



2022-2023 TAMUS Employee Benefits Guide

Medical
Dental
Vision
Life Insurance
Long-Term Disability
Flexible Spending Accounts
Retirement Programs
Wellness



TAMU Benefits Enrollment Guide

FOR PLAN YEAR BEGINNING SEPTEMBER 1, 2022

After you become benefits eligible, you will have orientation or a meeting with a benefits representative. They will help you with the following important information about your benefits enrollment.

Date of hire/initial benefits eligibility date

Deadline for enrolling in benefits (31 days after initial eligibility)

My coverage is effective

My state contribution date

My universal identification number

For help with enrollment or eligibility, to update information for you or covered dependents, or to make benefit changes due to a qualifying life event (within 31 days), please contact your Human Resources office at the number or email for your workstation found at the back of this guide.

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The Texas A&M University System is committed to offering its employees a comprehensive benefits package at a competitive cost. This package includes medical, dental, vision, life insurance, accidental death & dismemberment, long-term disability, flexible spending accounts, employee assistance programs, retirement programs, and various worklife benefits included in our wellness program.

As part of this commitment, we provide you with access to a variety of tools and resources — including this Benefits Guide — to provide awareness of the programs we offer and to help you make informed benefits decisions.

In addition to this guide, the following resources can be found on the System Benefits Administration website:

- Plan description booklets for most insurance benefits.
- Links to sites for the insurance carriers and other benefits plan providers.
- Most forms and benefit publications, which can be downloaded and printed.
- Additional information about the A&M System retirement programs.

At the back of this guide is a list of websites and phone numbers for each plan, as well as contact information for your campus or agency Human Resources office.

Understanding Benefits Language

Knowing and understanding your benefits is important to choosing the path that is best for you and your family. These definitions will help you understand the terminology used in describing the coverage to help you make informed decisions.

Brand Name Medications

Drugs that are patented, manufactured and distributed by only one pharmaceutical manufacturer.

Coinsurance or Cost Sharing

A percentage of the cost of a medical or dental expense that is shared between you and the plan after you pay your deductible. For example, the A&M Care plan's share of most expenses is 80% and your share (coinsurance amount) is 20%.

Copayment (Copay)

A set dollar amount you pay for services, such as an office visit or prescription drug. The remaining cost is covered by the plan.

COBRA

The Consolidated Omnibus Budget Reconciliation Act allows you and/or covered dependents to extend medical, dental and/or vision coverage beyond the date on which eligibility would normally end. You pay the full premiums plus a 2% administrative fee for this continuation coverage.

Deductible

The amount you must pay toward medical, prescription drug, vision, or dental expenses for each family member each year before benefits for those expenses are reimbursable. After you meet your deductible, future expenses are covered at the coinsurance or copayment amount. Copayments do not count toward the deductible.

Flexible Spending Account (FSA)

A FSA allows you to set aside pre-tax money for eligible expenses. The Health Care FSA can be used for most out-of-pocket medical, prescription drug, dental and vision expenses such as deductibles, coinsurance and copays. The Dependent Day Care FSA can be used for day care and elder care expenses for a child or older person who requires care while you work. FSA funds must be used by the end of the plan year.

Generic Medications

Drugs that are manufactured, distributed and available under a chemical name without patent protection. A generic drug must have the same active ingredient as its brand name counterpart. Generic drugs typically cost less than brand name drugs.

Health Assessment

A health survey that measures your current health, your health risks and quality of life based on responses you provide.

Non-Preferred or Non-Formulary Drugs

Brand name medications that are not on the Preferred List because less expensive and equally effective alternatives are available. Non-Preferred medications require a higher copayment.

Out-of-Pocket Maximum

Generally, the most you will have to pay each plan year for each covered family member. The annual deductible, copayments and coinsurance are counted towards this maximum. Once you meet the out-of-pocket maximum on yourself or a covered dependent, the plan pays 100% of most remaining expenses for you and your covered dependent for the rest of that plan year.

Primary Care Physician (PCP)

Under the medical plans, a PCP is a general or family practitioner, an internal medicine doctor, a pediatrician, an OB/GYN, or a behavioral health practitioner. Although it is not required, this provider usually coordinates your medical care and provides referrals to specialists.

Preferred or Formulary Drugs

A list of drugs that are periodically reviewed and updated by a committee of physicians, pharmacists and other health professionals for effectiveness and cost effectiveness. Each plan has its own Preferred Drug List. Often, brand name medications that have generic equivalents available will not be on the formulary list to encourage individuals to purchase the less expensive generic drug.

Reasonable and Customary Fee/Allowed Amount

The lower of the actual charge for services or supplies, or the usual charge of most other doctors, dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies as determined by the carrier.

Network Provider/In-network Provider

A healthcare provider who is part of a plan's network.

Non-Network Provider/Out-of-Network Provider

A healthcare provider who is not part of a plan's network. Costs associated with out-of-network providers may be higher or some costs may not be covered by your plan. Consult your plan for more information.

Benefit Eligibility and Coverage Information

Employee Coverage

Your eligibility for a benefits package depends on the type of job you have, the percentage of time you work and the length of your appointment.

Eligibility

- You work at least 50% time for at least 4½ months
- Your appointment is expected to continue for a term of at least 4½ months, **AND**
- You are eligible for retirement benefits as a member of the Teacher Retirement System of Texas (TRS), or as a graduate student employee
- You are also eligible if you are a graduate student fellow

Dependent Coverage

You may enroll any or all of your eligible dependents in medical, dental, vision, dependent life and/or AD&D, if you have that coverage on yourself. Dependents are covered only if you enroll them in Workday. However, if you elect family AD&D coverage, all eligible dependents will automatically be covered under that plan.

Eligible Dependents include:

- Your current spouse;
- Your common-law marriage partner, as defined by state law;
- Your dependent children up to age 26 (regardless of marital status); including a natural child, stepchild, a legally adopted child, grandchildren you claim on your income tax.
- Managing Conservatorship/Legal Guardian dependents up to age 18 unless accepted court order states otherwise.

Examples of dependents who are not eligible for coverage include:

- A former spouse, or former stepchildren
- Siblings
- An elderly parent

Proof of Eligibility

You must provide proof of eligibility to enroll any dependents.

Dependent documentation must be submitted and approved before their effective date of coverage. This paperwork is required not only to support the coverage of eligible dependents but also to support a mid-year Qualifying Life Event such as marriage or birth of a child. To enroll medically incapacitated dependents, medical records documenting the incapacitating condition and dependency must be submitted within 31 days of initial eligibility.

Dependent Documentation

In order for your dependents to have coverage, their **dependent documentation must be submitted and approved before their effective date of coverage.** All foreign documents should be accompanied by an English translation.

You can upload dependent documentation in HRConnect Legacy after enrollment in Workday, or submit it to your Human Resources office.

Documentation needed to qualify your dependents for coverage:

Legal Marriage Documents

If you are legally married, even if physically separated, you will need:

- Your most recent Federal Tax Return (financial information can be redacted), **OR**
- Marriage certificate **AND** proof of joint ownership dated less than six months old. Recommended documents for proof of joint ownership include:
A mortgage or bank statement, residential leasing agreement, property tax bill, or joint credit card statement. Documents must include both the employee's name and the spouse's name. If within two years of marriage, then only the marriage certificate is required.

Common Law Marriage Documents

If you are legally married by a Common Law Marriage you will need:

- Your most recent Federal Tax Return(s) showing that you are married filing jointly or separately, **OR**
- Texas Declaration of Informal/Common Law Marriage from the County where the marriage was recognized or recorded **AND** proof of joint ownership dated less than six months old. Recommended documents for proof of joint ownership include:
A mortgage or bank statement, residential leasing agreement, property tax bill, or joint credit card statement. Documents must include both the employee's name and the spouse's name.

Biological Child Documents

Birth certificate of the biological child listing the employee as either the mother or father. If the child is under 6 months old, documentation on hospital letterhead indicating the birth date of the child or children will be accepted as temporary enrollment but must be followed by the birth certificate when received.

Step Child Documents

Child's birth certificate showing the child's parent is the employee's spouse, **AND** marriage certificate showing legal marriage between the employee and the child's parent.

Adopted Child Documents

The documents will depend on the current stage of the adoption. Official court/agency placement papers for a child placed with you for adoption (initial stage), **OR** Official Court Adoption Agreement for an Adopted Child (mid-stage), **OR** birth certificate (final stage).

Disabled/Incapacitated Child age 26 or older

A doctor's statement regarding the physical or mental condition of the dependent, whether the dependent is able to maintain self-sustaining employment and whether the condition occurred before the child reached age 26. In order for the medically incapacitated dependent to be enrolled in coverage when he/she is age 26 or older, the following documentation must be submitted either before the child/grandchild reaches age 26 if currently enrolled or at the time of enrollment:

1. For medical coverage including optional coverages (if applicable) submit the [BCBSTX Dependent Child's Statement of Disability form](#).
2. For optional coverage only excluding medical, submit the [TAMUS Dependent Child's Statement of Disability](#) to System Benefits Administration for review.

Grandchild Documentation

Most recent filed tax return, including the signature or confirmation of e-file, showing the grandchild as a claimed dependent (financial information can be redacted).

Foster Child Documentation

Official Court or Agency Placement papers.

Legal Guardianship Documentation

Court order establishing guardianship of a child. Eligible up to age 18 unless court order defines otherwise.

Managing Conservatorship Documentation

Court order establishing managing conservatorship of a child. Eligible up to age 18 unless court order defines otherwise.

Benefits Enrollment

You must enroll in benefits within 31 days from the date you become eligible. You have some options on when your coverage begins:

- You can elect coverage for you and your dependents to start on your hire/initial eligibility date if you enroll before, on, or within seven days after your hire/initial eligibility date.
- You can elect for coverage to begin on the first of the month following hire/initial eligibility if you enroll before the end of the month of your hire/initial eligibility.
- If you enroll beyond the seventh day after your hire/initial eligibility date, but during your 31 day enrollment period, your coverage will start on your employer contribution eligibility date (the first of the month after your 60th day of employment).

You will pay the total monthly premium if you elect benefits to start before your employer contribution eligibility date.

You may cover your dependents beginning on your hire/initial eligibility date if you enroll before, on, or within seven days after your hire/initial eligibility date, or you may delay the start of their coverage. If you enroll yourself or your dependents immediately, you must pay the full month's premium even if coverage begins partway through the month. You may also have your coverages begin before your employer contribution eligibility date, but have your dependents' coverages begin on your employer contribution eligibility date.

If you do not enroll in health coverage and do not waive health coverage by the end of your 31 day enrollment period, you will automatically be enrolled in a basic package on your employer contribution eligibility date.

This basic package includes the A&M Care medical plan and \$5,000 in Accidental Death and Dismemberment (AD&D) coverage for you only and Basic Life coverage for you and any eligible dependent children. You pay any cost that is greater than the employer contribution.

Current Employee

Open Enrollment is held each year during the month of July. During this time you may add, change, or drop coverage for yourself and/or your dependents using Workday. Elections and/or changes made during this time will be effective the following September 1. If Optional Life or Spouse Life insurance changes are made during Open Enrollment and

Coverage Start Date	Time Period to Enroll
Date of hire/initial eligibility	7 days from date of hire/initial eligibility date
First of the month following date of hire/initial eligibility	End of the month in which you are hired/initially eligible
Employer contribution eligibility date (first of the month after your 60th day of employment)	31 days from date of hire/initial eligibility

Evidence of Insurability (EOI) is required, the change will be effective on the first of the month following approval if approved after September 1.

If no changes are made during Open Enrollment, benefits will automatically roll over to the next plan year, with the exception of any Flexible Spending Account elections and life insurance coverage reductions due to age.

IF YOU DO NOT NEED MEDICAL COVERAGE

If you do not need A&M System medical coverage and you certify that you have other medical coverage, you may use up to half of the employee-only employer contribution to pay for other coverage. For example, if your spouse works for the A&M System, you may choose to be covered under your spouse's medical plan and use your employer contribution for dental and vision coverage for you and your spouse.

You can also use your employer contribution to pay for Alternate Basic Life, Accidental Death and Dismemberment, Dental, Vision and Long Term Disability (LTD), in that order. You may not use the employer contribution to pay for Optional Life or Dependent Life.

If you are enrolled in medical coverage from the University of Texas System, Teacher's Retirement System of Texas, or the Employees Retirement System, you are not eligible for an additional employer contribution. You can receive an employer contribution from only one Texas state agency or institution of higher education.

If the employer contribution is used for LTD and you receive LTD benefits, part or all of those benefits may be taxable income; if you pay the premium then the benefits are not taxable. If you do not want the employer contribution applied to your LTD coverage, you can enroll to pay for it yourself, or waive the contribution as you complete your online enrollment.

IF YOU BOTH WORK FOR THE A&M SYSTEM

If you and your spouse are both employed by the A&M System:

- You can be covered as an employee on some coverages and as a dependent on others but you cannot be covered as an employee and a dependent on the same coverages, except on AD&D.
- Children can be covered as dependents by either spouse, but not by both, except on AD&D.
- Both spouses may set up Flexible Spending Accounts and use them to pay dependent expenses. Each spouse may contribute up to \$2,850 to a Health Care Flexible Spending Account, but the combined maximum spouses may contribute to Dependent Day Care Flexible Spending Accounts is \$5,000.
- You can each enroll separately in medical coverage and receive separate employer contributions.
- Or, one of you can enroll in medical and cover the other as a dependent on medical. If you do this, the employee covered as a dependent will receive half of the employee-only employer contribution, which can be used to purchase other coverages for the employee, spouse and/or family. A spouse who is covered on medical as a dependent is not eligible for Basic Life coverage. To be covered under different medical plans, you must each enroll as employees.
- If you elect Alternate Basic Life or Optional Life on yourself, you may not be covered by your spouse on Spouse Life.
- You may elect employee coverage for AD&D and be covered as a dependent on your spouse's family AD&D coverage, but your benefit will not be more than the maximum for which you are eligible under employee coverage. If both you and your spouse elect family AD&D coverage, your children may be covered under both plans. However, you will not receive more than \$25,000 total benefit for each child.

For more information, read the A&M System brochure, [When You and Your Spouse Both Work for the A&M System](#), available on the A&M System Benefits Administration website.

How To Enroll Online

Log in to Workday at sso.tamug.edu using your Universal Identification Number (UIN) and your SSO password. Once you're logged on, click on Workday.

- **New employees** should refer to the Onboarding job aid available on the Workday Help website for more information about the initial enrollment process.
- **During a Life Event:** Select the Benefits worklet from the Workday Dashboard and click on "Benefits" in the Change column. You will be asked to select a Reason for the change.
- **During Open Enrollment:** Select the Open Enrollment task in your Workday inbox and follow the steps to elect coverages. If you do not want to make any changes, you can leave your current elections selected, and submit the task.

