

Provisions	A&M Care 350 Network/Out-of-Network benefits	A&M Care 1250 Network/Out-of-Network benefits						
<i>Regions offered</i>	BlueCross BlueShield of Texas (BCBSTX) has networks in all states and all but the following Texas counties: Donley, Hansford, Lipscomb, Ochiltree and Wheeler.							
<i>Pre-existing condition limitations</i>	None							
<i>Out-of-service-area restrictions</i>	Emergency care—Network benefit; must notify BCBSTX within 48 hours. Nonemergency care—Out-of-network benefit unless you go to a BCBS provider in that area.							
<i>Deductibles</i>	Network: \$350/person/plan year Out-of-Network: \$700/person/plan year; \$350/hospital	Network: \$1,250/person/plan year Out-of-Network: \$2,500/person/plan year; \$500/hospital						
<i>Out-of-pocket maximum</i>	Network: \$3,000/person/plan year Out-of-Network: \$6,000/person/plan year	Network: \$3,500/person/plan year Out-of-Network: \$7,000/person/plan year						
<i>In-hospital care</i>	Network: 20% after deductible Out-of-Network: \$350/admission, then 50%	Network: 30% after deductible Out-of-Network: \$500/admission, then 50%						
<i>Emergency room</i>	Network: 20% after deductible Out-of-Network: 20% after deductible if emergency; otherwise 50%	Network: 30% after deductible Out-of-Network: 30% after deductible if emergency; otherwise 50%						
<i>Office visits</i>	Network: \$25/visit for Primary Care Physician (PCP) visits; \$45 for specialists; certain expensive surgeries—20% after deductible Out-of-Network: 50% after deductible	Network: \$25/visit for Primary Care Physician (PCP) visits; \$45 for specialists; certain expensive surgeries—30% after deductible Out-of-Network: 50% after deductible						
<i>Lab/X-rays</i>	Network: Benefit depends on setting and procedure; see plan description booklet or call BCBSTX for details Out-of-Network: 50% after deductible	Network: Benefit depends on setting and procedure; see plan description booklet or call BCBSTX for details Out-of-Network: 50% after deductible						
<i>Surgery</i>	Network: 20% after deductible (inpatient and outpatient) Out-of-Network: 50% after deductible (inpatient and outpatient) Network and out-of-network: In physician's office, see office visit	Network: 30% after deductible (inpatient and outpatient) Out-of-Network: 50% after deductible (inpatient and outpatient) Network and out-of-network: In physician's office, see office visit						
<i>Chiropractic care</i>	Network: \$45/visit, 30 visits/plan year Out-of-Network: 50% after deductible, 30 visits/plan year	Network: \$45/visit, 30 visits/plan year Out-of-Network: 50% after deductible, 30 visits/plan year						
<i>Vision/Hearing/Speech</i>	Network and Out-of-Network: Vision—Routine preventive vision exams not covered; Hearing—Illness/accident coverage only							
<i>Maternity care</i>	Network: Hospital—20% after deduct; Doctor—\$25, initial visit only Out-of-Network: Hospital and doctor—50% after deductible	Network: Hospital—30% after deduct; Doctor—\$25, initial visit only Out-of-Network: Hospital and doctor—50% after deductible						
<i>Well-baby care</i>	Network: \$25/visit; Out-of-Network: Not covered							
<i>Physical therapy</i>	Network: \$45/visit Out-of-Network: 50% after deductible	Network: \$45/visit Out-of-Network: 50% after deductible						
<i>Durable medical equipment</i>	Network: 20% after deductible Out-of-Network: 50% after deductible	Network: 30% after deductible Out-of-Network: 50% after deductible						
<i>Home health care</i>	Network: 20% after deductible; \$40,000 lifetime maximum; \$8,000/person/plan year maximum Out-of-Network: 50% after deductible; \$40,000 lifetime maximum; \$8,000/person/plan year maximum	Network: 30% after deductible; \$40,000 lifetime maximum; \$8,000/person/plan year maximum Out-of-Network: 50% after deductible; \$40,000 lifetime maximum; \$8,000/person/plan year maximum						
