vein,
- ☆ kidney,
- ☆ kidney and pancreas,
- ☆ joint replacement,
- ☆ heart valve replacement,
- ☆ implantable prosthetic lenses in connection with cataracts,
- ☆ prosthetic bypass or replacement vessels,
- ☆ bone marrow,
- ☆ heart,
- ☆ heart and lung, and
- ☆ liver.



EXPENSES NOT COVERED

Some expenses are not covered by your health plan. These include expenses for solely cosmetic procedures, experimental treatment or employment-related injuries.

Some health care expenses are not covered by the plan. Most of these are listed below. Others that are specific to a certain medical service, supply or provider are listed in the section “Covered Expenses” where those services, supplies or providers are discussed. For information on prescription drug expenses that are not covered, see “Prescription Drugs” on pages 38-43.

If you cannot find a specific expense listed in this section or in the list of covered expenses beginning on page 23, call BCBSTX Customer Service at (866) 295-1212.

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 on page 32,
- ☆ 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

Expenses not covered - continued

- repair or replacement of sound natural teeth due to an accident while you are covered by the plan, but only within 24 months of the accident,
- ☆ 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 surgical treatment of morbid obesity,
- ☆ for marriage counseling,
- ☆ for family counseling, except for one visit that includes the covered patient and is billed under the patient's name,
- ☆ for scholastic education or vocational training,
- ☆ for medical social services, except as part of hospice services (see page 25),
- ☆ for food allergy testing, except when medically necessary for a diagnosis,
- ☆ for eye exams, orthoptics or visual training, LASIK surgery, radial keratotomy, eyeglasses or contact lenses, except those due to cataract surgery immediately after surgery or as described on page 44,
- ☆ for hearing aids or devices, except as described on page 45,
- ☆ 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, in vitro fertilization, embryo implant or transplant and gamete intrafallopian transfer,
- ☆ for sex change surgery,
- ☆ for vitamins or over-the-counter drugs, even if prescribed, except prescribed prenatal vitamins,

Expenses not covered - continued

- ☆ 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 on page 25 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 nonambulatory 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:
 - videofluoroscopy,
 - 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 physician or obtaining medical records.

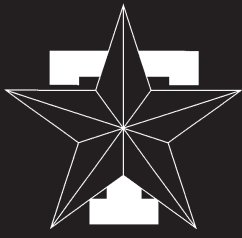
Expenses Not Covered - continued

☆ 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:

1. Surgery performed on the wrong body part.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient.
4. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility.
5. An infant discharged to the wrong person.
6. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

7. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life.
8. Artificial insemination with the wrong donor sperm or donor egg.
9. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility.

Other conditions may apply as identified by the Centers for Medicare and Medicaid Services, (CMS).



PRESCRIPTION DRUGS

The A&M Care plans include a prescription drug program administered by Caremark.

Caremark administers the prescription drug part of the A&M Care plans. You receive a separate ID card with a separate ID number from Caremark.

You should use your Caremark card, not your BCBSTX card, to purchase drugs at a pharmacy.

Caremark has a nationwide network of more than 40,000 chain and independent pharmacies.

If you have questions about prescription drugs, call Caremark at (866) 935-5433.

PRESCRIPTION DRUG DEDUCTIBLE

The plan includes a \$50-per-person annual deductible (with a 3-person maximum). This deductible applies to the first \$50 in prescription drugs that each covered person buys, whether at a retail pharmacy or through mail order. After you meet the deductible, you pay the applicable copayments (see next section) for any remaining drug purchases through the end of the plan year.

If you meet the deductible on a prescription drug purchase, but it

doesn't cover the full cost of the drug, the copayment will be applied to the rest of the cost. If the remaining cost is less than the copayment, you will pay only the remaining cost. If the remaining cost is more than the copayment, you pay only the copayment.

PURCHASING PRESCRIPTION DRUGS

You have four options for purchasing prescription drugs:

- ☆ If you go to a participating Caremark pharmacy and show your Caremark drug card, you pay \$10 for generic, \$25 for brand-name formulary and \$50 for brand-name nonformulary drugs for a 30-day supply.
- ☆ For maintenance drugs, you can order a 90-day supply by mail from Caremark. You pay two copayments. You receive your prescription within 10 to 14 days of ordering.
- ☆ For maintenance drugs, you can purchase a 90-day supply at CVS, Walgreens, K-Mart, Kroger, Sam's Club, Target, HEB or Rite-Aid by paying three copayments.
- ☆ You can go to a nonparticipating pharmacy for your prescription and file a claim for reimbursement with Caremark. You will be reimbursed for 75% of the *reasonable*

and customary charges after you pay your \$50 prescription drug deductible and a \$10 (generic), \$25 (brand-name formulary) or \$50 (brand-name nonformulary) copayment.