How To Enroll Dependents

If you are adding dependents to your coverage, before electing coverage, enter the dependent's names and other required information (DOB and SS#) under Dependents in the Benefits Worklet. Adding the name in Workday does not complete dependent coverage. After entering dependents, you will begin the enrollment task. You must go into each coverage and select the dependents to add.

Other Enrollment Tasks

- Designate your beneficiaries for Basic Life, Optional Life and Accidental Death and Dismemberment coverage, if elected.
- Update tobacco user status for yourself and your spouse, if covered on your plan.

Before exiting the system, be sure to "sign & submit" to finalize your elections for processing.

Costs and Premiums

Employer Contribution

You will begin receiving a monthly employer contribution the first of the month after your 60th day of employment. If you are transferring from another Texas state agency or institution of higher education with no break in coverage, your contribution will begin as soon as you enroll in coverage.

Your employer contribution amount will depend on whether you are a full-time (30 hours/week or more) or part-time (20-29 hours/week) employee and whether you enroll dependents. Premiums listed in this guide include the total premium and your cost after the employer contribution begins.

If you elect for coverage to begin before your employer contribution eligibility date, you will have to pay the total monthly premium until your employer contribution eligibility date.

Pretax Premiums

When you enroll in medical, dental, vision, FSA or AD&D coverage, your share of the premium for you and your covered dependents will be deducted from your paycheck before your federal income and Social Security taxes are calculated.

Summer Premiums

For 9-11 month, full-time monthly paid positions, premiums are prorated so that you pay for 12 months of premiums in 9 months. This means that you pay for 12 months of premiums by May 31. You do not have to pay premiums during the summer and you will have coverage, unless you are terminating employment. In this case, you will receive a refund for the summer months.

If you are a newly benefit eligible employee and your insurance coverage begins after September 1, you will not have prorated premiums during your first year of employment; your summer premiums will be deducted from your May paycheck.

Tobacco user and wellness charges, if applicable, are \$40/month since they are prorated. If you have a wellness credit, that is prorated as well. All rates are inclusive of the wellness premium. Premiums increase by \$40 if you or your spouse is a tobacco user.

For employees holding 9-11 month positions, if there is a reasonable expectation that you will be in a benefit-eligible position the upcoming fall semester, your summer premiums (June, July, August) will be deducted from

your May paycheck, unless you are eligible for 12 over 9 premiums. You will receive the employer contribution for these months unless you terminate employment before September 1. You will receive more information about this in April, if applicable.

12 Over 9 Premiums

The expected premium due each month, over 9 months, is based on an assumed full plan year of the same coverage. If coverage changes mid-year, you may be entitled to a refund or owe an additional premium. Your Benefits Partner will calculate your adjusted premium and communicate with the Payroll department if any Life Events take place which result in a change in coverage. These may include adding or removing a dependent due to birth of a child or divorce in the middle of a plan year. 12 over 9 premium payment is not available to graduate student employees.

Payroll Deductions

If you are paid monthly, premiums deducted from your paycheck are for your insurance benefits coverage during the previous month. For example, the premiums deducted from your October 1 paycheck are for your September coverage. If you are paid bi-weekly, your premiums will be deducted twice per month (24 times per year).

Billing or Bank draft

If you are not working, and are paying premiums through billing or bank draft, you are being billed for coverage for the following month.

Tobacco User Premium

Designate a tobacco user status for yourself and your spouse, if he/she is enrolled in medical coverage or Dependent Life. An additional monthly premium charge for medical coverage of \$30 for an employee or a covered spouse will be deducted for those who use tobacco products.

A tobacco-user is someone who uses tobacco products more than five times in three months. Tobacco products include cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, smokeless tobacco, and e-cigarettes/vaping. You can change your tobacco use category at any time. You must be tobacco-free for at least 3 months to be considered a non-tobacco user. If you do not provide tobacco status information, the default designation for you and a covered spouse will be a tobacco user. The tobacco premium does not apply to the Graduate Student Employee Plan.



Certain life events allow you to change your coverages outside of the Open Enrollment period.

Changes can be made to your benefits during the Open Enrollment period each July. During the plan year, you can only change your medical, dental, vision or flexible spending account coverage within **31 days of a Qualifying Life Event**. For example, if you have a new baby, you can add the baby to your health coverage, but you cannot drop your spouse from health coverage.

If you do not make your changes within 31 days of the Life Event, you cannot change coverage until the next Open Enrollment in July to be effective the following September 1.

Qualifying Life Events include:

- Employee's marriage or divorce or death of employee's spouse
- Birth, adoption or death of a dependent child
- Change in employee's, spouse's or dependent child's employment status that affects benefit eligibility, such as leave without pay
- Child becoming ineligible for coverage due to reaching maximum age
- Change in the employee's, spouse's or a dependent child's residence that affects eligibility for coverage
- Employee's receipt of a qualified medical child support order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) medical coverage for a child
- Changes made by a spouse or dependent child during his/her open enrollment period with another employer
- The employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid
- Significant employer or carrier initiated changes, such as, significant premium increase, coinsurance increase or cancellation of the employee's, spouse's or dependent child's coverage
- The employee or dependent reaching the lifetime maximum for all benefits from a non-A&M System medical plan (medical plan changes only)
- Change in day care costs due to a change in provider, change in provider's fees (if the provider is not a relative) or change in the number of hours the child needs day care (for Dependent Day Care Spending Accounts)
- The employee or dependent child loses coverage under the state Medicaid or CHIP plans or becomes eligible for premium assistance under the Medicaid or CHIP.

Documentation is required for Life Event changes	
Benefit Life Event Type	Documentation Required
Birth/Adoption	See Dependent Documentation
Marriage	See Dependent Documentation
Changes due to spouse's Open Enrollment	Documentation from spouses's HR/benefits office confirming add or drop of benefits, including the effective date of the change, corresponding coverages and dependents impacted by the change.
Dependent daycare provider cost/hour change	Receipt or notice of change from provider
Gain other coverage	Documentation confirming enrollment in other coverage, including the effective date of the change, corresponding coverages and dependents impacted by the change.
Loss of other coverage	Documentation confirming loss of other coverage, including the effective date of the change, corresponding coverages and dependents impacted by the change.
Medicaid change	Copy of Medicaid announcement
Medical Support Order	Copy of Medical support order
Spouse becoming Medicare eligible	Copy of spouse's Medicare card

Qualifying for COBRA

If you or your covered dependents lose eligibility for benefits coverage due to a COBRA qualifying event, you and/or your dependents will be able to continue coverage for medical, dental, vision, and/or a Health Care Flexible Spending Account if you are enrolled at the time of the qualifying event. COBRA coverage is the same coverage provided to all other participants, but the costs are 102% of the total premium and there is no employer contribution.

Cobra Qualifying Events

- Death of a covered employee
- Covered employee's termination of employment or reduction in the hours of employment
- Divorce or legal separation from the covered employee
- Dependent child ceasing to be a dependent under the generally applicable requirements of the plan

Survivors

Survivor(s) of deceased employees or retirees may be eligible for coverage beyond the time period allowed through COBRA regulations. Coverage in all cases depends on the survivor having been covered at the time of the employee's/retiree's death. Survivors of A&M System employees or retirees may continue medical, dental and/or vision coverage only. The total premium for survivors is the same as those for active employees, but survivors are not eligible for the employer contribution.

Indefinite coverage for survivor(s) is available if:

- the deceased was a retiree of the A&M System, or
- the deceased was an employee of any age with at least five years of TRS- or ORP-creditable service, including at least three years of service with the A&M System, and his/her last state employment was with the A&M System.

If the deceased was a disability retiree with less than five years of service, the survivor is eligible for benefits for the number of months equal to the months of service of the deceased retiree. If this is less than 36 months, the survivor could elect COBRA for the remaining months (36 months from the date of death).

Spouse survivor coverage can continue indefinitely, however, coverage for eligible children or grandchildren covered at the time of the employee's/retiree's death may be subject to an age maximum. Managing conservatorships/legal guardians can be covered until age 18, or the age assigned on the court order. Dependents who were covered at the time of the employee's/retiree's death can receive coverage for 36 months or until age 26 for health coverage, whichever is longer. Health includes medical, dental, and vision coverage. Coverage for disabled surviving children may continue indefinitely, subject to coverage rules for disabled children. Dependents not covered at the time of the employee's/retiree's death cannot be added to coverage.

Medical Plan Overview

A&M CARE

EMPLOYEES &
RETIREES

65 PLUS

RETIREES NOT WORKING FOR
TAMU & ENROLLED IN
MEDICARE A&B

J PLAN

EMPLOYEES ENROLLED
UNDER A J1 OR J2 VISA

GRADUATE

GRADUATE STUDENT
EMPLOYEES

Plan Choices: A&M Care and 65 Plus Plan

A&M Care Plan - available to all benefits-eligible employees and some retirees.

J Plan - available to benefits eligible employees holding a J1 or J2 visa. This plan meets the requirements of your visa.

Graduate Student Plan - available if you are a benefits eligible graduate student employee. This plan meets the J1 and J2 Visa requirements.

65 Plus Plan - only option available if you and all of your covered dependents are enrolled in Medicare Parts A&B and you are not working for the A&M System.

You and your enrolled family members must all be in the same medical plan, unless a spouse or dependent child works for the A&M System and chooses separate coverage.

None of the medical plans have pre-existing condition limitations. All plans have a few limits on specific benefits such as home health care. You cannot change medical plans during the plan year and you cannot add or drop coverage for yourself or any dependents during the plan year unless you have a Qualifying Life Event.

Enrollment Rules

If you do not enroll during your initial enrollment period, you can enroll yourself and dependents only during Open Enrollment or if you have a corresponding Qualifying Life Event. You do not have to provide evidence of insurability to enroll in any of the medical plans.

Prescription Drugs

Each A&M System medical plan includes coverage for prescription drugs. You are responsible for the drug deductible and the drug copayment.

Copayments for prescription drugs apply towards the out-of-pocket maximum for the medical plan in which you are enrolled. In cases where the dispensing pharmacy's charge is less than the copayment, you will be responsible for the lesser amount.

Each medical prescription plan has a Preferred or Formulary list. This list can change during the year due to pharmaceutical review. Check your medical prescription plan's preferred/formulary drug list to determine your medication cost.

For the A&M Care Plan, the 65 Plus Plan and the J Plan, Express Script's online resource, My Rx Choices, allows members to:

- Order prescriptions through their home delivery program;
- View prescription history;
- Conduct a personal assessment for possible lower cost alternatives;
- Request assistance from Express Scripts in contacting providers to request approval for changing to lower cost alternatives/equivalents;
- Compare brand to generic and retail to mail costs.

A&M Care Plan

Vendor: Blue Cross Blue Shield of Texas (BxBSTX)

Member Services Contact Information:

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

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

Website: bcbstx.com/tamus

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

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

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

	Network Provider	Brazos Valley Network (BVN)	Baylor Scott & White Health (Brazos Valley)	Non-Network
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A&M Care Plan Information (cont)

Preventive exam:	100% covered	100% covered	100% covered	Not covered
Lab/X-rays:	Benefit depends on setting & procedure	Benefit depends on setting & procedure	Benefit depends on setting & procedure	50% after deductible
Skilled nursing facility (not custodial care):	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Home health care:	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year

Other Healthcare Benefits

*Chiropractic care:	\$30/visit; 30 visits/plan year	\$15/visit; 30 visits/plan year	\$15/visit; 30 visits/plan year	50% after deductible; 30 visits/plan year
Durable medical equipment:	20% after deductible	10% after deductible	10% after deductible	50% after deductible
*Maternity care:	Hospital: 20% after deductible; Doctor: \$20 initial visit only	Hospital: 10% after deductible; Doctor: \$5 initial visit only	Hospital: 10% after deductible; Doctor: \$20 initial visit only	Hospital: 50% after deductible; Doctor: 50% after deductible
*Mental health:	Inpatient: 20% after deductible; Outpatient: \$20/visit	Inpatient: 10% after deductible; Outpatient: \$5/visit	Inpatient: 10% after deductible; Outpatient: \$20/visit	Inpatient: 50% after deductible; Outpatient: 50% after deductible
*Physical therapy:	\$30/visit	\$15/visit	\$15/visit	50% after deductible
*Vision:	\$30/visit	\$15/visit	\$15/visit	Routine preventive exams not covered
Hearing:	Illness/accident coverage; 20% coinsurance, hearing aid up to \$1,000 per ear, every 3 years	Illness/accident coverage; 20% coinsurance, hearing aid up to \$1,000 per ear, every 3 years	Illness/accident coverage; 20% coinsurance, hearing aid up to \$1,000 per ear, every 3 years	Illness/accident coverage; 20% coinsurance

Prescription Drug Vendor: Express Scripts

Member Services Contact Information: 1 (866) 544-6970 | [express-scripts.com/](https://www.express-scripts.com/)

After you meet the \$50/person/plan year prescription drug deductible (three-person maximum):

- 30-day supply: \$10/generic, \$35/brand-name formulary, \$60/brand-name non-formulary; brand-name copayment + difference between brand name and generic when available
- 90-day supply: Two copayments required if purchased by mail-order; three if purchased through most retail pharmacies

For more information

Medical Summary Plan Description Booklet:

assets.system.tamus.edu/files/benefits/pdf/ae/FY22/SPD/SPDHealth.pdf

J Plan

Vendor: Blue Cross Blue Shield of Texas (BxBSTX)

Member Services Contact Information:

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

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

Website: bcbstx.com/tamus.com

The Texas A&M University J Plan is only available to employees on a J Visa and their family members. The benefits are the same as those in the A&M Care Plan, including the BCBSTX in-network and out-of-network benefit levels below. Since this coverage is a requirement of employment, if you are working for the A&M System on a J1 or J2 visa, the J plan will be your default plan.

Graduate student employees on a J1/J2 visa may also enroll in the Graduate Student plan, which meets the visa requirements for insurance coverage.