<i>Skilled nursing facility (not including custodial care)</i>	Network: 20% after deductible; \$35,000 lifetime maximum Out-of-Network: 50% after deductible; \$35,000 lifetime maximum	Network: 30% after deductible; \$35,000 lifetime maximum Out-of-Network: 50% after deductible; \$35,000 lifetime maximum						
<i>Non-serious mental health*</i>	<table border="0"> <tr> <td data-bbox="204 1503 329 1545"><i>Inpatient</i></td> <td data-bbox="329 1503 930 1545">Network: Inpatient—20% after deductible up to 30 days/plan year; Outpatient—\$45/visit, 40 visits/plan year</td> </tr> <tr> <td data-bbox="204 1545 329 1608"><i>Outpatient</i></td> <td data-bbox="329 1545 930 1608">Out-of-Network: Inpatient—50% after deductible up to 30 days/plan year; Outpatient—50% after deductible, 40 visits/plan year</td> </tr> </table>	<i>Inpatient</i>	Network: Inpatient—20% after deductible up to 30 days/plan year; Outpatient—\$45/visit, 40 visits/plan year	<i>Outpatient</i>	Out-of-Network: Inpatient—50% after deductible up to 30 days/plan year; Outpatient—50% after deductible, 40 visits/plan year	<table border="0"> <tr> <td data-bbox="930 1503 1523 1545">Network: Inpatient—30% after deductible up to 30 days/plan year; Outpatient—\$45/visit, 40 visits/plan year</td> </tr> <tr> <td data-bbox="930 1545 1523 1608">Out-of-Network: Inpatient—50% after deductible up to 30 days/plan year; Outpatient—50% after deductible, 40 visits/plan year</td> </tr> </table>	Network: Inpatient—30% after deductible up to 30 days/plan year; Outpatient—\$45/visit, 40 visits/plan year	Out-of-Network: Inpatient—50% after deductible up to 30 days/plan year; Outpatient—50% after deductible, 40 visits/plan year
<i>Inpatient</i>	Network: Inpatient—20% after deductible up to 30 days/plan year; Outpatient—\$45/visit, 40 visits/plan year							
<i>Outpatient</i>	Out-of-Network: Inpatient—50% after deductible up to 30 days/plan year; Outpatient—50% after deductible, 40 visits/plan year							
Network: Inpatient—30% after deductible up to 30 days/plan year; Outpatient—\$45/visit, 40 visits/plan year								
Out-of-Network: Inpatient—50% after deductible up to 30 days/plan year; Outpatient—50% after deductible, 40 visits/plan year								
<i>Prescription drugs</i>	<p>After you meet the \$50/person/plan year prescription drug deductible (three-person maximum):</p> <ul style="list-style-type: none"> <li>• 30-day supply: \$10/generic, \$25/brand-name formulary, \$50/brand-name nonformulary; brand-name copayment + difference between brand-name and generic when generic is available</li> <li>• 90-day supply: Two copayments required if purchased by mail-order; three if purchased through certain retail pharmacies. Medco—(800) 251-7690 ; <a href="http://www.medcohealth.com/medco/corporate/home.jsp">http://www.medcohealth.com/medco/corporate/home.jsp</a></li> </ul>							
<i>How does this health plan work?</i>	This plan is a preferred provider organization (PPO). If you live in a network area, you may choose any provider in a BlueCross BlueShield network to receive the highest level of coverage. You receive benefits for services provided by an out-of-network provider, but they will be lower. Most employees and retirees live in network areas. However, if you do not live in a network area, you may visit any provider and receive non-network benefits. See pages 8-10 for details.							
<i>Member Services phone number/website</i>	BlueCross BlueShield of Texas—(866) 295-1212; for information on networks outside Texas—(800) 810-BLUE (2583) <a href="http://www.bcbstx.com">http://www.bcbstx.com</a>							

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\* The benefits above apply to most mental health conditions. However, for certain serious conditions, the state sets minimum coverage requirements. They are 60 days/plan year for inpatient care (subject to plan's in-hospital care copayment) and 45 days/plan year for outpatient care (subject to the plan's office visit copayment).

