Navigating Your Texas A&M University System Student Health Insurance Plan

An easy-to-use guide to help you understand your Student Health Insurance benefits.
Attending college is a big step that can mean many changes and new challenges, like learning about health insurance and how it works. You’re on your own health plan now, and it is important to learn how to take control of your health care and get the most from your plan.

Keep this available throughout the year and it will guide you whether you are sick or just have a question about your health plan at The Texas A&M University System.
**WHO IS ELIGIBLE?**

**ANY ENROLLED** Texas A&M University System student taking at least six (6) credit hours of classes is eligible to enroll in this insurance plan. Students who are enrolled in special classes and take less than six (6) credit/contact hours of classwork will be determined eligible for this Student Health Insurance Plan if the reduced coursework meets the criteria for the completion of a degree plan or international program as defined and approved by The Texas A&M University System.

**INTERNATIONAL STUDENTS** (those who are not United States citizens or permanent residents of the United States) ARE REQUIRED to maintain approved health insurance coverage continuously while enrolled and attending a Texas A&M System institution, unless the student provides proof of coverage that meets the Texas A&M University System waiver requirements. (See the TAMU Policy #26.99.01).

All registered and enrolled Texas A&M University System **GRADUATE STUDENTS** employed by The System are eligible to enroll in this insurance plan (**no minimum hour requirement**).

A student must actively attend classes for at least the first 31 days after the date for which coverage is purchased unless he or she withdraws from classes due to an Injury or Sickness and the absence is an approved medical leave.

**HOW THE PLAN WORKS**

**Health Insurance 101**

The term, Health Insurance, refers to a variety of insurance policies, ranging from those that cover the costs of doctors and hospitals to those that meet a specific need — like long-term care or dental coverage. When most of us talk about health insurance, we refer to the kind of plan that covers doctor bills, surgery and hospital costs.

You may have heard terms like “PPO,” “SOB” and “Exclusions.” Understanding these words will help you understand your student health plan. Confused? Don’t worry. We’ll help you make sense of the lingo.

**What is a PPO or a Network Provider?**

PPO stands for **“Preferred Provider Organization”** and PPO plans are a type of health insurance plan sometimes referred to as managed care. Blue Cross and Blue Shield of Texas (BCBSTX) has negotiated discounts with physicians and facilities nationwide. This group is collectively referred to as **“Network Providers.”**

PPO plans encourage you to get treatment from a Network Provider. Usually, you will pay a Copayment and then pay a certain amount up front (the Deductible) before the insurance company begins to pay the Provider. After you’ve paid your Deductible, the insurance company will begin to pay for a certain percentage of eligible expenses. Remember that it’s less expensive to visit one of the Network Providers. However, you can also go outside the plan’s list, to an **“Out-of-Network Provider,”** but your share of the bill will be higher.

Your plan includes an **Out-of-Pocket Maximum**, which is the amount of money you pay for your percentage of eligible health care services before the insurance company pays 100% of eligible services up to the Policy’s **Maximum Benefit.**
Your Schedule of Benefits

Often called an “SOB,” the Schedule of Benefits outlines what services are included in your plan. No single plan will cover all costs associated with medical care, but some cover more than others.

Since your plan is a PPO, your SOB will include network and out-of-network coinsurance percentages. Becoming familiar with your SOB is the first step in understanding your plan and its benefits. Before seeking treatment for a non-emergency condition, it is a good idea to review the SOB. If you have any questions about what your plan will pay for, you should call Customer Service at (855) 267-0214. Understanding your benefits up front will allow you to make informed choices about your care.

The Plan Pays Eligible Expenses:
- 80% of the Allowable Amount for Network Providers
- 60% of the Allowable Amount for Out-of-Network Providers

When you’ve paid your $5,000 out-of-pocket maximum, the plan pays 100% of the Allowable Amount for all remaining eligible expenses.