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

J Plan Information (cont)

Preventive exam:	100% covered	100% covered	100% covered	Not covered
Lab/X-rays:	Benefit depends on setting & procedure	Benefit depends on setting & procedure	Benefit depends on setting & procedure	50% after deductible
Skilled nursing facility (not custodial care):	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Home health care:	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year

Other Healthcare Benefits

Chiropractic care:	\$30/visit; 30 visits/plan year	\$15/visit; 30 visits/plan year	\$15/visit; 30 visits/plan year	50% after deductible; 30 visits/plan year
Durable medical equipment:	20% after deductible	10% after deductible	10% after deductible	50% after deductible
Maternity care:	Hospital: 20% after deductible; Doctor: \$20 initial visit only	Hospital: 10% after deductible; Doctor: \$5 initial visit only	Hospital: 10% after deductible; Doctor: \$20 initial visit only	Hospital: 50% after deductible; Doctor: 50% after deductible
Mental health:	Inpatient: 20% after deductible; Outpatient: \$20/visit	Inpatient: 10% after deductible; Outpatient: \$5/visit	Inpatient: 10% after deductible; Outpatient: \$20/visit	Inpatient: 50% after deductible; Outpatient: 50% after deductible
Physical therapy:	\$30/visit	\$15/visit	\$15/visit	50% after deductible
Vision:	\$30/visit	\$15/visit	\$15/visit	Routine preventive exams not covered
Hearing:	Illness/accident coverage; 20% coinsurance, hearing aid up to \$1,000 per ear, every 3 years	Illness/accident coverage; 20% coinsurance, hearing aid up to \$1,000 per ear, every 3 years	Illness/accident coverage; 20% coinsurance, hearing aid up to \$1,000 per ear, every 3 years	Illness/accident coverage; 20% coinsurance

Prescription Drug Vendor: Express Scripts

Member Services Contact Information: 1 (866) 544-6970 | [express-scripts.com/](https://www.express-scripts.com/)

After you meet the \$50/person/plan year prescription drug deductible (three-person maximum):

- 30-day supply: \$10/generic, \$35/brand-name formulary, \$60/brand-name non-formulary; brand-name copayment + difference between brand name and generic when available
- 90-day supply: Two copayments required if purchased by mail-order; three if purchased through most retail pharmacies

About Medical Evacuation and Repatriation

Repatriation of remains of at least \$25,000 and medical evacuation coverage of at least \$50,000 are required of those on a J-1 or J-2 visa. GeoBlue, provided with the J Plan, exceeds this requirement.

GeoBlue includes the following required coverage:

- Evacuation/Repatriation: \$250,000
- Repatriation of Remains: \$50,000
- Visit of Family Member or Friend: General Conditions Applicable to all Emergency Transportation Benefits and Arrangements
- Political Emergency/Disaster Evacuation: Covered 100% up to \$100,000 per person subject to a combined \$5,000,000 aggregate limit per any one covered event for all persons covered under the plan.

For more information

Medical Summary Plan Description Booklet:

assets.system.tamus.edu/files/benefits/pdf/ae/FY22/SPD/SPDHealth.pdf

Plan Administration

The A&M Care plan is administered by Blue Cross and Blue Shield of Texas (BCBSTX), with Express Scripts administering the prescription drug portion.

How the Plan Works

Under the A&M Care plan, you may use any doctor, hospital or other provider and receive benefits.

However, you receive higher benefits by using a **network provider**. You do not need a referral to see a specialist, but the copayment for a specialist is higher than the copayment for a primary care physician. The plan has a prescription drug deductible and drug copayments.

For other health care services, including stress tests, outpatient surgeries, emergency room visits and hospitalizations, you first pay an annual deductible, then you and the plan share the remaining costs (coinsurance) until you meet your annual out-of-pocket maximum. After that, the plan pays 100% of remaining eligible expenses for the remainder of the plan year. Out-of-network hospital deductibles do not count toward the annual medical deductibles or out-of-pocket maximums. If you use a hospital that is outside the network, you will have an out-of-network hospital deductible for each admission.

You receive network benefits if you use a **network provider**. You receive out-of-network benefits if you use a **provider not in the network**. See Retiree Medical Coverage in this guide if your primary carrier is Medicare.

When you choose a **provider who is not in the network**:

- You are not eligible for copayments.
- You may need to file claims for reimbursement.
- You must pre-certify hospitalizations to avoid a \$500 penalty.
- Preventive care is not covered.
- Your deductible and out-of-pocket maximum will be double the network deductible and out-of-pocket maximum.
- After your deductible is met, the plan pays a percentage of the allowable cost for eligible services and you may be responsible for the difference between what is billed and the allowable amount.

Brazos Valley Network

The Brazos Valley Network, also known as the CHI St. Joseph and Texas A&M Health Network, is a network tier within the A&M Care Plan. The tier features a 75% reduction in primary care copays, a 50% reduction in specialty care copays and a 50% reduction in co-insurance costs at all of CHI St. Joseph Health's locations throughout the Brazos Valley. This translates to a \$5 copay for a primary care physicians, a \$15 copay for specialists and 10% coinsurance for other costs, such as hospitalization. All other coverage is the same.

The Brazos Valley Network benefits are available to all employees and retirees in the A&M Care Plan, as long

as they receive care from covered, in-network physicians in the Brazos Valley area. Use the Blue Cross and Blue Shield Provider Finder to find eligible Brazos Valley Network providers.

Blue Distinction Centers

With the Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+) designation, you have access to specialty care facilities that meet national measures for quality and cost-efficient care. When you use a BDC, you may get a better outcome and may have lower out-of-pocket costs, depending on the plan and procedure.

Blue Distinction Centers for specialty health care services include bariatric surgery, cardiac care, knee and hip replacement, spine surgery and transplants. To find a Blue Distinction Center in your area, log in to Blue Access for Members at bcbstx.com/tamus and use the Provider Finder. Blue Distinction is listed under the ratings section when you search for a hospital or care facility. You pay 10% coinsurance when you use a Blue Distinction Center for inpatient services.

Two-Step Wellness Incentive Program

Employees and covered spouses enrolled in the A&M Care Plan are eligible for the lowest medical premium if they each complete two steps from their MyEvoke Personalized Checklist found on MyEvoke (tamus.myevoke.com or sso.tamus.edu). A premium differential of \$30/month is added to the monthly premium for each individual (employee and spouse). If you or your spouse complete your two wellness tasks in the current plan year, a \$30 credit for each of you will be applied to your pay stub in Workday for the following plan year. You must complete the tasks between September 1 and June 30 each year. Newly enrolled employees and spouses have a grace period of the current plan year plus one additional year to complete their two steps. For example, if you enroll in the plan on March 1, 2022, you must complete your two tasks between September 1, 2022 and August 31, 2023. We recommend completing both tasks before June 30 to ensure the claims are processed and the credit is recorded before the plan year begins. Retirees and graduate student employees already receive the lower premium and are not eligible to participate in the Two-Step Wellness program. More information is available online at tamus.edu/business/benefits-administration/wellness. You can check your incentive status at any time on MyEvoke, or contact your BCBSTX Benefit Value Advisor to check your status.

Emergency Admissions

If you are admitted to a hospital on an emergency basis, you must precertify with Blue Cross and Blue Shield of Texas (BCBSTX) within 48-hours of admission (unless Medicare is your primary coverage). Call 1 (866) 295-1212 to precertify. This number is also on the back of your BCBSTX ID card for easy reference.

International Claims

To file international claims, you will need to complete an international claim form and submit it to the address

printed on the form. Hospitals that are part of the worldwide network can file claims electronically, which may make filing claims easier for you. Charges incurred will be converted into U.S. currency at the exchange rate in effect at the time the claim is processed by BCBSTX. More information, including the international claim form, is available online at bcbsglobalcore.com or by calling 1 (800) 810 - BLUE (2583).

Coordination of Benefits

If you or another family member has other medical coverage that is primary, the A&M Care Plan will pay benefits based only on the amount the other plan does not pay. This means the deductible and your coinsurance will be applied to the amount the other plan does not pay and not to the entire bill. If the primary plan has a copayment for the service, the A&M Care plan will pay no benefits.

Vision Benefits

The A&M Care plan provides coverage for one preventive eye exam per person, per year (copayment, if in-network, will apply). Additionally, A&M Care participants can also receive discounts on exams, frames, lenses and laser vision services through Davis Vision, Inc. and EyeMed Vision Care. To receive the discount, visit a participating provider and show your A&M Care ID card. For provider information, visit davisvision.com or eyemedexchange.com/blue365.

Medical Care While Traveling

All A&M System medical plans provide benefits in the event of an emergency while traveling. If you know you will be traveling outside your network area or outside the U.S., plan ahead and know how to use your medical plan's emergency benefit features to minimize your out-of-pocket costs. Emergency care is defined as treatment required because permanent disability or endangerment of life would result if the condition were to go untreated. Examples include unconsciousness, severe bleeding, heart attack, serious burns and serious breathing difficulties. If you have an emergency while traveling, seek help immediately at the nearest emergency facility. These providers should then file the claims with the local BCBS group, who will forward payment and claim information to BCBSTX.

For all plans, if you need non-emergency care or a prescription refill, call your network or primary care doctor. You can call 1 (800) 810-BLUE (2583) for information on network physicians or facilities outside of Texas. You will receive network benefits if you use a network doctor and out-of-network benefits if you use a non-network doctor. Some treatments are considered experimental or investigational and may not be recognized forms of treatment in the U.S. or may not normally be covered by the A&M Care plan. These will not be reimbursed.

MDLive Virtual Visits with Blue Cross and Blue Shield

Virtual Visits is a feature provided by MDLive through your Blue Cross and Blue Shield medical plan.

This digitally-based solution provides health care for simple, non-emergency medical and behavioral health conditions 24/7/365. Virtual Visits are included in the A&M Care plans with a \$10 copay.

Members can select their doctor from a large, national virtual visit network in private, secure and confidential environments via telephone, online video or mobile app. When appropriate, prescriptions can be sent instantly to the member's pharmacy of choice. Behavioral health consultations are available by appointment and video only.

For all retirees including those with Medicare or in the 65 Plus Plan – you can use these services for a \$10 charge. These services are not covered by Medicare and will be paid by Blue Cross Blue Shield without being submitted to Medicare. You will be asked to pay up front before you speak with the physician.

A&M Care 65 Plus Plan

Vendor: Blue Cross Blue Shield of Texas (BxBSTX)

Available everywhere. Policy holder must be retired, enrolled in Medicare Parts A&B and not working for the A&M System for 50% or greater time for more than four months. All covered dependents must also be enrolled in Medicare Parts A&B.

Member Services Contact Information:

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

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

Website: bcbstx.com/tamus

Express Scripts: 1 (855) 895-4647

Website: express-scripts.com

Limitations and Restrictions	
Pre-existing condition limitations:	None
Benefit Maximum:	None
Out-of-service area restrictions:	None
Maximums and Deductibles	
Deductibles:	\$400 Medical
Out-of-pocket maximum: (9-1 through 8-31) Medical	Single: \$1,000 + \$400 medical deductible Family: \$2,000 + \$800 medical deductible
Benefit maximum:	No annual/lifetime maximums
Hospital Benefits	
In-Hospital care:	20% after deductible
Emergency Room:	20% after deductible
Surgery:	20% after deductible In-physician's office, 20% after deductible
Non-Hospital Visits	
Office visits:	20% after deductible
Lab/X-rays:	20% after deductible
High Technology Radiology (MRI, CT & pet scans, stress test, angiogram & myelography):	20% after deductible
Skilled nursing facility (not including custodial care):	20% after deductible; 60-days/plan year
Home health care:	20% after deductible; 60-visits/plan year
Other Healthcare Benefits	
Chiropractic care:	20% after deductible, 30-visits/plan year
Durable medical equipment:	20% after deductible
Mental health:	Inpatient - 20% after deductible Outpatient - 20% after deductible
Physical therapy:	20% after deductible
Vision:	20% after deductible
Hearing:	Illness/accident coverage; 20% coinsurance, hearing aid up to \$1,000 per ear, every 3 years
Prescription Drugs - Express Scripts. This is a Medicare Part D Plan.	
Deductibles: (1-1 through 12-31)	\$0
Out-of-pocket maximum: (1-1 through 12-31)	\$400
Retail Prescription Copays:	31 Day 32-90 Day
Generic	\$10 \$30
Formulary	\$35 \$105
Non-Formulary	\$60 \$180
Mail-Order Prescription Copays:	1-90 Day
Generic	\$20
Formulary	\$70
Non-Formulary	\$120

For more information

Medical Summary Plan Description Booklet:

assets.system.tamus.edu/files/benefits/pdf/ae/FY22/SPD/SPDHealth.pdf

Plan Administration

The A&M Care 65 Plus Plan is administered by Blue Cross and Blue Shield of Texas (BCBSTX), with Express Scripts administering the Medicare Part D prescription drug portion.

How the 65 Plus Plan Works

If you and your eligible dependents are age 65 and older or otherwise eligible for and enrolled in Medicare A&B, you will be placed in the 65 Plus Plan. Under the 65 Plus Plan, Medicare is the primary payer for all claims with Blue Cross Blue Shield as the secondary payer. The plan allows you to use any doctor, hospital or other provider and receive benefits. You do not need a referral to see a specialist. Medicare will continue to pay as the primary coverage. Your A&M plan may pay the remaining billed amount or the difference between the Blue Cross Blue Shield allowed amount and the amount Medicare paid. You will receive the maximum benefit under the plan when your provider who accepts Medicare assignment is also a BCBS in-network provider for medical services.

For health care services, including stress tests, outpatient surgeries, emergency room visits and hospitalizations, you must first meet the Medicare and Blue Cross Blue Shield deductibles. Once the deductibles have been met, you and the plans (Medicare & BCBS) share the remaining costs (coinsurance) until you meet your out-of-pocket maximum for the plan year. Once the out-of-pocket maximum is met, the plan may pay up to 100% of the remaining eligible expenses when utilizing a Blue Cross Blue Shield in-network provider who accepts Medicare assignment.

The 65 Plus Plan includes a prescription drug plan which has no annual deductible. Retirees and covered dependents will each have a \$400 out-of-pocket maximum for drug copayments, per calendar year. When the annual prescription drug out-of-pocket amount has been met, prescriptions will be minimal or no cost to you for the remainder of the calendar year.

Retirees who are eligible for Medicare A&B will be moved to the 65 Plus Plan. If you are or become eligible for the 65 Plus Plan and opt out of this coverage because you have medical coverage through another source other than Medicare, or for most other reasons, you will no longer be able to remain in the A&M Care Plan. Opting out of 65 Plus Plan coverage will mean that you are opting out of any medical coverage through the Texas A&M University System.

Wellness Program

A&M System retirees enrolled in the 65 Plus Plan have access to a variety of wellness resources including Silver Sneakers and GuidanceResources through ComPsych.

You also have access to BCBSTX's digital wellness partners Hinge Health, Omada for pre-diabetes and pre-hypertension, Wondr for weight loss program, and Livongo for diabetes and hypertension. Enrollment in these services is based on eligibility outlined by each vendor partner. For example, Livongo will contact you if you are eligible due to a diabetes diagnosis or hypertension diagnosis. Omada, Wondr and Hinge have an application process. The A&M System does not receive your personal data and cannot identify your individual eligibility for these programs.

International Claims

If you receive medical services outside of the USA, you will need to complete an international claim form and submit it to the address printed on the form. Hospitals that are part of the worldwide network can file claims electronically, which may make filing claims easier for you. The plan covers you overseas even though Medicare does not. Charges incurred will be converted into U.S. currency at the exchange rate in effect at the time the claim is processed by BCBSTX. More information, including the international claim form, is available online at bcbsglobalcore.com or by calling 1 (800) 810-BLUE (2583).