Provisions	A&M Care 350/1250 Non-Network benefits	Scott & White Health Plan
<i>Regions offered</i>	See previous page	Bryan/College Station, Killeen, limited access in Austin, Prairie View, Stephenville areas
<i>Pre-existing condition limitations</i>	None	None
<i>Out-of-service-area restrictions</i>	None	Emergency care only at hospital, <b>\$150/visit</b> (waived if admitted); urgent care, \$40/visit at any facility other than College Station S&W facility
<i>Deductibles</i>	350 plan: \$350/person/plan year 1250 plan: \$1,250/person/plan year	None
<i>Out-of-pocket maximum</i>	350 plan: \$3,000/person/plan year 1250 plan: \$3,500/person/plan year	\$3,000/person/plan year; \$6,000 maximum/family/plan year
<i>In-hospital care</i>	20% (350 plan) or 30% (1250 plan) after deductible	<b>20% of charges</b>
<i>Emergency room</i>	20% (350 plan) or 30% (1250 plan) after deductible	<b>\$150/visit</b> (waived if admitted); urgent care, \$25/visit at College Station S&W facility, \$40/visit at any other facility
<i>Office visits</i>	20% (350 plan) or 30% (1250 plan) after deductible	\$25/visit
<i>Lab/X-rays</i>	20% (350 plan) or 30% (1250 plan) after deductible	Covered in full
<i>High Technology Radiology (MRI, CT &amp; pet scans, stress test, Angiogram &amp; myelography)</i>	20% (350 plan) or 30% (1250 plan) after deductible	<b>20% of charges</b>
<i>Surgery</i>	Inpatient, outpatient and in physician's office—20% (350 plan) or 30% (1250 plan) after deductible	Inpatient – <b>20% of charges</b> ; Outpatient - <b>20% of charges</b>
<i>Chiropractic care</i>	20% (350 plan) or 30% (1250 plan) after deductible, 30 visits/plan year	Not covered, limited discount network available
<i>Vision/Hearing/Speech</i>	Vision—Routine preventive vision exams not covered; Hearing—Illness/accident coverage only	Vision—\$25, one exam/plan year; \$10/lenses w/frames or \$10/bifocals/trifocals w/frames (biennially); \$10/box for disposable or daily wear contacts or \$10/contact lens for specialty lenses Hearing/Speech (testing and/or therapy)—\$25/visit
<i>Maternity care</i>	Hospital and doctor—20% (350 plan) or 30% (1250 plan) after deductible	Hospital— <b>20% of charges</b> ; Doctor—\$25/visit or \$300 total fee
<i>Well-baby care</i>	20% (350 plan) or 30% (1250 plan) after deductible	\$25/visit
<i>Physical therapy</i>	20% (350 plan) or 30% (1250 plan) after deductible	\$25/visit
<i>Durable medical equipment</i>	20% (350 plan) or 30% (1250 plan) after deductible	20%, up to \$2,000/person/plan year (includes diabetic supplies and equipment)
<i>Home health care</i>	20% (350 plan) or 30% (1250 plan) after deductible; \$40,000 lifetime max; \$8,000/person/plan year max	\$25/visit with approval of medical director
<i>Skilled nursing facility (not including custodial care)</i>	20% (350 plan) or 30% (1250 plan) after deductible; \$35,000 lifetime maximum	<b>20% of charges</b>
<i>Non-serious mental health*</i> <i>Inpatient</i> <i>Outpatient</i>	20% (350 plan) or 30% (1250 plan) after deductible up to 30 days/plan year 20% (350 plan) or 30% (1250 plan) after deductible, 40 visits/plan year	<u>Inpatient</u> - <b>20% of charges</b> , max 30 days \$25/visit up to 30 visits/plan year
<i>Prescription drugs</i>	See previous page	After you meet the \$50/person/plan year prescription drug deductible: • 34-day supply: \$5/generic (level A), \$25/brand-name formulary (level B), \$50 or 50% (whichever is less)/nonpreferred formulary (includes some generics; level C), \$50 or 50% (whichever is greater)/brand-name nonformulary • Outpatient specialty drugs: \$50 (level 1), \$100 (level 2 – preferred), \$250 (level 3 – premium preferred), 50% of charges (level 4 – nonpreferred) • 90-day supply: two copayments required; mail-order purchase available but not required; you must purchase 34-day supply on new prescriptions for the first six months of use
<i>How does this health plan work?</i>	See previous page	The Scott & White Health Plan (SWHP) is an HMO composed of several regional clinics, as well as a network of providers outside the clinics contracted with the health plan. You must select a Primary Care Physician (PCP). Your PCP will coordinate your care and can refer you to any specialist in the SWHP network.
<i>Member Services phone number/website</i>	See previous page	(800) 791-8777 or (979) 268-7947 <a href="http://www.swhp.org">http://www.swhp.org</a>