TO SUMMARIZE:

<table>
<thead>
<tr>
<th>DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS</th>
<th>NETWORK PROVIDER</th>
<th>OUT-OF-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>After you pay the per Policy year Deductible of:</strong></td>
<td>$300 per Covered Person</td>
<td></td>
</tr>
<tr>
<td><strong>The plan pays the following percentage after the Deductible has been satisfied at:</strong></td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Up to the per Policy year Out-of-pocket maximum of:</strong></td>
<td>$5,000 per Covered Person</td>
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</tbody>
</table>

Understanding the Network

The Student Health Insurance Plan for students is a PPO plan provided through Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX has negotiated discounted service rates with the Providers in their network in order to provide health care value to you.

The plan encourages you to use Network Providers to maximize your health care dollars. Using Network Providers results in a lower Deductible and a lower out-of-pocket maximum. Out-of-Network service charges by physicians and facilities are also higher since they have not agreed to provide their services at a discounted rate.

Want to see if your doctor is in the BCBSTX PPO Network? Go to www.ahpcare.com/tamus to search for participating Providers. You can also call Customer Service at (855) 267-0214 between the hours of 8:00 a.m. to 6:00 p.m. C.S.T.
AN OVERVIEW OF YOUR PLAN BENEFITS

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>NETWORK PROVIDER</th>
<th>OUT-OF-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Doctor's Visits</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>$35 Copayment per visit, including consultants. (Deductible waived)</td>
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</tr>
<tr>
<td>Diagnostic, X-ray and Laboratory Procedures</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Emergency Room Expenses</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount for Non-Emergency</td>
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<tr>
<td></td>
<td></td>
<td>80% of Allowable Amount for Emergency</td>
</tr>
<tr>
<td>Surgical Expense</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>At pharmacies contracting with the Prime Therapeutics Network</td>
<td>60% of Allowable Amount after a $15 Copayment for each Generic Drug</td>
</tr>
<tr>
<td>Prescription filed at SHC: 100% of Allowable Amount after a $15 Copayment. (Deductible waived)</td>
<td>100% of Allowable Amount after a $15 Copayment for each Preferred Brand Name Drug</td>
<td>60% of Allowable Amount after a $15 Copayment for each Preferred Brand Name Drug</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25 Copayment for each Preferred Brand Name Drug</td>
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<td></td>
<td></td>
<td>35 Copayment for each Non-PREFERRED Brand Name Drug</td>
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</table>

This chart presents highlights of your plan only. For plan details please refer to pages 15-17 of this brochure. Students are responsible to pay amounts over the Allowable Amount, if any.


RECEIVING MEDICAL CARE

There are a variety of situations in which you might need to receive medical care. Depending on your circumstances, here’s how to access your benefits.

Services at the Student Health Center

Staying healthy is especially important during your college years. Getting routine physicals on a regular basis can help prevent problems from developing later on down the line. Preventive care encompasses everything from annual checkups and immunizations to X-rays and lab work. If your campus has a Student Health Center, the Deductible will be waived and benefits paid at 100% of the Allowable Amount of Covered Expenses incurred at the Student Health Center.

The Student Health Center can help keep you healthy with services such as:

- Allergy injections
- Gynecological exams
- Health education
- Immunizations
- Lab tests
- Mental health counseling and group therapies
- Nutrition Services
- Pregnancy tests
- Referrals
- STD/HIV antibody testing
- Telephone advice
- Throat cultures
- Tuberculosis screening
When You Are Sick or Injured

It can be difficult to determine if a sudden illness or accident requires emergency care or can be treated by making an appointment to see a doctor. There are certain cases which usually require emergency care. They are provided in the “Is it An Emergency?” section.

Tips for Choosing a Doctor

If you are far from home, you may not be able to see your family doctor for non-routine visits. You may need to select a doctor in the area, and here is some advice on how to select a new physician:

- Ask your family doctor for a referral in the area. Talk with friends and associates about their physician recommendations.
- Search the Provider database at www.ahpcare.com/tamus.
- Once you’ve found a doctor that fits your criteria, call to confirm their office hours and admitting privileges at network hospitals.
- Remember that if you are not comfortable with your chosen physician, you are free to search the Provider database and select a different physician at any time.
Do I Need to go to the Emergency Room?