- ☆ Members can request a refill through a retail pharmacy once they have used 80% (or about 24 days) of their medication and through mail order when they have used 60% (about 54 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 A&M Care plans have a mandatory

generic drug substitution policy. It applies when a generic substitute is available for a brand-name drug.

Here's how the program works:

- ☆ You will automatically be given a generic drug, if available, unless your doctor has written "DAW" or dispense as written on the prescription. You will pay the generic copayment. If you request the brand-name drug, you will pay the difference in cost between the generic and brand-name drugs as well as the brand-name formulary or nonformulary copayment.
- ☆ If your doctor writes the prescription as DAW, you will receive the brand-name drug and will pay the difference in cost between the

HOW THE DEDUCTIBLE WORKS

- ☆ Bill's first drug purchase after Sept. 1 is a generic drug that costs \$20. Bill will pay the full \$20, which will apply toward his deductible. The second drug he purchases is a \$90 brand-name formulary mail-order drug. He will pay \$80. The first \$30 of that will complete his \$50 deductible, and the remaining \$50 will be his copayment (two \$25 copayments for a 90-day supply). The plan will pay the remaining cost of that drug (\$10). Bill has now met his deductible, so he will pay only the drug copayments for any other prescription drugs he purchases through Aug. 31.
- ☆ Laura's first prescription drug purchase of the year is two generic drugs totaling \$60 at a retail pharmacy. She will pay the full \$60. The first \$50 meets her deductible. Because the remaining cost of the drugs (\$10) is less than the copayment for two generic drugs (\$20), she pays only the remaining cost of the drugs. After that, Laura will pay only the drug copayments for any other prescription drugs she purchases through Aug. 31.
- ☆ Bryan has A&M Care 350 coverage on himself, his wife and their two children. By May, the two children have each met the \$50 deductible and will pay only copayments for drug purchases made during the remainder of the plan year. Bryan, on the other hand, is \$20 away from meeting his deductible, while his wife is \$10 away. In June, Bryan purchases a brand-name formulary drug totaling \$70. He pays \$45 (\$20 to meet his deductible and \$25 for his brand-name formulary copayment). In August, Bryan's wife purchases a \$50 brand-name formulary drug. Because three covered family members have met their prescription deductibles, Bryan's wife no longer has to meet her deductible. She will pay only the \$25 copayment.

generic and brand-name drugs as well as the brand-name copayment. You may ask the pharmacist to call your *doctor* for permission to substitute a generic. If the *doctor* gives permission, you will receive the generic drug and pay only the generic copayment.

- ☆ If you cannot take the generic drug for a documented medical reason, your *doctor* can complete a form, available from Caremark, in advance, 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 nonformulary 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 nonformulary drug by completing a Physician Prior Authorization Request form, available at tamus.edu/benefits/publications/forms/pharma_priorauth.pdf, or calling (866) 935-5433. If this is approved, you will receive the nonformulary drug and pay only the formulary copayment. You may have your doctor send in a request that your drug be added to the Caremark formulary. A committee at Caremark reviews formulary additions and deletions.

Drugs While Traveling: If you need more than a 90-day supply of a drug

because you will be traveling out of the country, you should send a letter to your benefits office indicating your destination, length of stay and that you will remain covered through the health plan. Your benefits office will send you a letter confirming your coverage. You must then send your letter and the benefits office letter to Caremark with your prescription and copayment. If the drug is a controlled substance, you will need a separate prescription for each 90-day period and a letter from your *doctor* explaining the diagnosis and confirming that the *doctor* knows you will receive a large quantity at once.

Drugs While Hospitalized: Drugs you receive while hospitalized or in a *skilled nursing facility*, convalescent *hospital* or hospice will be paid as part of the benefits for that facility.

PRIOR AUTHORIZATION

Certain prescription drugs require prior authorization before Caremark will pay claims. Prior authorization is when Caremark conducts a clinical review of a drug to verify that it is the most appropriate way to treat a condition.

Drugs that require prior authorization typically are expensive, have uses not approved by the FDA, or have the potential to be used inappropriately.

Some medications have a quantity limitation. This limitation is typically in

place for medications that have an abuse potential or for medications that have been determined by the FDA to be safe only in limited amounts.