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## Provisions

## Humana Health Plan

<i>Regions offered</i>	Corpus Christi/Kingsville, San Antonio
<i>Pre-existing condition limitations</i>	None
<i>Out-of-service-area restrictions</i>	Urgent or emergency care only, \$100/visit (waived if admitted); notify Humana within 48 hrs.
<i>Deductibles</i>	None
<i>Out-of-pocket maximum</i>	\$4,000/person/calendar year; \$8,000/family/calendar year
<i>In-hospital care</i>	\$500/day; \$1,500 maximum/admission
<i>Emergency room</i>	\$100/visit (waived if admitted); must notify Humana within 48 hrs
<i>Office visits</i>	\$20/visit in PCP's office or \$30/visit for specialty care
<i>Lab/X-rays</i>	<u>Inpatient</u> - \$500/day; \$1,500 maximum/admission <u>Outpatient</u> - \$20/visit in PCP office or \$30/visit in specialist's office; \$150/visit at outpatient facility <b>Preventive - child up to age 18, covered in full (with office visit co-pay); adults, age 18 and up \$20 PCP, \$30 specialist office visit, outpatient hospital, free standing facility - covered in full</b> <b>PET, MRI, MRA, CET, SPECT \$150/ copay per visit</b>
<i>Surgery</i>	<u>Inpatient</u> - \$500/day; \$1,500 maximum/admission <u>Outpatient</u> - \$20/visit in PCP's office or \$30/visit in specialist's office; \$300/visit at outpatient surgical facility
<i>Chiropractic care</i>	<b>\$20 PCP, \$30/specialist, limit 20 visits/year– Authorization Required</b>
<i>Vision/Hearing/Speech</i>	<b>Vision – provider must be in network-\$20 copayment, limited to one exam per member per calendar year.</b> <b>Hearing Screening – Covered in full.</b> Speech Therapy—\$30/visit
<i>Maternity care</i>	Hospital—\$500/day; \$1,500 maximum/admission; Doctor—\$20 in PCP's office or \$30 in specialist's office, initial visit only
<i>Well-baby care</i>	\$20/visit in PCP's office or \$30/visit in specialist's office
<i>Physical therapy</i>	\$30/visit
<i>Durable medical equipment</i>	Covered in full
<i>Home health care</i>	Covered in full
<i>Skilled nursing facility (not including custodial care)</i>	Covered in full up to 100 days/calendar year
<i>Non-serious mental health*</i>	<u>Inpatient</u> - \$100/admission up to 30 days/calendar year <u>Outpatient</u> - \$10/visit for first 20 visits/calendar year; \$30/visit for next 20 visits/calendar year
<i>Prescription drugs</i>	<ul style="list-style-type: none"> <li>• <b>30-day supply: Level 1 drug, \$7; Level 2 drug: \$25; Level 3 drug: \$50; Level 4 drug, 25% copay (out-of-pocket maximum \$2,500 person/plan year.)</b></li> <li>• 90-day supply: Three copayments required; must purchase through mail-order program</li> </ul>
<i>How does this health plan work?</i>	This plan is an HMO composed of independent practitioners and physician associations. You must select a PCP. If you select a PCP who is an independent practitioner, you can be referred to any specialist in Humana's network. If your PCP is part of a physician association (in San Antonio), you will be referred only to specialists in that association.
<i>Member Services phone number/website</i>	(800) 448-6262 or (888) 393-6765 (for potential members) or <a href="http://www.humana.com">http://www.humana.com</a>