If, after reviewing the guidelines at the right, you still have questions about whether you need emergency care, you can call the Blue Care Connection Program (24/7 Nurseline), anytime, day or night, 365 days a year. Registered Nurses, Licensed Professional Counselors, and Master Level Social Workers are available to answer your health questions at (866) 412-8795 (toll free).

If you need emergency care, go to the nearest emergency facility immediately or dial 911. You do not have to worry about ensuring that you are going to a Network Provider facility in an emergency; you will receive the same level of benefit either way.

If, after evaluating your situation, you determine that you need to see a physician, you may either visit the Student Health Center on your campus (for medical students).

You can also go to a physician who participates in the BCBSTX PPO Network to receive maximum benefits under the plan.

Is it an Emergency?

No one wants to go to the emergency room if it can be avoided. Using the emergency room for non-emergencies costs you money because emergency room benefits are only paid for true emergencies.

Having said that, in a life-threatening emergency, seek immediate attention by calling 911 or going to the emergency room at your nearest hospital.

Here is a list of situations that may be life threatening:

- Choking
- Not breathing or difficulty breathing
- Suspected poisoning or overdose
- Severe injuries, such as suspected broken bones, head injuries or heavy bleeding
- Seizures or convulsions
- Numbness or paralysis of an arm, leg or one side of the body
- A sudden, severe headache, especially if there is neck pain or a change in consciousness at the same time
- Domestic violence or rape
- A change in mental ability, such as not knowing where you are or being unable to recognize familiar people

For further details of the coverage refer to pages 15-17.
When You Need Care for Mental Health or Substance Abuse

Your emotional and mental well-being are just as important as your physical well-being. The stress of schoolwork and other commitments may cause some students to feel depressed, lonely or confused. If you think your mental health might be suffering and that counseling would be beneficial, help is available to you.

Follow-Up Care: In Your Hands

It is important to follow your doctor’s advice for ongoing treatment of your condition. A successful outcome is largely in your hands. Check this guide to make sure that additional treatment recommended by the doctor is covered under your plan.

If you are referred to another physician, specialist or facility, check that these Providers are a Network Provider in the BCBSTX PPO Network. If not, your physician may be able to provide an alternative that is a Network Provider.

If your condition requires surgery or hospitalization, try to gather as much information as possible to ensure that this is the appropriate course of treatment. You may want to get a second opinion and if you use a network physician, it may minimize your additional cost.

I Need a Specialist!

Your student health plan does not require referrals to visit a specialist. Just go to www.ahpcare.com/tamus to find a Network Provider in your desired specialty. You can search for a physician or facility regardless of whether you are currently insured under the Student Health Insurance Plan; however, benefits are only paid for insured students.
Health Resources Available 24/7 Online or by Phone

Information is power, and the more you know before you seek care, the better your health care decisions will be. Blue Cross and Blue Shield of Texas provides several resources through the Blue Care Connection® Program:

**Blue Care® Advisor** — a multi-disciplinary team of Registered Nurses, Licensed Professional Counselors, and Master Level Social Workers who assist selected members in navigating the health care system; coordinates members’ health care and benefits; educates and empowers members to make informed choices; and promotes wellness by encouraging self-management according to preventive care guidelines. *Please call (866) 412-8795 for more information.*

**24/7 Nurseline** — call 24/7 to ask your health care questions and get guidance on a wide variety of health care issues. *Please call (866) 412-8795 for more information.*

**Condition Management** — members diagnosed with chronic health conditions such as asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease, low back pain, cancer, metabolic syndrome and coronary artery disease can receive resources and tools to help manage their conditions. *Please call (866) 412-8795 for more information.*

**Case Management & Special Beginnings®** — pregnant members can enroll to receive a prenatal risk assessment, educational information and case management services to help reduce the incidence of low birth weight infants and premature delivery. *Please call (866) 412-8795 for more information.*

**Blue Access for Members™ (BAM)** — log on to [www.ahpcare.com/tamus](http://www.ahpcare.com/tamus) to register for BAM and get personalized information about your health care coverage such as date and amount of claims payments, prescription drug list and help finding a physician, hospital or pharmacy.