Other medications may be subject to contingent 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 Caremark with his/her diagnosis of your condition, along with any other necessary information. To do this, your doctor must complete a Physician Prior Authorization Request form, available at www.tamus.edu/benefits/programs/#health, or call (866) 935-5433. In some cases, your pharmacist can provide this information if it is included on the prescription.

Once this information is provided, Caremark will determine whether to cover the drug for your condition.

A list of common medications that require prior authorization can be found online at tamus.edu/benefits/programs/pharmacare_guidelines.pdf.

SPECIALTY PHARMACY

Caremark has a Specialty Pharmacy program designed to assist A&M Care participants who use specialty medications to treat chronic illnesses. The Specialty Pharmacy offers:

- ☆ Delivery of up to a 30-day supply of medication to the individual's

home or physician's office.

- ☆ Around-the-clock access to a staff of pharmacists, nurses and care coordinators who understand the individual's condition.
- ☆ Educational materials, support and home instruction.
- ☆ Better coordination of care with the individual's physician.

A&M Care participants who begin purchasing specialty medications on or after Sept. 1, 2006, will be required to go through the Specialty Pharmacy. Participants who began using specialty drugs before Sept. 1, 2006, will have the option of purchasing those drugs through the Specialty Pharmacy or through their regular retail pharmacy. However, if they begin purchasing other specialty medications on or after Sept. 1, 2006, they must go through the Specialty Pharmacy for the new drugs.

More information on specialty drugs is available by calling (800) 621-4786 or going to tamus.edu/benefits/programs/specialty_pharm.pdf.

A list of specialty drugs is available at tamus.edu/benefits/programs/specialty_pharm_drug_list.pdf

SMOKING CESSATION AND WEIGHT LOSS

Caremark provides limited coverage of prescription smoking cessation and weight loss products. You must receive authorization from Caremark before you can participate in either program.

To participate in the weight loss program, you must have either a body

mass index that is higher than 40 or a body mass index higher than 35 but suffer from weight-related diseases, such as diabetes or heart disease.

Caremark will follow medical guidelines to determine whether you qualify for either program, and the products will have refill limits. If you qualify for Caremark's CareEnhance or PatientCare disease management program, you must enroll in that program before receiving smoking cessation and/or weight loss medications.

To find out whether you qualify for either program, you or your doctor can call Caremark at (866) 935-5433.

MEDICARE PART D

All A&M System health plan prescription drug benefits have been certified to be comparable to or better than those provided by the Medicare Part D prescription drug plan. This means that if you have A&M System health coverage and become eligible for Medicare Part D but decide to enroll at a later date, you will not have to pay a higher premium than you would have paid if you'd enrolled when you first became eligible. You may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium.

Medicare Part D is available if you qualify for Medicare Part A and/or Part B. Enrolling or not enrolling in Medicare Part D will not change your enrollment in Parts A and/or B and will not impact the non-prescription drug

part of your A&M System health coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare or from Nov. 15 to Dec. 31 of any later year. If you drop or lose your A&M System health coverage and don't enroll in Medicare Part D within 63 days after your coverage ends, you may be required to pay more to enroll in Medicare Part D later. In this case, you may enroll as soon as you drop or lose A&M System coverage and don't have to wait until the normal Part D enrollment period.

Because System health plans usually provide better drug benefits at a lower cost, Medicare Part D enrollment is not necessary for most System employees and retirees enrolled in System health plans. However, if you qualify for financial assistance, you will save on Part D premiums, copayments and coinsurance, which could mean you would benefit from Part D. Financial assistance is available to Medicare beneficiaries with incomes up to 150% of the Federal Poverty Level and limited resources. To determine if you qualify for financial assistance with Medicare Part D, you can contact the Social Security Administration (SSA) at (800) 772-1213 (TTY 800-325-0778) or visit SSA online at www.socialsecurity.gov.

Medicare Part D is offered through private, Medicare-approved prescrip-

tion drug plans. All Medicare drug plans will offer a standard level of coverage set by Medicare. If you decide to enroll in a Medicare prescription drug plan, you will pay a premium of about \$32.50 per month, although some providers may charge less. This fee will likely change over time. You will also have to pay a \$250-a-year deductible.

If you are eligible for Medicare, you can be enrolled in both your System health plan and Medicare Part D, but you cannot receive prescription drug benefits from both plans. Your options include keeping your A&M System health coverage and not enrolling in Part D, or keeping your A&M System health coverage and also enrolling in Part D. If you enroll in Part D, drug coverage will continue to be a part of whichever A&M System health plan you currently have, and your System health premiums will not decrease.

You are entitled to receive a notice of creditable coverage at any time. It is available online at http://tamus.edu/benefits/medicare_creditable_coverage_letter.pdf or from your Human Resources office.