Coordination of Benefits (who pays first) between Medicare & Blue Cross Blue Shield when enrolled in the A&M 65 PLUS Plan

To avoid Coordination of Benefits (who pays first) discrepancies after enrolling in the 65 Plus Plan you will need to:

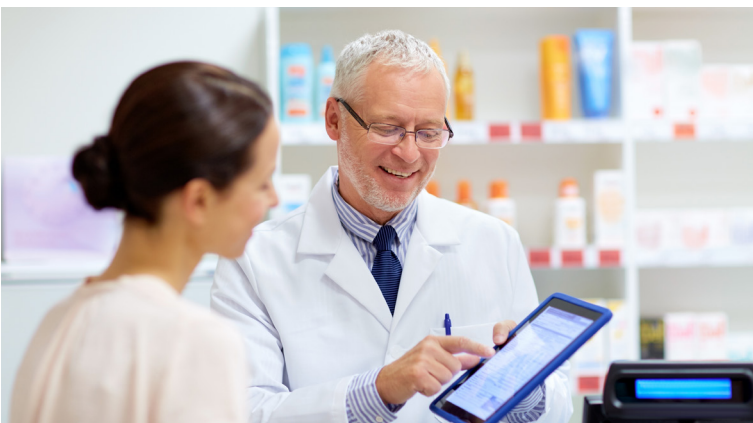
- Contact the Medicare Coordination of Benefits Office (855-798-2627) to request an update to the Medicare records to show Medicare-Primary.
- Contact Blue Cross Blue Shield (866-295-1212) and let them know you have retired and provide your Medicare MBI number so they can update their records to show Medicare-Primary.
- Contact your medical providers and advise that all medical claims should be filed with Medicare as the primary payer and BCBSTX as the secondary payer.

For more information, visit the Retiree Medical Coverage section on page 25 of this guide.

Vision Benefits

The A&M 65 Plus Plan provides coverage for one preventive eye exam per person, per year. Additionally, A&M Care participants can also receive discounts on exams, frames, lenses and laser vision services through Davis Vision, Inc. and EyeMed Vision Care. To receive the discount, visit a participating provider and show your A&M Care ID card. For provider information, visit davisvision.com or eyemedexchange.com/blue365.

Pharmacy Coverage



The A&M Care, 65 Plus and J Plan Pharmacy benefit is managed by Express Scripts. You will receive a separate ID card from Express Scripts. This benefit allows you to use both retail and home delivery pharmacy. Participating retail pharmacy information and formulary information is available at [express-scripts.com](https://www.express-scripts.com).

A&M Care, 65 Plus and J Plan Pharmacy Benefit

The A&M Care plans have three coverage management programs:

- Prior Authorization
- Step Therapy
- Drug Quantity Management

These programs are in place to ensure that medications are taken safely and appropriately. If you or a covered family member take certain medications, a “coverage review” may be necessary. If it is, your doctor must obtain prior authorization from Express Scripts so that your prescription can be covered.

Prior authorization

The coverage review process for prior authorization allows Express Scripts to obtain more information about your treatment (information that is not available on your original prescription) to help determine whether a medication qualifies for coverage under the plan.

Step Therapy

Some medications may require a coverage review to determine whether certain criteria have been met, such as age, sex, or condition; and/or whether an alternate therapy or course of treatment has failed or is not appropriate.

Drug Quantity management

To promote safe and effective drug therapy, certain medications may have quantity restrictions. These quantity restrictions are based on product labeling, FDA regulations or clinical guidelines and are subject to periodic review and change.

Express Scripts pharmacists will review your prescription to see if the criteria required for a certain medication have been met. If they have not been met, or the information cannot be determined from the prescription, a coverage review will be required. Express Scripts will automatically notify the pharmacist to tell you that the prescription needs to be reviewed for prior authorization.

If your prescription needs a coverage review, you or your doctor may start the review process by calling Express Scripts toll-free at 1 (866) 544-6970, 7:00 a.m. to 8:00 p.m., CST, Monday through Friday. After receiving the necessary information, Express Scripts will notify you and the doctor (usually within 2 business days) to confirm whether coverage has been authorized. If coverage is authorized, you will pay your copayment (and deductible if not previously met) for the medication.

If coverage is not authorized, you will be responsible for the full cost of the medication. If appropriate, you can talk to your doctor about alternatives that may be covered. You have the right to appeal the decision. Information about the appeal process will be included in the coverage denial letter that you will receive.

Specialty Medicines

Some medications must be filled through Accredo, the Express Scripts Specialty Mail Order Pharmacy. Specialty medications are drugs that are used to treat complex conditions, such as those listed in the chart on this page. Your initial prescription for a specialty medication can be filled at a retail pharmacy, however all subsequent refills must be filled through Accredo.

Below is a partial listing of some of the conditions treated with drugs considered to be “Specialty Medications”.

- | | |
|--|--|
| <ul style="list-style-type: none"> • Cancer • Growth Hormone Deficiency • HIV • Hepatitis C • Parkinson’s Disease | <ul style="list-style-type: none"> • Crohn’s Disease • Multiple Sclerosis • Pulmonary Arterial Hypertension • Hemophilia • Rheumatoid Arthritis |
|--|--|

For more information on specialty medicines, contact Express Scripts at 1 (866) 544-6970 or visit [express-scripts.com](https://www.express-scripts.com).

Graduate Student Employee Health Plan

Vendor: Blue Cross Blue Shield of Texas (BxBSTX)

Member Services Contact Information:

Academic Health Plans (AHP)

Phone: 1 (877) 624-7911

Website: tamus.myahpcare.com

Any registered and enrolled A&M System graduate student employed by the A&M System in a benefits-eligible position may enroll in the Graduate Student Health Plan. Graduate student employees on a J1/J2 Visa may also enroll in the Graduate Student plan, which meets the visa requirements for insurance coverage.

	Network	Non-Network
Limitations and Restrictions		
Pre-existing condition limitations:	None	n/a
Out-of-service area restrictions:	None	n/a
Maximums and Deductibles		
Benefit maximum:	No annual/lifetime maximums	No annual/lifetime maximums
Deductibles:	\$500/\$1,500	\$1,000/\$3,000
Out-of-pocket maximum: Individual/Family	\$7,900/\$15,800	\$15,800/\$31,600
Hospital Benefits		
In-Hospital care:	20% after deductible	40% after deductible
Emergency Room: Emergency Room Physician:	20% after \$150 copayment 20% after deductible	20% after \$150 copayment 20% after deductible
Surgery:	20% after deductible	40% after deductible
Non-Hospital Visits		
Office visits:	\$35 copay	40% after \$35 copayment
Preventive exam:	100% covered (deductible waived)	40% after deductible
Lab/X-rays:	20% after deductible	40% after deductible
Skilled nursing facility (not including custodial care):	20% after deductible; 25 days/plan year	40% after deductible; 25 days/plan year
Home health care:	20% after deductible; 60 visits/plan year	40% after deductible; 60 visits/plan year
Other Healthcare Benefits		
Chiropractic care:	\$35/visit; 35 visits/person	40% after \$35 copay; 35 visits/person
Durable medical equipment:	20% after deductible	40% after deductible
Mental health:	Inpatient - 20% after deductible Outpatient - \$35/visit	40% after deductible 40% after \$35 copay
Physical therapy:	\$35/visit; 35 visits/person	40% after \$35 copay; 35 visits/person
Vision/Hearing:	20% after deductible One preventive vision exam/per plan year	40% after deductible

For more information

Medical Summary Plan Description Booklet:

assets.system.tamus.edu/files/benefits/pdf/ae/FY22/SPD/SPDHealth.pdf

Graduate Student Employee Health Plan

The Graduate Student Employee Health Plan (GSE Plan) provides benefits-eligible graduate student employees with comprehensive benefits at a lower premium than the A&M Care Plans. It also includes medical evacuation and repatriation benefits that meet federal requirements for foreign nationals. This plan meets the visa requirement for J-1/J-2 visas. Visit tamus.edu/business/benefits-administration/student-insurance for additional information.

GSE Plan Pharmacy Benefits

The GSE Plan offers a Prescription Drug Copayment Plan. To access your benefits you should use the Student Health Center Pharmacy or a pharmacy contracting with the Prime Therapeutics network. The Group Number for the prescription drug benefit is the same as your medical group number. To locate a pharmacy in your area or for general questions, call Prime Therapeutics at 1 (800) 423-1973 or call the phone number listed on the back of your member card. You can also visit the Academic HealthPlan website at tamus.myahpcare.com or the Prime Therapeutics website at myprime.com. Students have the option to purchase a 90-day supply for all medications at 3 times the 30-day retail pharmacy copayment where permitted by law.

Please Note: If your record has not yet been activated in the Student Health Plan system or you are buying a prescription at a pharmacy other than the Student Health Center Pharmacy or a pharmacy contracting with Prime Therapeutics, you will need to pay for your prescription in full. Contact Academic HealthPlans at 1 (877) 624-7911 to have your information added to their system within 7 business days of purchasing your prescription and you may return to the pharmacy to have your prescription reprocessed. If it's been longer than 7 days or if you have purchased your prescription at an Out-of-Network Provider, you will need to complete the [Prescription Drug Claim Form](#) and attach a copy of your prescription drug label along with the pharmacy receipt showing how much you paid (not the cash register receipt) for reimbursement.

If you have any questions regarding the GSE Plan, call Academic HealthPlans at: 1 (877) 624-7911 or email support@ahpcare.com.

GSE Plan Pharmacy Benefit - Prime Therapeutics			
	Generic	Brand Formulary	Brand Non-Formulary
No annual deductible			
Student Health Center	\$10		\$35
Retail Pharmacy (30-Day Supply)	\$10	\$10	\$35
Mail-Order (90-day Supply)	\$45	\$45	\$90

AcademicLiveCare for Graduate Student Employees

Download the iOS or Android mobile app or visit academiclivecare.com to access 24/7 virtual medical and behavioral health services at zero cost to you when enrolled in the Student Health Insurance Plan. Non-emergency conditions that can be treated include: cough and cold, UTI, sinus infections, rashes, anxiety and depression, headaches, and more.

Academic Emergency Services

To ensure you have immediate access to assistance if you experience a travel related crisis, Academic HealthPlans has included Academic Emergency Services (AES) in your Student Health Insurance Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis. For more information, view the [Academic Emergency Services flyer](#).

Retiree Medical Coverage



Medicare Coordination of Benefits

Medicare-Eligible Retirees

If you are a Medicare-eligible retiree, you are considered Medicare Primary if you are:

- retired;
- eligible for Medicare A&B; and
- not working for the A&M System at 50% effort or more for at least 4½ consecutive months in a budgeted position.

If you are Medicare-Primary, all A&M plans pay benefits as if you are enrolled in Medicare Parts A and B. In addition, you will not be eligible for copayments.

Plan benefits are calculated based on the total billed amount from your health provider. After Medicare pays, your A&M plan pays either the full benefit or the difference between the Blue Cross and Blue Shield allowed amount and the amount Medicare paid. This means that you receive full reimbursement in some cases. The chart below shows an example of the coordination of benefits with Medicare and the A&M Care Plan if you have a \$213 doctor's office visit.

	Medicare Primary (A&M Care/65+ Secondary) Plan year: January-December	A&M Care Primary (Medicare Secondary) Plan year: September-August
Primary Payer	Cost: \$243 Medicare Deductible: \$233 Remainder: \$10 Medicare pays 80%: \$8	\$20 or \$30 copayment, depending on the provider. If using a network provider, claim is paid at in-network levels. If a non-network provider is used, deductible and co-insurance apply.
Secondary Payer	\$243 is applied toward your \$400 A&M Care deductible. If the A&M Care deductible has already been met, A&M Care will pay the \$233. Retiree pays 20%: \$2 Cost for retiree (deductible + 20%): \$235	\$233 is applied to the Medicare deductible.

Determining Primary and Secondary Coverage

The chart below will help you determine whether Medicare is primary or secondary in various situations. The chart also includes information for covered spouses and dependents of the retiree:

Retiree Eligible for Medicare	Dependents eligible for medicare	Eligible for the 65 Plus Plan	Plan Primary for Retiree	Plan Primary for Dependents
<i>If you are retired and NOT working for the TAMU System for 50% time or more for at least 4 1/2 months (benefits-eligible position)</i>				
Y	Y	Y	Medicare	Medicare
Y	N	N	Medicare	A&M Care
N	Y	N	A&M Care	Medicare
N	N	N	A&M Care	A&M Care
<i>If you ARE working for the TAMU System for 50% time or more for at least 4 1/2 months (benefits-eligible position)</i>				
N*	N	N	A&M Care	A&M Care

**If your terms of employment (percent effort or term months) change during the fiscal year, your primary/secondary status will change when coordinating benefits. Check with your Human Resources office if you are unsure of your status.*

For more information, you can check out the fact sheets on the System Benefits Administration website at tamus.edu/business/benefits-administration/medicare-information.

Medicare has a calendar-year deductible (January through December), while the A&M Care plans have plan-year deductibles (September through August). See the Medicare Notice of Creditable Coverage in the back of this booklet.

For more information about Medicare please refer to these resources:

Medicare website [medicare.gov/default.aspx](https://www.medicare.gov/default.aspx)

“Medicare & You” handbook ([medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf](https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf)), which contains detailed information about Medicare plans that offer prescription drug coverage.

Medicare customer service: 1 (800) 633-4227. TTY users should call 1 (877) 486-2048.

[State Health Insurance Assistance Program \(SHIP\)](#)

For More Information

A&M Care Plan Summary Plan Description Booklet:

assets.system.tamus.edu/files/benefits/pdf/ae/FY22/SPD/SPDHealth.pdf

Dental Coverage



Plan Choices

There are two dental plan options: A&M Dental PPO and the DeltaCare USA Dental HMO. If you enroll in a dental plan, you may also enroll your eligible family members in that plan.

Enrollment Rules

- Eligibility for the HMO depends on where you live and whether there are HMO dentists in the area.
- You may elect the PPO dental plan regardless of where you live.
- If you do not enroll during your initial enrollment period, you can enroll yourself and dependents only during Open Enrollment or if you have a Qualifying Life Event.
- You do not have to provide evidence of insurability to enroll in either plan.
- The plans have no pre-existing condition limitations.

Benefits

A&M Dental PPO

This plan has two levels of network providers and a non-network provider option. Each time you need services, you can choose a PPO dentist, a Premier dentist or a non-network dentist.

PPO providers reduce their fees by about 30%, and Premier providers reduce their fees by about 15%. Both group network providers have agreed to specific fee schedules, and you are not liable for any costs over Delta's allowable amount based on the fee schedule. To find a network dentist in your area, visit deltadentalins.com/tamus.