**Lifestyle Management & Wellness programs** — targeted wellness initiatives that can help prevent diseases or identify them early when they are more treatable. *Please call (866) 412-8795 for more information.*
Using Your Prescription Drug Benefit

You may need to fill a prescription during your time as a student. This section explains in simple terms the prescription drug benefits available under the plan.

Online Account Access

Prime Therapeutics is the Pharmacy Benefit Manager (PBM) for your plan. Pharmacies contracting with the Prime Therapeutics Network provide competitive prescription drug pricing and plan management.

Online access to prescription information, a pharmacy locator, and prescription pricing is available through (BAM) at www.ahpcare.com/tamus. Just log in and select “Find A Pharmacy” from the menu under the “Benefits” column and follow the onscreen prompts.

Three Cost Options

Prescription medications are categorized within three cost options. Each cost option is assigned a Copayment, which is an amount you pay when you fill a prescription at a participating retail pharmacy or refill your ongoing prescription through the network mail-order pharmacy service.

Your health plan sets the actual Copayment and Coinsurance amounts for the medications covered under your pharmacy benefit. Consult www.ahpcare.com/tamus for further details of the Policy about the Copayment and Coinsurance that may apply to your pharmacy benefit coverage.

Your Lowest Cost Option

Generic Drugs are your lowest Copayment option at $15 per prescription. For the lowest out-of-pocket expense, you should always consider Generic Drug medications if you and your doctor decide they are appropriate for your treatment.

Midrange Cost Option

Preferred Brand Name Drugs are your middle Copayment option at $25 per prescription. Consider Preferred Brand Name Drug medications if you and your doctor decide that a Preferred Brand Name Drug medication is the most appropriate to treat your condition.

Highest Cost Option

Non-Preferred Brand Name Drugs are your highest Copayment option at $35 per prescription. Sometimes there are alternatives available in Generic or Preferred Brand Name Drugs. If you are currently taking a Non-Preferred Brand Name Drug medication, ask your doctor whether there are Generic or Preferred Brand Name Drug alternatives that may be appropriate for your treatment.

Compounded medications, those medications containing one or more ingredients that are prepared “on site” by a pharmacist, are classified at the Non-Preferred Brand Name Drug level, provided that the individual ingredients used in compounding are covered under the pharmacy benefit.

Your doctor will be able to determine which drugs are classified under which cost option, but you can call (800) 423-1973 to determine in which cost option your current prescription resides.

Out-of-Network Benefits

If you go to a pharmacy outside of the Prime Therapeutics Network, your covered prescription will be processed at 60% of the Allowable Amount after a $15 Copayment for each Generic Drug, $25 Copayment for each Preferred Brand Name Drug and $35 Copayment for each Non-Preferred Brand Name Drug.
Mail Order Prescriptions

If you take a certain drug for an ongoing condition such as allergies or diabetes, you can save money by using mail order as your prescription program. See the chart for an overview of your prescription drug benefits, including mail order costs.

<table>
<thead>
<tr>
<th>Prescription Drug Category for a Network Provider</th>
<th>How Much You Pay for Up to a 30-Day Supply (Per Prescription)</th>
<th>How Much You Pay for Up to a 90-Day Supply Through the Mail Order Drug Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>All options are subject to the plan maximum of $500,000 per Covered Person per Policy year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drug</td>
<td>100% after a $15 Copayment</td>
<td>100% after a $25 Copayment</td>
</tr>
<tr>
<td>Preferred Brand Name Drug</td>
<td>100% after a $25 Copayment</td>
<td>100% after a $40 Copayment</td>
</tr>
<tr>
<td>Non-Preferred Brand Name Drug</td>
<td>100% after a $35 Copayment</td>
<td>100% after a $40 Copayment</td>
</tr>
</tbody>
</table>

How Much Do Prescription Drugs Really Cost?