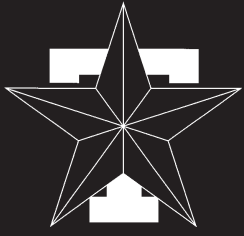
PRESCRIPTION DRUGS NOT COVERED

Prescription drugs that are not covered include, but are not limited to:

- ☆ those that are experimental or investigative,
- ☆ those that you are entitled to receive at no charge under any

- workers' compensation program,
- ☆ nicotine or those containing nicotine or other smoking-deterrent medications (except as covered under the smoking cessation program, as explained on page 41),
- ☆ anorectics or those used for weight control (except as covered under the weight loss program, as explained on page 41),
- ☆ tretinoin (Retin A) for cosmetic use if you are 26 or older,
- ☆ those used to treat or cure baldness,
- ☆ non-legend drugs other than 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 to plan participants.



SPECIAL PROGRAMS

The plan offers several special, voluntary programs to help you get the best value from your health coverage.

The plan offers several additional programs, services and education pieces that can help you get the most for your health-care dollar. All of these programs are voluntary.

MOTHER/BABY PROGRAM

The Mother/Baby Program is a voluntary educational program for women who are at high risk for premature labor and delivery.

You are automatically registered with the program when you precertify your hospitalization. We encourage you to precertify before four months or when you are hospitalized for a complication during pregnancy.

Once you are registered, you will be sent a questionnaire to fill out and return. Based on your answers, the Mother/Baby Program will evaluate your risk for premature delivery. If you are high risk, your *doctor* will be notified so he/she will be aware that you may need special treatment.

DAVIS VISION

The A&M Care plans do not cover annual eye exams. However, BCBSTX offers discounts on exams, frames, lenses and laser vision correction through Davis Vision. You simply go to a participating provider and show your A&M Care ID card to receive the discount. Provider information is available at www.davisvision.com (enter 2295 as your client control number) or by calling (800) 501-1459. A flier listing the discounts is also available online at www.tamus.edu/offices/benefits/programs/DavisVisionFlier.pdf.

CASE MANAGEMENT

When you have a catastrophic illness or injury that is likely to result in long *hospital* stays and big bills, Case Management can help you identify more comfortable and less expensive alternatives.

Case Management can look at your situation and develop alternatives to long-term hospitalization that may provide better and more convenient care, such as care in your home. Case Management can remove the plan limitations on some forms of alternative care to allow you to take advantage of these for longer periods, thus avoiding further hospitalization.

Case Management will automatically review your case when they learn of a likely long-term hospitalization through precertification.

You can learn more about Case Management by calling BCBSTX, (866) 295-1212.

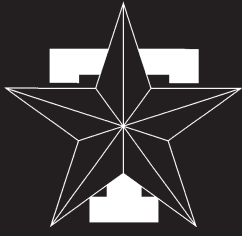
Discount Hearing Program

The A&M Care plans offer a discount hearing program through TruHearing. This program allows you to receive discounts of 30% to 60% off of the manufacturer suggested retail price for digital hearing instruments.

The program also includes a free hearing screening, hearing instrument fitting and related services through the TruHearing network of participating providers.

More information is available in an online flier at www.tamus.edu/benefits/programs/TruHearingFlier.pdf or on the TruHearing web site, www.TruHearing.com.

To access the program, call the toll-free customer service number, 1-877-882-2020, between 8 a.m. and 8 p.m., Central Time, Monday through Friday.



FILING CLAIMS

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

If you use a BlueChoice or BlueCard doctor or hospital, you file no claim forms.

For other services, you must file a claim for health benefits. To file a claim, be sure your name and Social Security number and the patient's name are on the bill. The bill must also include the diagnosis code, the date of service, the service provided and the procedure code for that service. If information is missing, payment of your benefits may be delayed. Each time you file a claim, you must include a BCBSTX claim form, available from your Human Resources office. Mail the bill with the claim form to:

BlueCross BlueShield of Texas, Inc.
Claims Division
P.O. Box 660044
Dallas, Texas 75266-0044

You may choose to have payment made directly to your *doctor* or other provider, or you may pay the bill yourself and have payment made to you.

Be sure to keep a copy of your claim for your records. You must send the original bill to BCBSTX.

You may want to wait until you have enough expenses to satisfy your deductible before submitting your first claim. However, you need to file all claims for a plan year soon after the plan year ends on Aug. 31. All claims from a plan year *must* be postmarked by Jan. 31 of the next plan year. The plan is not obligated to pay claims received after that date.