You can also use a non-network provider and receive the plan benefits shown in the chart based on the provider's full fees, but your out-of-pocket costs may be higher.

When you elect the Dental PPO Plan and don't use a network provider, Delta Dental will pay up to the maximum plan allowance for each service provided by a non-Delta Dental dentist. Non-Delta Dental dentists are not required to accept Delta Dental's allowed amounts and are not required to file your claim for you. These dentists can balance bill you the difference between Delta Dental's allowed amount and their submitted charge.

DeltaCare USA Dental HMO

The DeltaCare USA plan is not available in all parts of Texas. The plan is also available and has networks outside of Texas, in Tennessee, Florida, Georgia, California, Washington, D.C., Maryland, Colorado, New York and Utah.

You must live or work within the same first-three-digit zip code area as an HMO dentist. If you do not, but are willing to travel to a network dentist, you can contact your Human Resource office.

To receive benefits under the DeltaCare USA plan, **you must use the network general dentist listed on your ID card** or be referred to a specialist by a network general dentist. When you enroll, Delta Dental will assign you a dentist. If you wish to change dentists, contact Delta Dental at 1 (800) 422-4234.

To find a network general dentist, go to deltadentalins.com/tamus or contact Delta Dental directly for information about specialists.

Delta Dental PPO

Vendor: Delta Dental

Member Services Contact Information:

Delta Dental: 1 (800) 422-4234

Website: deltadentalins.com/tamus

Provisions	
Deductible	\$75/person/plan year; \$225 family/plan year
Maximum benefit	Regular: \$1,500/person/plan year; Orthodontia: \$1,500/person/lifetime
Your cost for preventive care	\$0 (if you use a network provider). The plan covers three regular or periodontal cleanings per plan year at 100% up to the maximum allowable charges. Deductible does not apply.
Your cost for basic care	You pay the deductible plus 20% of the maximum allowable charges for fillings, root canals, extractions and periodontics. Once you reach your maximum annual benefit of \$1,500, you pay 100%.
Your cost for major restorative care	After you meet your deductible, you pay 50% of the maximum allowable charges for crowns, dentures and bridges. Once you reach your maximum annual benefit of \$1,500, you pay 100%.
Your cost for orthodontics	After you meet your deductible, you pay 50% until you reach your maximum lifetime benefit of \$1,500, then you pay 100%.
Filing Claims	PPO and Premier dentists file claims for you.
Alternate benefit provision	When more than one procedure could provide suitable treatment, the plan will pay for the least expensive procedure. You may apply this benefit to whichever procedure you wish to have.

The following chart illustrates the difference in the amounts you would pay based on using a network dentist (PPO or Premier) or a non-network dentist.

Procedure: Crown	Delta Dental PPO Network Dentist	Delta Dental Premier Network Dentist	Non-Delta Dental Dentist
Dentist bills	\$800.00	\$800.00	\$800.00
Dentist accepts as payment in full	\$548.00 (Delta Dental's allowed amount)	\$688.00 (Delta Dental's allowed amount)	\$800 (No fee agreement with Delta Dental)
Delta Dental's payment Major benefit paid at 50%	\$274.00	\$344.00	\$344.00
Patient share*	\$274.00	\$344.00	\$456.00
Patient savings	\$252.00	\$112.00	\$0.00

*Patient's share is the coinsurance, any remaining deductible, any amount over the annual maximum and any services your plan does not cover. However, when visiting a non-Delta Dental dentist, the patient share also includes the difference between the allowed amount and the dentist's submitted charge.

For More Information

Dental Summary Plan Description Booklet:

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

Delta Dental HMO

Vendor: Delta Dental

Member Services Contact Information:

Delta Dental: 1 (800) 422-4234

Website: deltadentalins.com/tamus

If you enroll in the DeltaCare USA Dental HMO, you must use the general dentist shown on your ID card. To change dentists, contact Delta Dental at 1 (800) 422-4234.

Provisions	
Deductible	None
Maximum benefit	Regular: None; Orthodontia: None
Your cost for preventive care	Comprehensive oral exam: \$0; Cleaning (once each six months): \$5; Panoramic X-rays (once every three years): \$0
Your cost for basic care	You pay a pre-set fee, for example: Amalgam fillings: \$8-\$22; Resin-based composite filling; two surfaces, posterior; permanent: \$75;
Your cost for major restorative care	You pay a pre-set fee, for example: Crown; porcelain/ceramic: \$395; Complete denture; maxillary: \$365
Your cost for orthodontics	You pay a pre-set fee, for example: Orthodontic evaluation: \$25; Orthodontic treatment plan and records: \$200; Comprehensive treatment, permanent teeth: children up to age 19, \$1,900; adults: \$2,100
Alternate benefit provision	None; you choose the procedure you want from the covered services and pay the applicable copayment.

The chart below provides a sample of some of the copayments applicable to services provided under the DeltaCare USA Dental HMO Plan.

Dental Service	Copayment
Deductible	\$0
Oral Exam - X-rays, Cleaning	\$5
Fluoride Treatment - child (age <19)	\$0
Filling - Amalgam, one surface	\$8
Crown	\$185-\$395
Root Canal - molar	\$365
Extraction - erupted tooth or exposed root	\$14
Orthodontia (child to age 19)	\$1,150

For More Information

Delta Dental Schedule of 6 payments:

assets.system.tamus.edu/files/benefits/pdf/programs/DHMO15B.pdf

Vision Coverage



Plan

This plan is administered by Superior Vision. It provides coverage for eye exams, eyeglass frames and lenses, and contact lenses as well as discounts on some eye surgeries. You may use either the vision exam coverage through your health plan or the vision plan's exam benefit.

Enrollment Rules

- You can enroll yourself and eligible dependents during your initial enrollment, Open Enrollment or if you have a certain Qualifying Life Event.
- You do not have to provide evidence of insurability to enroll.
- The plan has no pre-existing condition limitations.

Benefits

The plan covers exams for a \$10 copayment and has a \$15 copayment for materials if you use a network provider. If you use a provider not in the network, the plan will pay limited benefits. The chart below describes plan benefits for the most common products and services. If you use a non-network provider, you pay the full cost to the provider and submit a claim, including the original bill, to Superior Vision for reimbursement of the covered amount. If you have receipts for services and materials purchased on different dates, you must submit the receipts at the same time and within 12 months of the date of service.

	Network Benefit	Non-Network Benefit
Eye exam (one per plan year)	100% after \$10 copayment.	Up to \$50. Copayment doesn't apply
Materials	100% after \$15 copayment for: <ul style="list-style-type: none"> • Frames - every plan year, up to \$150. • Eyeglass lenses - one standard pair every plan year Standard single vision; standard lined trifocal, standard lined bifocal, standard lenticular and standard progressive.	Copayment doesn't apply. <ul style="list-style-type: none"> • Frames: Up to \$90. • Lenses: \$50 to \$100, depending on type of lenses.
Contact lenses (once every plan year in place of eyeglass benefit)	Conventional/Disposable - \$150 Allowance; Medically Necessary - Covered in Full up to the Allowable Amount	Conventional/Disposable - \$150 Allowance; Medically Necessary - \$210 Allowance
Refractive eye surgery	15% off reasonable and customary cost, or 5% off promotional price	Not applicable

For More Information

Vision Summary Plan Description Booklet:

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

Superior Vision website:

microsite.superiorvision.com/tamus

Customer service: 1 (800) 507-3800

Life Coverage

Plan Choices

The A&M System offers Basic Life, Alternate Basic Life, Optional Life and Dependent Life insurance. Eligibility for some of these plans depends on whether you have medical coverage through the A&M System. The plan you select for yourself can affect eligibility for the dependent life plans.

Enrollment Rules

When you enroll during your initial eligibility period, your coverage for life insurance begins on the effective date you elected, or the first of the month following approval if evidence of insurability is required.

- You must be actively at work on the day your coverage, or increase in coverage, is to begin.
- If you and your spouse both work for the A&M System and you take Optional or Alternate Basic Life, your spouse may not cover you through his/her Dependent Life.
- Children may not be covered on Dependent Life by both parents. Only dependents you enroll are covered under Dependent Life.
- After your initial enrollment period, you may:
 - » Enroll in coverage at any time by providing Evidence of Insurability (EOI).
 - » Enroll in Optional Life coverage of ½ or one times salary **within 31 days of a Qualifying Life Event** without providing EOI.
 - » Increase Optional Life coverage by one increment up to three times salary **within 31 days of a Qualifying Life Event** without providing EOI, or
 - » Enroll **new** dependents **within 31 days** of acquiring them without providing EOI. Spouses must always provide EOI for coverage over \$50,000, or if coverage is added at any other Open Enrollment period for the first time.

Benefits

You are automatically enrolled in Basic Life and Basic AD&D if enrolled in an A&M System medical plan. Life insurance pays benefits to your beneficiaries if you die or to you if a covered family member dies. Basic Accidental Death and Dismemberment (AD&D) pays an additional benefit in the event of the accidental death or dismemberment of a covered employee.

If you have a salary increase, your Optional Life coverage will increase at the beginning of the following plan year, but the dependent coverage amount will not change. During Open Enrollment, or as a result of a Qualifying Life Event, you may make a change to your dependent life coverage amount. To increase coverage on your spouse, your spouse must provide EOI, and the coverage amount cannot exceed your Optional Life coverage amount.

Premiums

Lower Optional Life premiums are available if you have not used any tobacco products in the last three months. You can change your tobacco status at any time. If you or your spouse do not designate a tobacco user status, the status will default to tobacco user.

Accelerated Death Benefit

If you have Basic, Alternate Basic or Optional Life coverage and a doctor certifies that you have less than 24 months to live, you may apply for immediate payment of 50% of your plan benefit. Your beneficiary will receive the remaining benefit after your death. This benefit is also available for dependents covered under Dependent Life.

Additional Benefits

Employee Assistance Plan (EAP)

The Hartford's EAP services include:

- 3 confidential, face-to-face counseling sessions, unlimited telephonic support
- Legal services (i.e. family law, real estate, bankruptcy, etc.)
- Personal convenience services (i.e. childcare, elder care, education, moving/relocation, etc.)
- Financial services (i.e. budgeting, investments & credit matters)
- Health Advocacy services (i.e. navigating health benefits, resolving claims and billing issues, etc.)
- Easy access to support - dedicated toll-free number available 24 hours a day, seven days a week

To access the EAP service, contact 1 (800) 964-3577.

Funeral Planning and Concierge Services by Everest

The Hartford's Funeral Concierge service offers a suite of online tools and live support to help guide you through key decisions. It allows for pre-planning, documentation of wishes, and even offers cost comparisons of funeral-related expenses.

After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers – often resulting in significant savings.

Call toll-free at 1 (866) 854-5429 or visit everestfuneral.com/hartford to access this service.

EstateGuidance Will Services

This service helps you protect your family's future allowing you to create a free will online – backed by online support from licensed attorneys.

The online will is simple to create, legally binding and will save you the time and expense of a private legal consultation. There is no fee to create your will.

If you have questions while creating your will, the online education center provides answers regarding family law. You can also access licensed attorneys who will respond to you online. All information is kept secure and confidential with the latest encryption technology.

Additional estate planning services are also available for purchase, including the creation of living wills and trusts, guidance about divorce proceedings and durable power of attorney. Visit estateguidance.com and use the promotional code WILLHLF to begin preparing your personal will.

Beneficiary Assist Counseling Services

The Hartford offers you Beneficiary Assist counseling that can help you or your beneficiaries (named in your policy) cope with emotional, financial and legal issues that arise after a loss.

Includes unlimited phone contact with a counselor, attorney or financial planner and five face-to-face sessions for up to a year from the date a claim is filed. Call toll-free at 1 (800) 411-7239 to use this service.

Travel Assistance and ID Theft and Protection Services

Travel Assistance with ID Theft Protection includes pre-trip information to help you feel more secure while traveling. It can also help you access professionals across the globe for medical assistance when traveling 100+ miles from home for 90 days or less.

ID Theft services are available to you and your family at home or when traveling. In addition to prevention education, this service provides advice and help with administrative tasks resulting from identity theft:

- Fraud alert to three credit bureaus
- Resolution guidance and assistance
- Personal services such as translation

Call toll-free at 1 (800) 243-6108 to use this service.

Life Benefit Guidance

The Hartford partners with OG Benefits to provide additional guidance on the life insurance plans. You can contact them at 1 (833) 867-5300, Monday-Friday 8 AM to 5 PM, for a consultation about Life and Dependent Life Insurance coverage. This service also provides:

- Assistance with Evidence of Insurability
- Answers to questions about Beneficiaries under Texas law
- Death claim support and additional services, including survivors' questions
- Advice on special circumstances like Accelerated Death Benefits

Age Reductions

When you retire, your life insurance coverage maximums are decreased as follows:

	Maximum Optional Life Retiree	Maximum Dependent Life Spouse
Retiree under age 70	\$100,000	\$50,000*
Retiree age 70 through age 79	\$60,000	\$30,000
Retiree age 80 and older	\$30,000	\$15,000

*Dependent Spouse Life cannot exceed the Retiree Optional Life.

Evidence of Insurability

You must provide Evidence of Insurability (EOI) to enroll in certain coverage amounts or to elect or increase coverage after your initial enrollment period. Providing EOI involves answering questions about your health.

EOI is required to:

- Add Optional Life of more than three times your annual salary during your initial 31 day enrollment period, or for any amount after your initial 31 day enrollment period.
- Add Spousal-Dependent Life over \$50,000 within your initial 31 day enrollment period.
- Add or increase Spousal-Dependent Life after your initial 31 days outside of a Qualifying Life Event.
- Increase Optional Life one increment up to 3x salary within 31 days of a commensurate Qualifying Life Event.

As a new employee or during Open Enrollment, you can complete the EOI information on The Hartford's website, which is accessible through Workday, or Optional/Dependent Life EOI forms are available from your Human Resources office. You can also apply to increase coverage at any other time during the year using Workday. The Hartford may ask for more medical information before deciding whether to grant your request. This process normally takes about four weeks but may take longer.

- You are responsible for expenses incurred to provide the requested medical information.
- The Hartford will notify you of the acceptance or denial of your application.
- You will not have the coverage unless you receive approval. If you are approved, coverage begins September 1 (if you apply during the Open Enrollment period) or the first of the next month if you are approved after September 1.
- You should confirm the increase in Workday or with your HR Office once you receive your approval letter.