Although you pay a fixed fee — $15, $25 or $35 — at the pharmacy counter, the plan pays the majority of the cost of your prescription, so you may be surprised to learn how much your medications really cost. Each time you fill a prescription, the plan pays the difference between the true drug cost and your Copayment. The Prescription Drug Plan has a $500,000 Maximum Benefit per Covered Person, per Policy year. After the plan has paid $500,000, you will be responsible for paying the full cost of the prescription drug thereafter. Most likely, you won’t reach this limit, but it’s something to keep in mind if you expect to incur a lot of prescription drug expenses during the year.

How to Fill a Prescription

With participating pharmacies nationwide and a convenient mail order program, BCBSTX makes it easy for you to get your prescription filled.

1. Locate a participating pharmacy at www.ahpcare.com/tamus under the Benefits column by clicking on Find A Pharmacy and follow the prompts provided or by calling (800) 423-1973.
2. Present your BCBSTX ID card along with your prescription at the pharmacy counter.
3. Pay the applicable Copayment at the pharmacy and you’re done.

1. The first time your doctor prescribes medication that you will take on a regular basis, ask for two prescriptions. The first prescription should be for one month that can be immediately filled at a participating retail pharmacy. The second should be written for a 90-day supply with refills. Use the 90-day prescription to obtain your medication from the mail order pharmacy.

2. Use the process that is most convenient for you to fill mail order prescriptions:
   - FAX — Give your doctor your ID number. Then have your doctor call (800) 423-1973 to get instructions on how to fax your prescription to the pharmacy.
   - MAIL — Go to www.ahpcare.com/tamus to download the PrimeMail Refill Prescription Order Form. Click on Mail Order Prescriptions then look under Mail Service Program and you will find the order form to complete and mail.
3. Your prescription will arrive within 7 to 11 days.
Refill Your Order
When you have only a two-week supply of your medication left, it’s time to reorder. Have your ID number, prescription number (the 12-digit number on your refill slip), and credit card ready.

Go to www.ahpcare.com/tamus to access prescription refills by clicking on Mail Order Prescriptions then look under Mail Service Program and you will find the PrimeMail Refill Prescription Order Form to complete and mail. You may also call Prime Therapeutics Network by phone at (800) 423-1973. When ordering your refill by phone be sure to record your confirmation number.

Pay For Your Prescriptions
You can pay by check, money order or credit card for prescription refills by mail. For more information on payment types call (800) 423-1973.

Always Show Your ID Card
Be sure to always present your ID card when seeking health care services and at the pharmacy when purchasing a prescription. This will ensure that you receive the benefits under the plan and that the Provider will submit a claim on your behalf.

Blue Access for Members (BAM)
BCBSTX provides each insured student with access to their plan online through BAM. Go to www.ahpcare.com/tamus and click on Register for Blue Access for Members under the Claims column. You will be required to do the following:

- Click on New User? Register Now
- Fill in the boxes with the required information

Once you have registered, you will be able to log on as a member and go directly to your BAM page. If you need more assistance, you may call Customer Service at (877) 624-7911.

Plan Management at Your Fingertips
BAM can help you manage your plan at your convenience. Go to www.ahpcare.com/tamus and click on View Claims Online then log on to BAM to access plan and account information. Some details of what to look for:

- Track your claims status
- View Explanations of Benefits
- Print a temporary ID card or request a permanent replacement ID card
- Locate Network Providers
- Link to the Pharmacy Information to manage your prescriptions
Submitting a Claim

Typically, for network and out-of-network benefits, the physician or facility will file a medical claim on your behalf. Once you’ve met the Deductible, the insurance company will pay the Provider the agreed upon amount, based on negotiated discounts and your plan benefits. BCBSTX will send you an Explanation of Benefits (EOB) detailing the amounts paid to the Provider. You will then receive a bill for any remaining balance from the Provider, which you pay directly to that Provider.

Stretching Your Health Care Dollars

Included in your plan is the Blue365 money-saving program. This program is not insurance, but provides discounts on the following health and wellness services:

- Complimentary Alternative Medicine
- Davis Vision | TruVision
- Procter & Gamble Dental Products
- Seattle Sutton’s Healthy Eating
- TruHearing

Go to www.ahpcare.com/tamus to get detailed information about the Blue365 program. To use Blue365, simply show your BCBSTX ID card to a participating Provider to receive your discount.