If you live in Texas, are retired and enrolled in Medicare, you may have Medicare send your claims directly to BCBSTX.

You cannot assign your rights and benefits under the plan to anyone at any time. In the absence of a written agreement with a health care provider, BCBSTX can make benefit payments to the provider or to you at BCBSTX's option to fulfill its responsibility to pay benefits under the plan.

HOW TO APPEAL A CLAIM

Although the A&M System is the plan administrator, it has given BCBSTX the authority to interpret and determine benefits in accordance with the A&M Care plan provisions.

If your claim for benefits is denied in whole or in part, BCBSTX will notify you in writing within 30 days of receipt of your claim.

The written notice will give specific reasons for the denial and reference the specific plan provisions on which the denial is based. It will also describe any additional material you must submit and explain the plan's claim review procedures.

In special circumstances, a response to your claim may take more than 30 days. If an extension is needed, you will receive written notice before the end of the 30-day period. In no event will the extension be more than 30 days.

Within 180 days of receiving written notice of a claim denial, you may submit a written request for reconsideration to BCBSTX (see address on previous page). Be sure to state why you believe the claim should not have been denied and submit any data, questions or comments you think are appropriate. You may also review any pertinent plan documents. Your appeal will be reviewed by the claims administrator. If you prefer, you may designate a representative to act on your behalf during the review process. Such designations must be provided to BCBSTX in writing.

A decision on the appeal will be made within 60 days after receipt of your request for review unless special circumstances require additional time.

SYSTEM REVIEW

If you are not satisfied with the decision reached by the claims review process, you may request a review by the System Review Panel within 30

days of your receipt of the final written decision from BCBSTX.

The review panel will review the claim to ensure that all BCBSTX procedures have been properly followed. The panel will also review issues of medical necessity of care, reasonable and customary charges, benefit eligibility and other matters.

To request review, you must send written notification of your desire to have your claim reviewed, with a copy of the decision, to:

Employee Benefits Manager
The Texas A&M University System
A&M System Building, Suite 1120
200 Technology Way
College Station, TX 77845-3424
Mail Stop: 1117 TAMU

If you or any of your witnesses or representatives wish to meet with the Review Panel from outside College Station via audioconference or the Trans-Texas Video Network, your notification letter must state that preference.

Within five working days of receiving your letter, the Employee Benefits Manager will mail you acknowledgment of your request. This mailing will include release forms that you must sign to authorize the release of relevant information about the problem to members of the Review Panel and to release panel members from any and all liability arising from the panel's conclusions.

You must return the release forms to

the Employee Benefits Manager within 30 days of receiving the forms.

Within 10 working days of receiving the release forms, the Employee Benefits Manager will contact the Review Panel members and set a review date. This group will meet to review the case within 30 days of the Employee Benefits Manager's notification to the panel. Within 30 days of the meeting, the panel will make a decision on the case, unless special circumstances require additional time.

You may address the panel and submit relevant information and expert opinions and/or witnesses. You must submit five copies of all documentation on your claim problem to the Employee Benefits Manager at least 72 hours before the meeting with the panel.

You also must inform the Employee Benefits Manager at least 72 hours in advance of the meeting of any witnesses or representatives you will have at the meeting. You are responsible for any expenses arising from use of witnesses or representatives.

The Employee Benefits Manager will notify you and BCBSTX of the panel's decision. This will be the final decision on your case, and the panel will not review it again.

If the review panel's decision would require the plan to violate state or federal law or A&M System policy or regulation, the plan administrator, after consulting with the General Counsel, may prohibit implementation of the panel's decision.

You may cancel a review of your case at any time by written request to the Employee Benefits Manager.

All powers exercised by the A&M System and BCBSTX will be exercised in a non-discriminatory manner and applied uniformly to ensure that individuals in similar circumstances are treated the same.

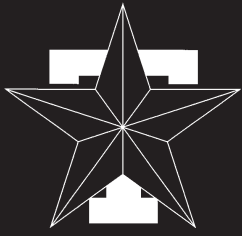
OVERPAYMENTS

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.



COORDINATION OF BENEFITS

Your health benefits are coordinated with other group plans and Medicare.

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 payor, the A&M Care benefit is based only on the amount the other plan does not pay. This means the deductible and your share of the cost (20% for 350 plan, 30% for 1250 plan) will be applied to the amount the other plan does not pay and not to the entire bill. You will not be reimbursed 100% of the charge unless you have

met your out-of-pocket maximum. If the primary plan has a copayment for the service, the A&M Care plan will pay no benefits.