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# Provisions

# FirstCare

# Graduate Student Health Plan

<i>Regions offered</i>	Bryan/College Station, Abilene/Midland/Odessa, Amarillo/Canyon/Lubbock, Ft. Stockton, Stephenville	Available worldwide; outside U.S. benefits paid at 80%
<i>Pre-existing condition limitations</i>	None	80% up to \$1,000 benefit for an existing condition for 12 months; continuous coverage before enrollment offsets limitation period
<i>Out-of-service-area restrictions</i>	Emergency only (\$100/visit, waived if admitted) or medical support order (Deductible applies)	None
<i>Deductibles</i>	\$250/person/plan year	\$100/person; \$300/family; <b>in or out-of-network</b> ; waived at student health center
<i>Out-of-pocket maximum</i>	2 × total annual premium; injectable medication IF received at the Dr's office- \$2,500; NO Maximum if received through retail pharmacy	\$3,000/person/plan year; \$6,000 maximum/family/plan year
<i>In-hospital care</i>	Tier 1 (\$150/day up to \$750 maximum/admission) applies if admitted to a contract hospital within service area. Tier 2 (25% of the Allowable Amount up to \$5,000/member or \$10,000/family) applies if admitted to a contract hospital outside the service area or a noncontract hospital within or outside of the service area and the admission is due to an emergency (otherwise, no coverage) (Deductible applies)	20% (network)/40% (out-of-network) after deductible
<i>Emergency room</i>	\$100/visit (waived if admitted); must notify Primary Care Physician (PCP) within 24 hrs.. (Deductible applies)	After deductible, \$100 copayment plus 20% (network)/40% (out-of-network)
<i>Office visits</i>	\$20/visit; \$50/visit for specialty care (No Deductible)	\$25/visit plus 20% (network)/40% (out-of-network); covered in full at student health center
<i>Lab/X-rays</i>	General lab & x-ray covered in full (No Deductible); \$100 for Arteriograms, CT Scans, MRI, EEG, Myelogram & PET Scans; \$75 for radio-nuclide stress test; \$50 co-pay for bone mass density test; 50% for non-pregnancy ultrasound; 50% for infertility diagnosis (Deductible applies)	20% (network)/40% (out-of-network) after deductible
<i>Surgery</i>	Tier 1 (\$150/day up to \$750 maximum/admission) applies if admitted to contract hospital within service area. Tier 2 (25% of allowable amount up to \$5,000/member or \$10,000/family) applies if admitted to a contract hospital outside the service area or a noncontract hospital within or outside service area and the admission is an emergency (otherwise, no coverage). (Deductible applies) OUTPATIENT - \$250 deductible	20% (network)/40% (out-of-network) after deductible
<i>Chiropractic care</i>	\$50/visit; must be pre-approved (No Deductible)	\$25/visit plus 20% (network)/40% (out-of-network), when medically necessary due to accident or illness
<i>Vision/Hearing/Speech</i>	Routine vision screening - \$20/visit PCP, up to age 18 only (No Deductible) Hearing/Speech (testing) - \$20/visit, \$50/visit for specialty care; therapy \$50/visit (No Deductible)	\$25/visit plus 20% (network)/40% (out-of-network), when medically necessary due to accident or illness
<i>Maternity care</i>	Tier 1 (\$150/day up to \$750 maximum/admission) applies if admitted to contract hospital within service area. (Deductible applies) Tier 2 (25% of allowable amount up to \$5,000/member or \$10,000/family) applies if admitted to a contract hospital outside the service area or a non contract hospital within or outside the service area and the admission is due to an emergency (otherwise, no coverage). (Deductible applies)	20% (network)/40% (out-of-network) after deductible