Premium Rates

Please see below rates. If you have a spouse or child(ren) whom you would like to cover under our Student Health Insurance Plan, your annual cost for health care insurance is listed in the chart below.

<table>
<thead>
<tr>
<th>IF YOU WANT COVERAGE FOR</th>
<th>ANNUAL COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Only</td>
<td>$ 1,277.00</td>
</tr>
<tr>
<td>Student &amp; Spouse</td>
<td>$ 5,159.00</td>
</tr>
<tr>
<td>Student &amp; Children</td>
<td>$ 3,389.00</td>
</tr>
<tr>
<td>Student, Spouse and Children</td>
<td>$ 7,271.00</td>
</tr>
</tbody>
</table>

To purchase Dependent coverage or if your situation changes during the year, go to www.ahpcare.com/tamus. You may only cover your Dependents if you are also enrolled in the plan. Please see the plan brochure for the Dependent definition.
IF YOU LEAVE THE UNIVERSITY

To be eligible for insurance coverage under the System plan, you must be fully enrolled and actively attending classes for the first 31 days of the academic term. If you are not enrolled for the first 31 days, or if you leave the University within the first 31 days of your enrollment as a student, your coverage under The Texas A&M University System Student Health Insurance Plan will end. If you do not meet these eligibility requirements, BCBSTX’s only obligation is to refund the premium.

CONTINUING COVERAGE

If your insurance under The Texas A&M University System Student Health Insurance Plan for students ends for any reason, you may be eligible to continue your coverage. To qualify, you must have participated in the plan for the three (3) months immediately preceding the date your coverage ended. Continuation coverage can be purchased for up to six (6) months. Enrollment must be made and the applicable premium must be paid directly to Academic HealthPlans and be received within 30 days after the expiration date of your student coverage.

To learn more about continuation coverage, contact Academic HealthPlans at (877) 624-7911 before your student coverage ends.
SCHEDULE OF MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

$500,000 Maximum Benefit, per Covered Person, per Policy year

$300 Deductible per Covered Person, per Policy year

Maximum two Deductibles per family, per Policy Year

$5,000 Out-of-pocket Maximum per Policy Year

The Network Provider for this plan is Blue Cross and Blue Shield of Texas (BCBSTX) BlueChoice® PPO Network.

Student Health Center, the Deductible will be waived and benefits paid at 100% of the Allowable Amount of Covered Expenses.

After the Deductible is satisfied, benefits will be paid based on the selected provider. Benefits will be paid at 80% of the Allowable Amount for services rendered by Network Providers in the Blue Cross and Blue Shield of Texas (BCBSTX) BlueChoice® PPO Network, unless otherwise specified in the Policy. Services obtained from Out-of-Network Providers (any provider outside the BCBSTX BlueChoice® PPO Network) will be paid at 60% of the Allowable Amount, unless otherwise specified in the Policy. Benefits will be paid up to the maximum for each service as specified below regardless of the provider selected, not to exceed the Maximum Benefit of $500,000.

Out-of-pocket Maximum means the maximum liability that may be incurred by a Covered Person in a benefit period for covered services under the terms of a Coverage Plan.

Once the Out-of-pocket limit has been satisfied, Covered Expenses will be payable at 100% for the remainder of the Policy year, up to any maximum that may apply. The Out-of-pocket limit does not include Deductible, Copayments or any charges exceeding the Allowable Amount.