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

CLAIMANT	PRIMARY PLAN	SECONDARY PLAN
<i>Wife</i>	Wife's	Husband's
<i>Husband</i>	Husband's	Wife's
<i>Child</i>	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.*

that covers you as an active employee pays first.

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.

COORDINATION WITH MEDICARE

If you are retired, not working for the A&M System and eligible for Medicare, Medicare will automatically be your primary plan and the A&M Care plan will be your secondary plan.

However, if you are working for the A&M System, the A&M Care plan will be primary during the months in which you receive a paycheck. If you work September through May, your

A&M Care plan will be primary all year.

While your A&M Care plan is primary, your A&M Care benefits will be the same whether or not you are enrolled in Medicare Part B. *When this plan coordinates with Medicare, benefits are calculated as if you are enrolled in Medicare parts A and B, even if you do not enroll in both parts.*

All A&M Care plans calculate their benefits based on the total charge—or the assigned charge if the *doctor* accepts assignment—*after* Medicare has paid its share. In other words, the A&M Care plans will consider only the difference between the bill and the Medicare benefits. Your deductible and cost sharing will be applied to this difference.

The example below shows you how each plan coordinates with Medicare. For this example, assume you have had

Date of Service	Doctor's Charge	Medicare Pays	A&M Care 65 PLUS		A&M Care 350		A&M Care 1250	
			Plan pays	You pay	Plan pays	You pay	Plan pays	You pay
Sept. 10	\$ 150	\$120 (80%)	\$ 0 *	\$ 30 †	\$ 0 *	\$30 †	\$ 0 *	\$ 30 †
Sept. 30	75	60 (80%)	0 *	15 †	0 *	15 †	0 *	15 †
Oct. 15	125	100 (80%)	0 *	25 †	0 *	25 †	0 *	25 †
Nov. 5	200	160 (80%)	0 *	40 †	0 *	40 †	0 *	40 †
Jan. 22	204 ‡	64	0 *	140 †	0 *	140 †	0 *	140 †
Feb. 15	225	180 (80%)	0 *	45 †	0 *	45 †	0 *	45 †
March 25	300	240 (80%)	0 *	60 †	4 *	56 †	0 *	60 †
May 7	500	400 (80%)	0 *	100 †	80	20	0 *	100 †
June 15	225	180 (80%)	0 *	45 †	36	9	0 *	45 †
July 3	500	400 (80%)	80	20	80	20	0 *	100 †
Total:	\$2,504	\$1,904	\$80	\$520	\$200	\$400	\$ 0	\$600

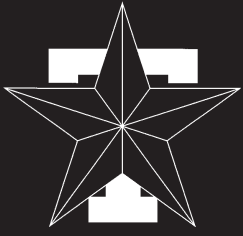
* Because you have not yet met your A&M Care plan deductible, the plan pays no benefit.

† This amount applies toward your A&M Care plan deductible.

‡ A portion of this charge applies toward your calendar-year Medicare deductible.

office visits throughout the year and have met your Medicare deductible by Sept. 1, when the new plan year begins. Because you've already met your Medicare deductible, charges for any office visits between Sept. 1 and Dec. 31 will be paid at 80% by Medicare. The 20% you pay will apply toward your A&M Care plan deductible. Beginning Jan. 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 doctor or you for the services you receive, and there is no limit to what the doctor may charge. However, the A&M Care plans will still treat the claim as if it had first been sent to Medicare for payment.



WHEN COVERAGE ENDS

In most cases, coverage ends on the last day of the month in which your employment ends. You can continue your coverage under COBRA for a limited time.

Your coverage will end on the earliest of the following dates:

- ☆ the last day of the month in which your employment ends or you become ineligible for coverage,
- ☆ the last day of the last month for which you pay your share, if any, of the cost of coverage,
- ☆ the last day of the plan year if you elect during Annual Enrollment not to continue coverage,
- ☆ the last day of the month in which you elect to terminate coverage due to a Change in Status, or
- ☆ the day this plan ends.

Coverage for your dependents ends on the earliest of the following dates:

- ☆ the day your coverage ends,
- ☆ the last day of the month in which the dependent stops meeting the eligibility requirements,
- ☆ the last day of the month for which you pay your full share, if any, of the cost for dependent coverage,
- ☆ the last day of the plan year if you elect during Annual Enrollment not to continue dependent coverage,
- ☆ the last day of the month in which you elect to drop dependent

coverage due to a Change in Status, or

- ☆ the day the plan stops offering dependent coverage.

You will receive a certificate of group coverage when you end your participation in this plan. However, you may request this form at any time while you are covered under this plan and for up to 24 months following the end of coverage by contacting your Human Resources office.