Life Coverage	
Basic Life/Basic AD&D	You are automatically covered if you are enrolled in an A&M System medical plan.
Coverage for you:	\$7,500 in life insurance and \$5,000 in AD&D coverage
Child Coverage:	\$5,000 in life insurance on each eligible dependent child.
Alternate Basic Life/Basic AD&D	If you are not enrolled in A&M System medical coverage, but certify that you have other medical coverage, you can pay for Alternate Basic Life using the employer contribution. If you select this coverage, you cannot enroll in Optional Life.
Coverage for you:	\$50,000 or the amount of optional life you had immediately before enrolling in this plan, whichever is less, as well as \$5,000 in Basic AD&D coverage
Child Coverage:	\$5,000 in life insurance on each eligible dependent child.
Optional Life	Employee: ½ to 6x salary with a maximum coverage amount of \$1,000,000. Retiree: Maximum of \$100,000 if younger than 70. Coverage will automatically be reduced to \$60,000 at age 70 and \$30,000 at age 80.
Dependent Life Plan A	You can enroll your dependents if you have Optional Life coverage. You pay for the coverage yourself.
Spouse Coverage:	Coverage amounts are: \$25,000, \$50,000, \$75,000, \$100,000, \$150,000 or \$200,000. Coverage over \$50,000 requires EOI within initial 31 day enrollment period or within 31 days of marriage. Enrollments outside of those time periods require EOI for all coverage amounts. The spouse coverage amount may not be greater than the employee coverage amount.
Child Coverage:	Retiree: Maximum spouse coverage is \$50,000 for retirees younger than age 70; \$30,000 for retirees ages 70–79; \$15,000 if retiree is age 80 or older. The retiree spouse coverage amount may not be greater than the retiree coverage amount. \$10,000 per child.
Dependent Life Plan B	
Spouse coverage:	\$5,000 in life and \$5,000 in AD&D coverage; if spouse is enrolled.
Child Coverage:	\$5,000 in life insurance on each eligible enrolled dependent child.
Dependent Life Plan C	You can enroll your dependents if you have Alternate Basic Life coverage. You pay for the coverage yourself.
Spouse coverage:	50% of your Alternate Basic Life coverage amount, if spouse is enrolled.
Child Coverage:	\$5,000 on each enrolled child.
<ul style="list-style-type: none"> If you had coverage prior to September 1, 2009 your dependent coverage amount(s) may be greater than the above referenced maximums. You must provide evidence of insurability to enroll in or increase Life insurance coverage for you or your spouse. 	

Naming a Beneficiary

You are automatically the beneficiary for dismemberment benefits on yourself and all benefits payable for a covered family member. You must name a beneficiary to receive benefits in case of your death. You may name one or more primary beneficiaries. If you name more than one person as a primary beneficiary, you should also designate the percentage of the benefit each should receive. Otherwise, benefits will be divided equally. For example, you might direct that your spouse receive 50% of the benefit and each of your two children receive 25%. Percentages must total 100%. You may also name one or more secondary beneficiaries to receive your benefit in case your primary beneficiary(ies) dies before or at the same time as you do. If you name more than one, you must designate the percentage of the benefit each is to receive. Secondary beneficiaries are paid benefits only if all primary beneficiaries die before or at the same time as you. You may change your beneficiary designation anytime in Workday at sso.tamu.edu.

For more information

Life Summary Plan Description:
assets.system.tamus.edu/files/benefits/website/SPDs/SPDLife.pdf

The Harford website:
thehartford.com/learn/tamus

Accidental Death and Dismemberment

Plan Choices

Accidental Death and Dismemberment (AD&D) coverage provides benefits in the event of an accidental injury that results in the death or dismemberment of a covered person. It is payable in addition to any life insurance you may have. You pay the full cost if you choose to enroll in AD&D. You may choose employee-only or family coverage.

If your annual pay is \$25,000 or less, you can buy coverage of up to \$250,000 in multiples of \$10,000. If your annual salary is more than \$25,000, you can buy up to 10 times your salary with a maximum coverage amount of \$800,000. Retirees can choose up to \$200,000 if younger than age 70, and up to \$60,000 if age 70 or older.

Family coverage will automatically cover all of your eligible family members.

- Your spouse will be covered for 50% of your coverage amount and each eligible child for 10% of your coverage amount.
- If you have no spouse, each eligible child will be covered for 15%
- if you have no eligible children, your spouse will be covered for 60% of your coverage amount. The maximum coverage for each child is \$25,000.

Enrollment Rules

- You can enroll during your initial enrollment period, during future Open Enrollment periods or within 31 days of a Qualifying Life Event.
- Evidence of Insurability (EOI) is not required for AD&D because the policy only pays for accidents.
- Once you enroll in the AD&D plan, you can reduce or drop your coverage at any time. You can change from individual to family coverage or family coverage to individual coverage only during Open Enrollment or within 31 days of a Qualifying Life Event.

Benefits

For Loss Of	Percentage of Coverage
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand	50%
One Foot	50%
Entire Sight of One Eye	50%
Speech	50%
Hearing	50%
Thumb and Index Finger on Same Hand	25%

Coma Benefit

The AD&D plan will pay a coma benefit if you or a covered family member lapses into a coma as a result of and within 365 days of a covered accidental injury if the coma lasts

for a minimum of 31 days. A monthly benefit is equal to a percentage of your amount of AD&D insurance will be paid for up to 11 months or until the person recovers, whichever occurs earlier.

Felonious Assault Benefit

If you die, or suffer a covered dismemberment as a result of a covered accident caused by a felonious assault, the AD&D plan will pay an additional benefit equal to a percentage of the amount payable due to the death or dismemberment.

Child Care Benefit

The AD&D plan will pay additional benefits equal to a percentage of your AD&D insurance to reimburse the surviving spouse for child care expenses for your dependent children up to age 13.

COBRA Benefit (Medical Continuation)

The AD&D plan will pay an additional benefit to allow surviving family members to continue their group medical coverage. The benefit will be a percentage of your death benefit and is payable for a maximum of three years.

Education Benefit

The AD&D plan will pay an education benefit equal to a percentage of your death benefit for your dependent children and a training benefit for your spouse.

Seat Belt and Air Bag Benefit

If an employee or covered dependent sustains an injury that results in a loss payable under the AD&D Benefit, this benefit provides an additional Seat Belt and Air Bag benefit.

Naming a Beneficiary

You are automatically the beneficiary for dismemberment benefits on yourself and all benefits payable for a covered family member. You must name a beneficiary to receive benefits in case of your death in a covered accident. You may name one or more primary beneficiaries. If you name more than one person as a primary beneficiary, you should also designate the percentage of the benefit each should receive. Otherwise, benefits will be divided equally. For example, you might direct that your spouse receive 50% of the benefit and each of your two children receive 25%. Percentages must total 100%. You may also name one or more secondary beneficiaries to receive your benefit in case your primary beneficiary(ies) dies before or at the same time as you do. If you name more than one, you must designate the percentage of the benefit each is to receive. Secondary beneficiaries are paid benefits only if all primary beneficiaries die before or at the same time as you. You may change your beneficiary designation anytime in Workday at sso.tamu.edu.

For more information

AD&D Summary Plan Description:

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

Long Term Disability



Long-Term Disability (LTD) provides income if you cannot work due to a permanent or temporary disability. You do not have to be permanently disabled or unable to work at all to qualify for benefits. LTD is an optional coverage and you pay the full cost.

Enrollment Rules

- You do not have to provide evidence of insurability (EOI) to enroll in LTD.
- If you do not elect coverage during your initial enrollment period, you may enroll during Open Enrollment without EOI.
- Lower premiums are available for non-tobacco users. You must be tobacco-free for at least 3 months to be considered a non-tobacco user.

Benefits

65% of your base pay minus other sources of income or disability earnings.

Definition of Disability

You are considered disabled if you are unable to perform one or more of the essential duties of your job due to sickness or injury and you are earning 80% or less of the amount you were earning before you became disabled due to that sickness or injury.

Monthly Benefit Limits

The maximum benefit is \$8,000. The minimum benefit is \$100 or 10% of your monthly benefit before deductions of other income, whichever is greater. Your benefit amount will be reduced by earnings you receive from: sick leave pay, workers' compensation, Social Security or any other government plan, or Teacher Retirement System (TRS) or

Optional Retirement Program (ORP) payments.

Elimination Period

90 days from onset of continuous disability

Pre-Existing Condition

The plan will not cover a disability resulting from a pre-existing condition until you have been covered under the plan for 12 months or until you have gone 90 days (after coverage begins) without receiving medical treatment, consultation, care or services, including taking prescribed medications for the condition.

If you pay the full LTD premium yourself, your deduction is taken after-tax and your LTD benefits will not be taxable when you receive them. If you apply part or all of the employer contribution to your premium, part or all of your benefit will be taxable. The taxable portion will be proportional to the amount of premium paid by your employer.

Non-organic Mental Impairments

Maximum Benefit period of 24 months.

Reducing Benefit Duration

Benefit is provided monthly until the greater of the “Reducing Benefit Duration” or Social Security Normal Retirement Age. The chart below shows the maximum time that benefits will be paid based on the employees age at the time of the disability.

Reducing Benefit Duration		SSN Normal Retirement Age	
Age at time of disability	Benefit duration	Birthdate	SSN Normal Retirement Age
Less than 60	To age 65	1937 or older	65
60	60 months	1938	65+2 months
61	48 months	1939	65+4 months
62	42 months	1940	65+6 months
63	36 months	1941	65+8 months
64	30 months	1942	65+10 months
65	24 months	1943-1954	66
66	21 months	1955	66+2 months
67	18 months	1956	66+4 months
68	15 months	1957	66+6 months
69+	12 months	1958	66+8 months
		1959	66+10 months
		1960<	67

Catastrophic Disability

An additional 10% benefit will be paid when the member is unable to perform at least two activities of daily living, which includes bathing, dressing, continence, toileting, feeding and transferring, (monthly maximum \$1,333).

For More Information

LTD Plan Description Booklet:

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

New York Life website:

mynylgbs.com

New York Life claim office:

1-800-362-4462

Flexible Spending Accounts

Plan Choices

Flexible Spending Accounts (FSAs) allow you to set money aside to reimburse yourself for health care and dependent day care expenses incurred during the plan year. You never pay federal income or Social Security taxes on this money. When you have eligible medical expenses, you can pay yourself back from your accounts with before-tax dollars.

You must re-enroll in your FSA each year during Open Enrollment if you want to continue using your FSA during the next plan year. Unused balances in your accounts do not carry over to the next year.

Health Care Spending Account:

- Maximum contribution: \$2,850/year

Dependent Day Care Spending Account:

- Maximum contribution: \$5,000/year (\$2,500 if married and filing a separate income tax return)

Enrollment Rules

You can enroll in the Health Care Flexible Spending Account, Dependent Care Spending Account, or both, within 31 days of employment, within 31 days of certain Qualifying Life Events, or during Open Enrollment.

Changing your elections

After enrolling, your elections remain in effect through August 31, the end of the plan year. During the plan year, you may change your elections only if you have certain Qualifying Life Events (QLE). You may change your elections within 31 days of the event. The change you make must be consistent with the type of Life Event you have. If you have questions about the changes you can make to your FSA, call Navia, our FSA vendor at 1 (800) 284-4885 or your Human Resources office. If you increase your contributions to the plan because of a Qualifying Life Event, the increased benefit is available only for services incurred after the first of the month following the receipt of your change. If you cancel participation in a Health Care Flexible Spending Account, only eligible charges with a date of service before the cancellation are reimbursable.

If you leave A&M System employment during the plan year (September 1 through August 31), you can continue contributing to the health care flexible spending account on an after-tax basis through COBRA. If you do so, you may continue to submit claims incurred between September 1 and August 31 as long as your payments continue. If you do not continue contributing, you may not submit any claims incurred after your employment ends. Contributions to your Dependent Day Care Account end when your employment ends; however, you may continue to submit claims incurred between September 1 and August 31 as long as you have an account balance.

Benefits

Health Care Account

The Health Care Flexible Spending Account allows you to use before-tax dollars to pay medical, dental, vision, prescription and hearing care expenses not paid by your A&M System benefit plans for you and your dependents. You do not have to be covered through an A&M System health plan to enroll. To cover a dependent child's health care expenses through this account, the child must be under age 26 and dependent upon you for support. You can use the Spending Account for the same medical expenses that are eligible for an income tax deduction, but you cannot use both the account and the deduction for the same expense.

Dependent Day Care Account

The Dependent Day Care Flexible Spending Account allows you to use before-tax dollars to pay for dependent day care expenses that are necessary to allow you and your spouse to work. If you are married, you may enroll only if your spouse works or is a full-time student or disabled. The dependent receiving the care must:

- live in your home at least eight hours a day,
- be claimed as a dependent on your tax return or be in your legal custody, and
- be 12 or younger, or an older dependent who requires care due to a physical or mental disability.

You can use the spending account for the same day care expenses that are eligible for a tax credit. However, you cannot use both the account and the tax credit for the same expense. Since the tax credit limit is \$6,000 and the spending account limit is \$5,000, you can pay some expenses through the spending account and take the tax credit on the rest. Consult your tax advisor or visit Naviabenefits.com to determine which works best for you.

Restrictions

Both types of accounts carry certain restrictions.

1. Your Flexible Spending Accounts must be used only for expenses incurred between the date of your participation and November 15 of the following year (due to the grace period). In other words, you must receive the service during that period. The date you pay the bill does not have to be within that period as long as the expense was incurred during that period.
2. Once you put money into your Flexible Spending Accounts, the money must remain in those accounts. You cannot transfer money between accounts or to a spouse's account, or take it out for any reason other than to reimburse yourself for an eligible expense that you or any eligible dependent has during the plan year
3. You should plan carefully how much money to put in your Flexible Spending Accounts. **Due to federal law, you will forfeit or lose any money in your accounts that you have not used by August 31 (or the following November 15).** Forfeitures are used to offset administrative expenses of the Flexible Spending Account plans.

Using the Spending Accounts

The amount you choose to contribute will be deducted from your paychecks before taxes and be put into your Health Care and/or Dependent Day Care Flexible Spending Account(s).

When you incur an eligible expense, you send a copy of the bill, receipt, or Explanation of Benefits from the provider showing the period of service, provider name and type of service to Navia to receive reimbursement from your account. You may also use your Navia debit card to make payments for health care or dependent day care.

Health Care Spending Account	
Covered Expenses	Non-Covered Expenses
<ul style="list-style-type: none"> • Copayments and deductibles • Orthodontia • Glasses, contact lenses and supplies (such as saline solution and enzyme cleaner) • LASIK surgery • Smoking cessation programs • Dental care • Hearing aids <p>For a list of eligible and ineligible expenses, visit naviabenefits.com/participants/resources/expenses/?benefit=health-care-fsa</p>	<ul style="list-style-type: none"> • Health insurance premiums • Nicotine patches or diet pills* • Exercise programs and equipment* • Medical or dental cosmetic surgery or drugs* <p>*Unless prescribed for treatment of an illness or injury.</p>

Dependent Day Care Spending Account	
Covered Expenses	Non-Covered Expenses
<ul style="list-style-type: none"> • Day care fees for children 12 or younger or older disabled dependents • Babysitting fees (work-related only) 	<ul style="list-style-type: none"> • Tuition and fees for private school, grades kindergarten through 12th • Overnight camps and extracurricular lessons • Supply fees • Club or organization membership fees

Debit Card

You will receive a debit card to pay for your eligible healthcare expense(s) at the point of service: the doctor's office, a pharmacy, or other health care service provider. It can also be used to purchase eligible items at some non-healthcare related merchants such as grocery stores and discount stores. When you have a copay, the money will be taken directly from your account, so you don't have to pay for the service and file for reimbursement. You may also use the debit card for dependent daycare expenses if your daycare provider provides electronic methods of paying for services or is able to scan the card.