<table>
<thead>
<tr>
<th>INPATIENT</th>
<th>NETWORK PROVIDER</th>
<th>OUT-OF-NETWORK PROVIDER</th>
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<tbody>
<tr>
<td>Hospital Expense, daily semi-private room rate; intensive care; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses such as the cost of the operating room, Laboratory tests, X-ray examinations, pre-admission testing, anesthesia, drugs (excluding take home drugs) or medicines, Physical Therapy, therapeutic services and supplies.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Surgical Expense, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure. The surgical procedure with the highest Allowable Amount should be priced at 100% of the Allowable Amount and the remaining eligible procedures should be priced at 50% of the Allowable Amount.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<tr>
<td>Assistant Surgeon</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<td>Anesthetist</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<tr>
<td>Doctor’s Visits</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<tr>
<td>Routine Well-Baby Care</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<tr>
<td>Mental &amp; Nervous Disorders, Alcoholism &amp; Drug Abuse</td>
<td>Paid as any other covered Sickness</td>
<td>Paid as any other covered Sickness</td>
</tr>
<tr>
<td>OUTPATIENT</td>
<td>NETWORK PROVIDER</td>
<td>OUT-OF-NETWORK PROVIDER</td>
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<tr>
<td>the same operative session, the primary or major procedure is eligible for</td>
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<td>full allowance for that procedure. The surgical procedure with the highest</td>
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<td>Allowable Amount should be priced at 100% of the Allowable Amount and the</td>
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<tr>
<td>remaining eligible procedures should be priced at 50% of the Allowable</td>
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<tr>
<td>Amount.</td>
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<tr>
<td>Day Surgery Miscellaneous, related to scheduled surgery performed in a</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<tr>
<td>Hospital, including the cost of the operating room, laboratory tests,</td>
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<tr>
<td>X-ray examinations, professional fees, anesthesia, drugs or medicines and</td>
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<tr>
<td>supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Doctor’s Visits, including consultants. $35 Copayment per visit (Deductible</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>waived)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy, $35 Copayment per visit (Deductible waived)</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy, includes dialysis and respiratory</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Expenses, benefits are payable for the use of the</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Emergency Room &amp; Supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care, $35 Copayment per visit (Deductible waived)</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Diagnostic X-rays &amp; Laboratory Procedures</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Injections, when administered in the Doctor’s office and charged on the</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Doctor’s statement. (Plan Deductible does not apply.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tests &amp; Procedures, diagnostic services and medical procedures performed</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>by a Doctor, other than Doctor’s Visits, Physical Therapy and X-rays and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab procedures. (Includes quaniferone gold (TB Blood Test)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs, allergy medications, birth control and diabetic</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>supplies are covered and included. Prescriptions are limited to a 30 day</td>
<td></td>
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</tr>
<tr>
<td>retail supply at (1) one times the Copayment or a 90 day retail supply at</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) times the Copayment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriptions filled at the SHC:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% of Allowable Amount after a $15 Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 day supply may be purchased through the Prime Therapeutics Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Order Program at a $25 Copayment for each Generic Drug and a $40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment for each Brand Name Drug.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental &amp; Nervous Disorder / Alcoholism &amp; Drug Abuse, $35 Copayment per</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>visit, includes all related or ancillary charges incurred as a result of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Mental &amp; Nervous Disorder. (Deductible waived)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At pharmacies contracting with the Prime Therapeutic Network:
- 100% of Allowable Amount after a $15 Copayment for each Generic Drug
- $25 Copayment for each Preferred Brand Name Drug
- $35 Copayment for each Non-Preferred Brand Name Drug

At pharmacies contracting with the Prime Therapeutic Network:
- 60% of Allowable Amount after a $15 Copayment for each Preferred Brand Name Drug
- $25 Copayment for each Preferred Brand Name Drug
- $35 Copayment for each Non-Preferred Brand Name Drug
<table>
<thead>
<tr>
<th>OTHER</th>
<th>NETWORK PROVIDER</th>
<th>OUT-OF-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Service</td>
<td>80% of Allowable Amount</td>
<td>80% of Allowable Amount</td>
</tr>
<tr>
<td>Durable Medical Equipment, when prescribed by a Doctor and a written prescription accompanies the claim when submitted.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Dental, $1,000 Maximum, made necessary by Injury to sound, natural teeth only.</td>
<td>80% of Allowable Amount</td>
<td>80% of Allowable Amount</td>
</tr>
<tr>
<td>Maternity/Complications of Pregnancy</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Needle Stick, only for students doing course work or hospital training.</td>
<td>100% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Preventive Care Services, includes immunizations, routine sexually transmitted disease testing, flu shots, human papillomavirus and cervical cancer screening.</td>
<td>100% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>a. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”);</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, child(ren), and adolescents; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. With respect to women, such additional preventive care and screenings, not described in item “a” above, as provided for in comprehensive guidelines supported by the HRSA.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Preventive Care services as mandated by state and federal law. Please refer to the Policy or call Blue Cross and Blue Shield of Texas for more information at (855) 267-0214.