WHEN COVERAGE IS EXTENDED

In some cases, your coverage can be extended due to changes in your System employment.

Approved Leave of Absence: If you take a paid leave, your coverage can continue and your share of premiums, if any, will continue to be deducted from your pay.

If your leave is unpaid, you may make arrangements to pay your premiums. Unless you are on FMLA (see below), you do not receive an employer contribution toward your coverage while you are on unpaid leave.

Should you drop your health coverage while on an unpaid leave, your coverage will automatically be reinstated when you return to work, regardless of the plan year. You have 60 days after your return to make enrollment changes.

office visits throughout the year and have met your Medicare deductible by Sept. 1, when the new plan year begins. Because you've already met your Medicare deductible, charges for any office visits between Sept. 1 and Dec. 31 will be paid at 80% by Medicare. The 20% you pay will apply toward your A&M Care plan deductible. Beginning Jan. 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 doctor or you for the services you receive, and there is no limit to what the doctor may charge. However, the A&M Care plans will still treat the claim as if it had first been sent to Medicare for payment.

but at least 10 years of A&M System service, you can keep your coverages and employer contribution for the number of months equal to your months of service credit.

In all cases, a physician's certification of disability may be required periodically, but no more than once a year. Your health coverage and employer contribution will end when you are no longer disabled, unless you return to work or meet the requirements for retiree insurance coverage.

If you don't qualify for disability retirement, you may continue benefits under COBRA for 18 months. You are not eligible for the employer contribution. You may be able to continue COBRA coverage for 11 months beyond the initial COBRA period if you are approved for Social Security disability benefits while on COBRA.

Retirement: You may continue health coverage if you meet the requirements listed on page 5 and you had health coverage through the 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 of 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.

Part-Time Employee: If your budgeted employment is reduced to less than 50% time after you have been covered by this plan for at least 4½ continuous months, you can continue your health coverage. You must make arrangements to pay the premium with no employer contribution.

COBRA COVERAGE CONTINUATION

In some cases, you, your spouse (including a former spouse) and your children have the option to extend

coverage beyond the time it would normally end by paying the full cost of coverage. The chart below describes these cases.

If, in anticipation of a divorce, you drop your spouse’s health coverage during Annual Enrollment or due to a change in status, under certain circumstances your spouse will be offered COBRA continuation coverage from the date of the divorce if you or your ex-spouse notifies your Human Resources office 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.

You must notify the 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. See the chart on page 56 for notification, election and payment deadlines.

Failure to meet these 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

COBRA QUALIFYING EVENTS AND CONTINUATION PERIODS

IF...	THEN . . .
<p>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...</p>	<p>Coverage for you and/or your covered family members can be extended for up to 18 months.</p>
<p>You die... or You divorce or legally separate...</p>	<p>Coverage for your covered family members can be extended for up to 36 months.</p>
<p>Your covered child no longer qualifies for coverage...</p>	<p>Coverage for the child can be extended for up to 36 months.</p>
<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>

notification, the System 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

COBRA TIMELINE

If...	If...
<ul style="list-style-type: none"> ☆ You divorce, or ☆ Your child becomes ineligible for coverage 	<ul style="list-style-type: none"> ☆ You leave employment, ☆ Your hours are reduced, ☆ You go on leave without pay, or ☆ You die
Then...	Then...
<p>You and/or your dependents have 60 days after the event to notify Human Resources of the event.</p> <p>The A&M System has 14 days after your notification to send you and/or your dependents a COBRA enrollment form.</p> <p>You and/or your dependents have 60 days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form.</p> <p>You and/or your dependents have 45 days after making your election to pay back premiums.</p>	<p>The A&M System has 14 days after the event (or notification of your death) to send you and/or your dependents a COBRA enrollment form.</p> <p>You and/or your dependents have 60 days after the event or date the COBRA enrollment form was sent, whichever is later, to elect COBRA coverage and return your enrollment form.</p> <p>You and/or your dependents have 45 days after making your election to pay back premiums.</p>

If you or your dependent becomes eligible for Social Security disability benefits within 60 days of the date your coverage ended, you or your dependent must notify your Human Resources office within **60** days of receiving notice from the Social Security Administration and before the end of the initial 18-month COBRA period. *If you and/or your dependents miss any of these deadlines, you and/or your dependents forfeit your rights to continue coverage.*

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 marriage or 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 A&M System 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 appropriate institution or agency Human Resources office 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:

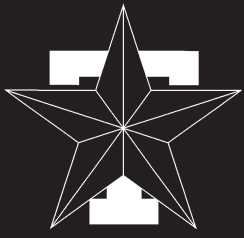
- ☆ the required premium is not paid,
- ☆ you or a family member becomes covered under another group health plan, unless that plan has a pre-existing condition provision that limits your benefits,
- ☆ you or a dependent becomes entitled to benefits under Medicare, or
- ☆ the System no longer offers health coverage to its employees.