Anyone who enrolls in a Health Care Flexible Spending Account or Dependent Daycare Flexible Spending Account:

- Will automatically receive a debit card.
- There is no annual fee for the card.
- Your card will be mailed to your home address in a plain envelope from Navia.
- The card is good for THREE years assuming you continue to be enrolled in Flexible Spending Accounts. Don't throw it away after you deplete the current year's funds.
- If you need additional cards for your dependents, contact Navia at 1 (800) 669-3539 or order on the Navia website at naviabenefits.com/.
- In most cases, you will not be required to submit a claim or receipt. However, be sure to save your itemized receipts, in the event you receive a "Request for Receipt" letter or email from Navia. If you receive a request for documentation from Navia, you must return the requested documentation within 21 days of the date of the letter to ensure your Navia debit card remains active.

PIN

Debit cards may be used as either "credit" or "debit". Some merchants may require you to select the "debit" option, and not allow you to use the "credit" option. If you choose "debit" you will be required to enter a PIN. Once you receive your debit card, or if you have an active debit card and have not called for your PIN, call Card Services at 1 (888) 999-0121. If your spouse and/or dependents have a Navia debit card for your spending account, they will use the same PIN you use.

Grace Period

The grace period allows the A&M System to extend the time participants have for withdrawing funds from their Health Care and Dependent Day Care Flexible Spending Accounts. Participants who have funds remaining in their accounts at the end of the plan year, August 31, can use those funds to pay eligible expenses incurred for an additional 75 days, through November 15.

Paper Claims

If you don't use your debit card for a particular purchase, you can still submit claims using the online Express claim, uploading, faxing, or mailing your claim to Navia.

Filing Deadline

Claims against your previous plan year account must be filed by December 31 of the next plan year.

For More Information

FSA Plan Description Booklet:

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

Navia website:

naviabenefits.com

Customer Service:

(800) 669-3539

Retirement Programs

Mandatory Plan Choices

If you are a benefits-eligible employee, you are required to participate in one of the two mandatory retirement plan options. You are automatically enrolled in the Teacher Retirement System of Texas (TRS) on your first day of work unless your position requires you to be a graduate student. If you are employed in an ORP-eligible position, you may make a one-time, irrevocable election within 90 days of eligibility to enroll in the Optional Retirement Program (ORP) instead of TRS. If you are eligible for ORP, you will receive additional information. You will be given only one 90-day period to elect ORP during your career in Texas public higher education.

If you participated in ORP through previous employment with a Texas state institution of higher education, you must continue participating in ORP, unless you had intervening TRS service at a Texas public school system. Under both plans, you and the A&M System contribute toward your retirement based on your eligible salary up to the federal limit. The employer/employee contribution amounts are set by state legislation and are subject to change.

Contribution Rules

Contributions to TRS and ORP are made on a before-tax basis. With before-tax contributions, you pay no federal income taxes on your contributions, but you do pay taxes on your retirement benefits when you receive them.

Teacher Retirement System of Texas (TRS)

You contribute 8% of your pay to TRS on a before-tax basis and the A&M System contributes a legislated amount.

Your retirement benefit is determined by a formula that considers your average salary and years of TRS service. Your normal retirement benefit will be 2.3% times your years of creditable service times your average salary. Average salary is figured using your highest-paid five years under TRS (if you were a TRS participant before September 1, 2005, your average salary may be calculated differently). You receive your benefit as a retirement annuity (monthly payments).

You can receive an unreduced standard annuity when the sum of your age and years of TRS service equals at least 80 or at age 65 with at least 5 years of TRS service. If you begin TRS participation on or after September 1, 2007, you can receive an unreduced standard annuity at age 60 when the sum of your age and years of TRS service equals at least 80 or at age 65 with at least 5 years of TRS service. If you begin TRS participation on or after September 1, 2014 or have less than five years of TRS service, you can receive an unreduced standard annuity at age 62 when the sum of your age and years of TRS service equals at least 80 or at age 65 with at least 5 years of TRS service. Reduced benefits are available for early age retirement if you are eligible. Contact TRS at 1 (800) 223-8778 for more information.

You are also eligible from your first day of TRS participation for disability and survivor benefits.

If you leave employment before retirement, you may withdraw your TRS contributions, plus interest. However, you will lose your years of TRS service credit and you will not be eligible for A&M System retiree insurance benefits (see “Retiree insurance benefits”). You must pay income tax, and possibly a penalty, on any withdrawals unless you roll them over to another retirement account. If you become vested in the plan (meaning you have at least five years of participation), you may choose instead to leave your contributions in the plan and receive a retirement annuity later.

Optional Retirement Program (ORP)

You contribute 6.65% of your pay to ORP on a before-tax basis. The A&M System currently contributes an amount equaling 6.6% of your pay. These contributions go into an individual account. If you enroll in ORP (the employer contribution may differ if enrolled in Texas ORP prior to 9/1/1995), you will forfeit all TRS benefits previously earned (except your contributions, which will be refunded to you or rolled into an individual retirement account).

You choose how to invest your money through one of the vendors who offer investment options. Your investment options include annuities and mutual funds. A list of vendors is available from your Human Resources or Payroll office and online at tamus.edu/business/benefits-administration/retirement-programs/orp/tda-approved-vendors/. You have the freedom to change your investment choices. You are responsible for the gains or losses in your account; the A&M System has no fiduciary responsibility.

Your retirement benefit is based on contributions from you and the A&M System and the investment earnings or losses on these contributions. Ownership of the employer contributions (vesting) is yours after participation in ORP for one year and one day. If your participation ends and you have less than a year of service, you will receive only your contributions, adjusted for investment gains or losses.

You are eligible to receive your account balance upon termination of employment in all Texas institutions of higher education, reaching age 70½, retirement or death. If you leave A&M System employment and withdraw your funds before age 55, your withdrawal may be subject to income tax, plus penalties, and you may not be eligible for A&M System retiree insurance benefits (see “Retiree insurance benefits” below). Your choice of benefit payment options after you retire depends on the payment options offered by the vendor(s) you chose. Consult your tax advisor before withdrawing any funds.

No loans or hardship withdrawals are permitted under ORP.

Retiree Insurance Eligibility

Under current state law, you are eligible for A&M System insurance coverage as a retiree when:

- You are at least age 65 and have at least 10 years of TRS, ERS, or ORP service credit, or your age plus years of service credit equal at least 80 and you have 10 years of TRS, ERS, or ORP service credit,
- You have 10 years of service with the A&M System, and
- The A&M System is your last state employer.

In some cases, you may combine years of service with other Texas state employers to meet the 10 years of service credit rule.

For information on “grandfathered” retirement rules for employees working for the A&M System prior to September 1, 2003, contact your Human Resources office.

If you are in TRS, you must be receiving TRS annuity payments to be eligible for health and other benefits. If you are in ORP, you must have an intact Texas ORP account.

Voluntary Plan Choices

Tax-Deferred Accounts and Deferred Compensation Plans

All System employees are eligible to participate in the Tax-Deferred Account (TDA) program and the Texa\$aver Deferred Compensation Plan (DCP) from their first day of employment. You may enroll in the TDA Program and/or the DCP at any time during your employment with the A&M System. These plans are in addition to your TRS or ORP participation.

These programs are referred to as tax-deferred retirement savings plans because you contribute part of your monthly or biweekly salary before you pay federal income tax. By contributing before tax, you reduce your current income tax. Your contributions and their investment earnings are tax-deferred until you withdraw them at retirement. You pay income taxes when you withdraw your tax-deferred dollars (including their investment gains). You can also enroll in a Roth TDA or Roth DCP, which allows you to contribute after taxes and pay no taxes on your earnings when you begin receiving your retirement funds. Enrollment in these programs enables you to take advantage of the tax laws to increase your retirement savings.

When you enroll in the TDA program, you select an investment vendor. A list of TDA vendors is available and online at tamus.edu/business/benefits-administration/retirement-programs/orptda-approved-vendors.

The DCP vendor is Empower Retirement. More information on the Texa\$aver DCP can be found at texasaver.com/.

You may want to talk to several vendors and carefully review their investment options, charges and past investment performance before making a choice. You should also consider the type of investment and the level of risk you are willing to assume.

You may contribute as little as \$20 per month to a DCP. There is not a minimum for the TDA plan. The maximum contribution is determined by the IRS. These limits are available at the System Benefits Administration website, assets.system.tamus.edu/files/benefits/pdf/retirement/DeferralLimitsChart.pdf.

The amount and frequency of benefit payments you receive during retirement will depend on your age at the time payment begins, how much you have in your account and the type of payment plan you choose. Payment options are determined by the product you choose. For example, some allow you to take all of your money out in a single payment when you retire, while others require you to receive payment over time, such as in monthly payments.

Enrollment Rules

Tax Deferred Accounts

To enroll, you must complete a Change Benefits (TDA Plan Change) Event in Workday. You should also contact your TDA vendor of choice and fill out a vendor application. Your investment vendor may be able to help you complete this process.

Texa\$aver DCP

To enroll, go to texasaver.com/ and select the 457 plan. The website contains instructions on enrolling and details the investment options available to plan participants. You may also contact a representative directly at 1 (800) 634-5091.

Health and Wellness Programs

As an A&M System employee, or retiree, you are also eligible for the programs listed below.

MyEvide

MyEvide is an online health and wellness online portal which provides a one-stop-shop of all of your health benefit information. In order to receive your \$30 Wellness Incentive for the next plan year, you must complete two tasks from your MyEvide Personalized Checklist.

MyEvide offers a variety of benefit resources:

- Take your Health Assessment to receive personalized resources tailored to you
- Track your A&M System Wellness Incentive Status
- Receive reminders and call-outs about doctor's appointments, prescription reminders, and a variety of health tasks
- Connect seamlessly with your benefit vendors through single-sign-on capability
- Access documentation and benefit resources for all of your insurance plans
- Upload and access your virtual ID Cards for Medical and Pharmacy benefit plans

To register, go online to tamus.myevide.com and enter your UIN and information from your BCBSTX insurance card. You can also download the MyEvide app and use the token code: **myevivetamus** to let MyEvide know you are a TAMUS employee. Retirees and Graduate Student Employees enrolled in the Grad Plan are not eligible for the wellness premium credit because they are already receiving the lower premium. If you are new employee, MyEvide is available 3-4 weeks after your coverage start date. Newly enrolled employees and spouses have a grace period of the current plan year plus one additional year to complete their two steps.

2nd.MD

Get a second opinion from a nationally known, board-certified specialist through 2nd.MD when facing a new diagnosis or possible surgery, or if you suffer from a chronic condition that has been diagnosed with minimal success in treatment. To register visit, 2nd.md/activate or call 1 (866) 841-2575.

Work/Life Solutions by GuidanceResources

Work/life solutions include in-person and telephonic counseling services, training, and resources to help employees deal with stressful issues like parenting, handling conflicts at work, coping with the death of a loved one, and more. These services are completely confidential, available to both employees and retirees, and can be easily accessed by visiting guidanceresources.com.

Hinge Health

Hinge Health takes non-surgical care guidelines and turns them into a digital 12-week program for chronic back and joint pain led by coaches using mobile and wearable technology. After an intensive 12-week treatment plan, members have continued access to the program for the rest of the year at no additional charge to their employer. This program is available to those enrolled in the A&M Care, J Plan, or 65 Plus Plan only. Program eligibility is determined by an application process and previous health history check.

The program includes:

- Personalized, science-based education curriculum
- Exercise regime that improves strength and mobility with real-time feedback and tracking
- Behavioral support and one-to-one coaching with team feedback to achieve goals
- Care pathways include knee, hip and low back, with neck and shoulder

For more information, visit hingehealth.com/tamus.

Omada for Pre-Diabetes and Pre-Hypertension

Omada's digital condition management programs strive to enable those with obesity-related chronic conditions like diabetes, heart disease and hypertension to change the habits that put them at risk.

The program empowers members to achieve their health goals through sustainable lifestyle changes using connected devices, education and social community. This program is available to those enrolled in the A&M Care, J Plan, or 65 Plus Plan. Program eligibility is determined by an application process and previous health history check.

Features include:

- 16 weeks of an interactive course with ongoing support for diabetes prevention and ongoing courses for hypertension
- Dedicated online health coach for diabetes prevention and a certified diabetes educator with specific training for hypertension
- A wireless weight scale that uploads to the member's portal for diabetes prevention and those with hypertension also receive a connected blood pressure monitor
- Employer reporting for enrollment, participation, clinical outcomes and risk reduction

For more information, visit go.omadahealth.com/tamus.

Livongo for Diabetes and Hypertension

Livongo for diabetes and hypertension provides end-to-end management programs that combine cellular-connected digital health devices (diabetes glucose meter and cellular monitor for reporting blood pressure) with personal support by individualized coaches and educators. This program is available to those enrolled in the A&M Care, J Plan, or 65 Plus Plan only. Program eligibility is determined by a diagnosis of either condition and, in most cases, you will be contacted if you are eligible. Features of their solutions include:

- Real-time monitoring of numbers with personalized messaging and coaching when needed
- Instant interventions when readings are out of range
- Tools and resources to manage the two chronic conditions
- Business reports on enrollment, activation and clinical outcomes

For more information or to register, visit get.livongo.com/TAMUS/register

Ovia for Women's Health and Family Planning

Ovia health is a maternity and family benefits solution to help navigate fertility, pregnancy, and parenting. As an employee or retiree enrolled in the A&M Care Plan, J Plan, or 65 Plus Plan you have access to all three Ovia products to support you through your parenthood journey. The Ovia programs are app-based and include real-time, personalized guidance with educational articles and videos, health tips, in-app coaching and more.

Silver Sneakers

The Texas A&M University System offers a fitness program for retirees age 65 and older. The Healthways SilverSneakers® Fitness program is the nation's leading fitness program designed exclusively for older adults. This program provides A&M System retirees a free, basic fitness membership with access to 15,000 classes in 13,000 locations nationwide. Available to retirees (including working retirees and survivors) age 65 and older and their spouses age 65 and older who are enrolled in A&M Care or 65 Plus plans.