<i>Well-baby care</i>	\$20/visit; \$50/visit for specialty care (No Deductible)	20% (network)/40% (out-of-network) after deductible
<i>Physical therapy</i>	\$50/visit (Deductible applies)	\$25/visit plus 20% (network)/40% (out-of-network); must be within 60 days of being released for rehabilitation
<i>Durable medical equipment</i>	20%, up to \$4,000/person/plan year (Deductible applies)	20% (network)/40% (out-of-network) after deductible
<i>Home health care</i>	Covered in full when authorized (Deductible applies)	No benefit
<i>Skilled nursing facility (not including custodial care)</i>	Tier 1 (\$150/day up to \$750 maximum/admission) applies if admitted to contract hospital within service area. (Deductible applies) Tier 2 (25% of allowable amount up to \$5,000/member or \$10,000/family) applies if admitted to a contract hospital outside the service area or a non contract hospital within or outside the service area and the admission is due to an emergency (otherwise, no coverage). (Deductible applies)	No benefit
<i>Non-serious mental health*</i>	Tier 1 (\$150/day up to \$750 maximum/admission) applies if admitted to contract hospital within service area. (Deductible applies) Tier 2 (25% of allowable amount up to \$5,000/member or \$10,000/family) applies if admitted to a contract hospital outside the service area or a non contract hospital within or outside the service area and the admission is due to an emergency (otherwise, no coverage). Limited to 30 days/plan year. (Deductible applies) <u>Outpatient</u> - \$50/visit, limited to 40 visits/plan year (No Deductible)	<i>Inpatient</i> - 20% (network)/40% (out-of-network) after deductible; limited to 30 days/plan year; \$25,000 lifetime maximum <i>Outpatient</i> - \$25/visit plus 20% (network)/40% (out-of-network), <b>(no maximum)</b>
<i>Prescription drugs</i>	Deductible - \$50/person/plan year 30-day supply: \$15/generic; \$30/brand-name formulary; \$60/brand-name non-formulary; 25%/injectables & high technology drugs 90-day supply: \$45/generic; \$90/brand-name formulary; \$180/brand-name non-formulary; 25%/injectables & high technology drugs	\$15 at student health center <b>up to \$1000 ; Plus</b> drug card \$15/generic, \$25/brand name, \$35/single source drug, <b>up to \$5,000 annual maximum benefit (no per illness maximum)</b> Generic Drug –A medication duplicated by another company once the patent expires Brand Name Drug –A medication developed by a pharmaceutical company Single Source Drug –A brand name drug without a generic equivalent
<i>How does this health plan work?</i>	This plan is an HMO composed of independent practitioners and physician associations. You must select a PCP. First Care does not require a referral to an in plan specialist.	This plan is for graduate student employees only. Students must be taking at least six credit hours or otherwise be working toward a degree. It is a preferred provider organization (PPO). You may choose any provider in the network to receive the highest level of coverage. You receive benefits for services provided by an out-of-network provider, but they will be lower. You will be reimbursed 100% for services you receive at a student health center.
<i>Member Services phone number/website</i>	(800) 884-4901	(800) 452-5772

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