RISK POOL

Conversion to an individual health insurance policy is not available when your coverage under this plan ends.

However, the State of Texas has established a Statewide Health Insurance Risk Pool for Texans who cannot obtain health insurance because of their medical history. You may be eligible for coverage under this program. If you would like more information on this coverage, you may call a toll-free telephone number, (888) 398-3927, or write to:

Texas Health Insurance Risk Pool
P.O. Box 90259
Indianapolis, IN 46290-0259



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 italicized 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.

Crisis stabilization unit means a 24-hour residential program that is short-term, provides intensive supervision and is licensed or certified by the Texas Department of Mental Health and Mental Retardation.

Custodial care means care (including room and board) that:

- ☆ is given mainly to help a person with personal hygiene or to perform the activities of daily living, and
- ☆ can, under generally accepted medical standards, be safely and adequately given by people who are not trained or licensed medical or nursing personnel.

Some examples of *custodial care* are training or help to get in and out of bed, bathe, dress, prepare special diets, eat, walk, use the toilet, or take drugs or medicines.

These services are custodial regardless of who recommends, provides, or directs the care, or where the care is given.

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

Home health care agency means a *hospital* or other organization:

- ☆ licensed or certified under a public health law or a similar law to provide home health care services, or
- ☆ recognized as a *home health care agency* by Medicare.

Hospital means a facility that:

- ☆ is legally licensed,
- ☆ provides a broad range of 24-hour-a-day medical services for sick and injured persons by, or under the supervision of, a staff of *doctors*, and
- ☆ provides 24-hour-a-day nursing care by, or under the direction of, a *nurse*.

Nurse means a registered professional nurse (R.N.).

Primary Care Physician (PCP)

means a general or family practitioner, an internal medicine doctor, a pediatrician or an obstetrician/gynecologist.

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 an institution that:

- ☆ provides residential care and treatment for unmarried dependents younger than 18, and
- ☆ is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

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 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.

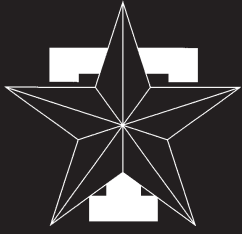
Services by other professionals will be considered as services performed by a specialist if the services are recommended by a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) and the services performed are within the scope of the professional's license. These include services performed by:

- ☆ 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 BlueChoice or BlueCard network or if you are referred to one of these providers by a *doctor*.

See professional services on page 32 for additional provider information.



ADMINISTRATIVE AND PRIVACY INFORMATION

Here are some other facts about the plan you might want to keep handy.

PLAN NAME

The official name of this plan is The Texas A&M University System Group Health Program. The more familiar names for these plans are A&M Care 350, A&M Care 1250 and 65 PLUS. This booklet also describes The Texas A&M University System Pretax Premiums Plan.

PLAN SPONSOR

Director of Risk Management and Safety

The Texas A&M University System
A&M System Building, Suite 1120
200 Technology Way
College Station, TX 77845-3424
Mail Stop: 1117 TAMU
(979) 458-6160 or (800) 258-4440

PLAN ADMINISTRATOR

The plan administrator is the Director of Risk Management and Safety.

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. Caremark, in accordance with an administrative agreement between Caremark 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:

Caremark
P.O. Box 2860
Pittsburgh, PA 15230-2860

Mail-order drug claims should be sent to:

Caremark
P.O. Box 9062
Clearwater, FL 33758-9748

The Pretax Premiums Plan claims administrator is the Plan Administrator.

The A&M Care and Pretax Premiums 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 Sept. 1 and runs through the next Aug. 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 Caremark 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 Caremark gather information about you from your applications, claims and other forms. They also have personal health information that comes in from your claims, your health care 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, Caremark 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, administra-

tors, 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 tamus.edu/benefits/publications/brochures/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 have questions about Caremark's privacy policy, please write to:

Ellen Hodge, Director
Business Practices and Compliance
9501 E. Shea Boulevard
Scottsdale, AZ 85260-6719

If you feel your privacy rights have been violated, you may file a complaint with the A&M System by contacting the Privacy Official at (979) 458-6160. 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
The Texas A&M University System
1117 TAMU
College Station, TX 77843-1117