Go to [www.ahpcare.com/tamus](http://www.ahpcare.com/tamus) to download the 2013-2014 Texas A&M University System Student Health Insurance Plan brochure which contains additional essential information about the Policy features. Complete details may be found in the Policy on file at your school’s office. The Policy is subject to the laws of the state in which it was issued.
**EXCLUSIONS AND LIMITATIONS**
Except as specified in this Policy, coverage is not provided for loss or charges incurred by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Allowable Amount;
2. Services that are provided, normally without charge, by the Student Health Center, infirmary or Hospital, or by any person employed by the University;
3. Acupuncture procedures;
4. Biofeedback procedures;
5. Breast augmentation or reduction;
6. Circumcision;
7. Any charges for surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are experimental or investigational;
8. Expenses incurred for Injury or Sickness, arising out of or in the course of a Covered Person’s employment, regardless if benefits are, or could be, paid or payable under any Worker’s Compensation or Occupational Disease Law or Act, or similar legislation;
9. Treatment, services or supplies in a Veteran’s Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment;
10. Expenses in connection with services and prescriptions for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems;
11. Sinus or other nasal surgery, including correction of a deviated septum by submucous resection and/or other surgical correction, except for a covered Injury;
12. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:
   - a covered Injury that occurred while the Covered Person was insured;
   - an infection or other diseases of the involved part; or
   - a covered child’s congenital defect or anomaly;
13. Injuries arising from Interscholastic Activities;
14. Riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;
15. Injury resulting from sky diving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping;
16. War or acts of war, whether declared or undeclared, when serving in the military or an auxiliary unit thereto;
17. Any expenses incurred in connection with sterilization reversal, vasectomy or vasectomy reversal and sexual reassignment;
18. Reproductive/Infertility procedures and fertility tests, including but not limited to: family planning, fertility tests, infertility (male or female), including any supplies rendered for the purpose or with the intention of achieving conception; premarital examinations. Examples of fertilization procedures are: ovulation induction; in vitro fertilization; embryo transplant; or similar procedures that augment or enhance the Covered Person’s reproductive ability;
Exclusions and Limitations Continued

19. Organ transplants. Neither donor nor recipient expenses will be covered;

20. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of injuries to sound natural teeth caused by a covered injury;

21. Foot care including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care;

22. Weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind;

23. Surgery for the removal of excess skin or fat;

24. Prescription drug coverage is not provided for:
   - refills in excess of the number specified or dispensed after one (1) year from the date of the prescription;
   - drugs labeled “Caution - limited by federal law to investigational use” or experimental drugs;
   - immunizing agents, biological sera, blood or blood products administered on an outpatient basis;
   - any devices, appliances, support garments, hypodermic needles except as used in the administration of insulin, or non-medical substances regardless of their intended use;
   - drugs used for cosmetic purposes, including but not limited to Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control, etc;
   - fertility agents or sexual enhancement drugs, medications or supplies for the treatment of impotence and/or sexual dysfunction, including but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra;
   - lost or stolen prescriptions.
This user’s guide highlights some of the features of The Texas A&M University System Student Health Insurance Plan underwritten by Blue Cross and Blue Shield of Texas.

Please go to www.ahpcare.com/tamus to download the 2013-2014 Texas A&M University System Student Health Insurance Plan brochure which contains additional essential information about the Policy and plan features.

**FOR MORE DETAILED INFORMATION ON THIS PLAN, GO TO WWW.AHPCARE.COM/TAMUS or call (877) 624-7911**