For more information, visit tools.silversneakers.com/Eligibility/StartHere.

ID Protection

As a Blue Cross and Blue Shield of Texas (BCBSTX) member, you have identity protection for you and your family. The IdentityWorks service is offered at no cost through Experian®, an independent company. You must be enrolled in the A&M Care, A&M 65Plus, or A&M Care J Plans and you have to proactively sign up with Experian to take advantage of the identity protection services. ID protection services include: credit monitoring, up to \$1 million in identity theft insurance, and identity repair.

For more information, visit tx.ag/IDProtection or to enroll log in to bcbstx.com/tamus.

Blue Points

Well onTarget understands how hard it can be to maintain a healthy lifestyle. With the Blue Points program, you will be able to earn points for regularly participating in many different healthy activities. You can redeem these points in the online shopping mall, which provides a wide variety of merchandise for you to choose from. You must be enrolled in the A&M Care, 65 Plus or J Plan to be eligible. Log on to bcbstx.com/tamus, select “Wellness”, and visit Well onTarget to find all the interactive tools and resources you need to start earning Blue Points.

Inside Rx Pets

The program applies to all A&M Care health plan members (including 65 plus) with Express Scripts prescription drug coverage. A prescription savings program to provide pet parents discounts on brand and generic human medications prescribed for pets at 40,000 participating retail pharmacies.

Inside Rx Pets provides you with:

- 77% average savings on the cost of generic medications
- Dedicated 15% average savings on the cost of brand medications
- A Easy access to savings at one of 40,000 participating retail pharmacies.

For more information, visit insiderxpets.com.

Fitness Program

The Fitness Program offers flexible options and access to a nationwide network of fitness locations to get in shape and stay active. Features of the Fitness Program include online enrollment & tracking, automatic monthly payment, choice of gym networks and studio classes to fit your budget and lifestyle, mobile app with check-in & activity history, and access to thousands of digital fitness videos and live classes. This program also includes pay-as-you-go classes. Save even more by bundling family members under one account. Available to all employees, retirees and their covered dependents enrolled in the A&M Care and J plans. To enroll, log in to Blue Access for Members at bcbstx.com/tamus and search for the Fitness Program under Wellness.

Learn to Live

Learn to Live is an online resource that can help with anxiety, stress, depression, substance abuse, sleep problems or other mental health concerns. Programs are based on therapy techniques with a track record of helping people feel better. In addition, you can receive one-on-one support from an expert coach that can guide you to reach your goals. Learn to Live is confidential, accessible anywhere and available at no added cost to you and your family. Choose the program that's right for you by taking a quick assessment today. Learn more about Learn to Live's programs by viewing this brief [Learn to Live video](#). To enroll, log in to Blue Access for Members at bcbstx.com/tamus, click Wellness, then choose Digital Mental Health. Available to you and your dependents enrolled in an A&M Care Plan.

Health premiums for the A&M Care plan below **include** a \$30 wellness premium for you and for your spouse in the appropriate column. If you have completed your two-step wellness activities or are waived because you are newly enrolled, you will see credit in Workday that will reduce your premium. Premiums increase by \$30/month if you or your spouse is a tobacco user:

Health

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	Monthly \$845.28	\$30.00	\$1,437.36 \$341.04	\$30.00	\$1,235.80 \$225.26	\$225.26	\$1,666.28 \$455.50	\$455.50
	Bi-Weekly \$845.28	\$15.00	\$1,437.36 \$170.52	\$15.00	\$1,235.80 \$112.63	\$112.63	\$1,666.28 \$227.75	\$227.75
J Plan	Monthly \$815.28	\$0.00	\$1,377.36 \$281.04	\$0.00	\$1,205.80 \$195.26	\$195.26	\$1,606.28 \$395.50	\$395.50
	Bi Weekly \$815.28	\$0.00	\$1,377.36 \$140.52	\$0.00	\$1,205.80 \$97.63	\$97.63	\$1,606.28 \$197.75	\$197.75

Part-Time Employees (work a 20-29 hour week)								
	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	Monthly \$845.28	\$440.00	\$1,437.36 \$891.56	\$891.56	\$1,235.80 \$732.88	\$732.88	\$1,666.28 \$1063.24	\$1063.24
	Bi-Weekly \$845.28	\$220.00	\$1,437.36 \$445.78	\$445.78	\$1,235.80 \$366.44	\$366.44	\$1,666.28 \$531.62	\$531.62
J Plan	Monthly \$815.28	\$410.00	\$1,377.36 \$831.56	\$831.56	\$1,205.80 \$702.88	\$702.88	\$1,606.28 \$1003.24	\$1003.24
	Bi-Weekly \$815.28	\$205.00	\$1,377.36 \$415.78	\$415.78	\$1,205.80 \$351.44	\$351.44	\$1,606.28 \$501.62	\$501.62
Graduate Plan	Monthly \$252.00	\$0.00	\$504.00 \$0.00	\$0.00	\$669.00 \$166.08	\$166.08	\$921.00 \$317.96	\$317.96
	Bi Weekly \$252.00	\$0.00	\$504.00 \$0.00	\$0.00	\$669.00 \$83.04	\$83.04	\$921.00 \$158.98	\$158.98

Dental

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Dental PPO	Monthly \$30.00	\$0.00	\$60.00 \$0.00	\$0.00	\$63.00 \$31.50	\$31.50	\$96.00 \$48.00	\$48.00
	Bi-Weekly \$15.00	\$0.00	\$30.00 \$0.00	\$0.00	\$31.50 \$15.75	\$15.75	\$48.00 \$24.00	\$24.00
DeltaCare USA	Monthly \$21.08	\$0.00	\$37.48 \$18.74	\$0.00	\$37.76 \$18.88	\$18.88	\$58.66 \$29.33	\$29.33
	Bi-Weekly \$10.54	\$0.00	\$18.74 \$0.00	\$0.00	\$18.88 \$9.44	\$9.44	\$29.33 \$14.66	\$14.66

Vision

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
Monthly	\$7.60	\$0.00	\$16.12 \$8.06	\$0.00	\$12.46 \$6.23	\$6.23	\$22.22 \$11.11	\$11.11
Bi-Weekly	\$3.80	\$0.00	\$8.06 \$0.00	\$0.00	\$6.23 \$3.11	\$3.11	\$11.11 \$5.55	\$5.55

AD&D

Rate per \$10,000:		Employee Only	Employee and Family
Monthly		\$.10	\$.24
Bi-Weekly		\$.05	\$.12

Non-Tobacco Rate

Tobacco Rate

Long-Term

Disability

Rate per \$100 of monthly salary:

Monthly	\$.178	\$.230
Bi-Weekly	\$.089	\$.115

Flexible Spending Account

Maximum you can deduct from your pay:

Health Care Spending Account - \$2,850
Dependent Daycare Spending Account - \$5,000

Basic Life

The premium for this plan is usually paid by the employer contribution.

Basic Life: \$4.70

Alternate Basic Life: \$.626 per \$1,000 of coverage

Optional Life

Your age on September 1 will be the age used to calculate your premiums for the rest of the fiscal year. If you are a bi-weekly employee, the life rates are divided in half per month. *Monthly rate per \$1,000:*

	Age =	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Non-Tobacco Rate	Monthly	\$.05	\$.05	\$.05	\$.06	\$.07	\$.12	\$.20	\$.36	\$.56	\$.76	\$.43	\$2.00
Tobacco Rate	Monthly	\$.10	\$.10	\$.10	\$.12	\$.14	\$.24	\$.40	\$.72	\$.12	\$.52	\$.86	\$4.00

Dependent Life

Plan A: Spouse Age-based rate per \$1,000 of coverage; Child: \$.06 per \$1,000 of coverage

Spouse Plan B: \$1.05/month (flat rate) for \$5,000 in DL and AD&D

Child Plan B: \$0.32/month (flat rate) for \$5,000 in DL and AD&D

Plan C: ½ Alternate Basic Life premium; 1/10 if no spouse is covered

	Age =	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Non-Tobacco Rate	Monthly	\$.05	\$.06	\$.08	\$.09	\$.10	\$.15	\$.23	\$.43	\$.66	\$.27	\$.06	\$2.06
Tobacco Rate	Monthly	\$.060	\$.072	\$.096	\$.108	\$.120	\$.180	\$.276	\$.516	\$.792	\$.524	\$.472	\$2.472

Premiums – 9 Month Full-Time Employee

September 1, 2022

For 9-month, full-time monthly paid positions, premiums are prorated so that you pay for 12 months of premiums over 9 months. This means that you pay for 12 months of premiums by May 31. **You do not have to pay premiums during the summer** and you will have coverage, unless you are terminating employment. In this case, you will receive a refund for the summer months. Tobacco user and wellness charges, if applicable, are \$40/month, since they are prorated. If you have a wellness credit, that is prorated as well. Health rates include a prorated \$30 wellness premium for both you and your spouse. Only the A&M Care Plan is eligible for the wellness premium. If you have completed your wellness activities, you will see a prorated \$30 credit in Workday that will reduce this premium. Premiums increase by \$40 if you or your spouse is a tobacco user:

Health	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	\$1127.04	\$40.00	\$1,916.48	\$454.72	\$1,647.73	\$300.35	\$2,221.70	\$607.33
J Plan	\$1087.04	\$0.00	\$1,836.48	\$374.72	\$1,607.73	\$260.35	\$2,141.70	\$527.33

Dental

	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
A&M Dental PPO	\$40.00	\$80.00	\$84.00	\$128.00
DeltaCare USA Dental HMO	\$28.11	\$49.97	\$50.35	\$78.21

Vision

	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
9-Months	\$10.13	\$21.49	\$16.61	\$29.63

AD&D

Rate per \$10,000:

Monthly*	Employee Only	Employee and Family
	\$.10	\$.24

Long-Term Disability

Rate per \$100 of monthly salary:

Monthly*	Non-Tobacco Rate	Tobacco Rate
	\$.178	\$.230

Flexible Spending Account

Maximum you can deduct from your pay:

Health Care Spending Account - \$2,850
 Dependent Daycare Spending Account - \$5,000

Optional Life Your age on September 1 will be the age used to calculate your premiums for the rest of the fiscal year. *Monthly rate per \$1,000:*

Age	25-29	30-34	35-39	40-44	45-49	25-29	50-54	55-59	60-64	65-69	70-74	75+
Non-Tobacco Rate	Monthly* \$.05	Monthly* \$.05	Monthly* \$.05	Monthly* \$.06	Monthly* \$.07	Monthly* \$.12	Monthly* \$.20	Monthly* \$.36	Monthly* \$.56	Monthly* \$.76	Monthly* \$ 1.43	Monthly* \$ 2.00
Tobacco Rate	Monthly* \$.10	Monthly* \$.10	Monthly* \$.10	Monthly* \$.12	Monthly* \$.14	Monthly* \$.24	Monthly* \$.40	Monthly* \$.72	Monthly* \$ 1.12	Monthly* \$ 1.52	Monthly* \$ 2.86	Monthly* \$ 4.00

Dependent Life

Plan A: Spouse Age-based rate per \$1,000 of coverage; Child: \$.06 per \$1,000 of coverage

Spouse Plan B: \$1.05/month (flat rate) for \$5,000 in DL and AD&D

Child Plan B: \$0.32/month (flat rate) for \$5,000 in DL and AD&D

Plan C: ½ Alternate Basic Life premium; 1/10 if no spouse is covered

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Non-Tobacco Rate	Monthly* \$.05	Monthly* \$.06	Monthly* \$.08	Monthly* \$.09	Monthly* \$.10	Monthly* \$.15	Monthly* \$.23	Monthly* \$.43	Monthly* \$.66	Monthly* \$ 1.27	Monthly* \$ 2.06	Monthly* \$ 2.06
Tobacco Rate	Monthly* \$.060	Monthly* \$.072	Monthly* \$.096	Monthly* \$.108	Monthly* \$.120	Monthly* \$.180	Monthly* \$.276	Monthly* \$.516	Monthly* \$.792	Monthly* \$ 1.524	Monthly* \$ 2.472	Monthly* \$ 2.472

**Employees deducted over 9 months: After calculating your monthly rate, multiply the rate by 12 to get your annual total, and divide it by 9 months.*

Monthly Premiums – Retirees

September 1, 2022

Health

	Retiree Only		Retiree & Spouse		Retiree & Child(ren)		Retiree & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	\$815.28	\$ 0.00	\$1,377.36	\$281.04	\$1,205.80	\$195.26	\$1,606.28	\$395.50
A&M Care 65 PLUS	\$729.67	\$ 0.00	\$1,231.22	\$134.90	\$1,078.08	\$67.54	\$1,435.59	\$224.81

The health care premium increases by \$30/month if you or your spouse is a tobacco user.

Dental

	Retiree Only	Retiree & Spouse	Retiree & Child(ren)	Retiree & Family
A&M Dental PPO	\$30.00	\$60.00	\$63.00	\$96.00
DeltaCare USA Dental	\$21.08	\$37.48	\$37.76	\$58.66

Vision

	Retiree Only	Retiree & Spouse	Retiree & Child(ren)	Retiree & Family
	\$7.60	\$16.12	\$12.46	\$22.22

Basic Life

The premium for this plan is usually paid by the employer contribution.

Basic Life \$4.70

Alternate Basic Life \$.626 per \$1,000 of coverage.

Optional Life

Your age on September 1 will be the age used to calculate your premiums for the rest of the fiscal year.

Monthly Rate per \$1,000:	Age	Non-tobacco rate	Tobacco rate	Age	Non-tobacco rate	Tobacco rate
		Under 25	\$.05	\$.10	50-54	\$.20
	25-29	.05	.10	55-59	.36	.72
	30-34	.05	.10	60-64	.56	1.12
	35-39	.06	.12	65-69	.76	1.52
	40-44	.07	.14	70-74	1.43	2.86
	45-49	.12	.24	75+	2.00	4.00

Dependent Life

Plan A: Child \$.06 per \$1,000 of coverage

Plan B: Spouse: \$1.05 (flat rate) for \$5,000 in DL & AD&D Child: \$0.32 (flat rate) for \$5,000 in DL & AD&D

Plan C: ½ Alternate Basic Life premium; 1/10 if no spouse is covered

Age	Non-tobacco rate	Tobacco Rate	Age	Non-tobacco rate	Tobacco Rate
Under 25	\$.05	\$.060	50-54	\$.23	\$.276
25-29	.06	.072	55-59	.43	.516
30-34	.08	.096	60-64	.66	.792
35-39	.09	.108	65-69	1.27	1.524
40-44	.10	.120	70-74	2.06	2.472
45-49	.15	.180	75+	2.06	2.472

AD&D

Monthly rate per \$10,000

Retiree Only

\$.28

Retiree & Family

\$.46

Survivor Rates

Survivors are eligible for only health, dental, and vision coverage.

	Participant Only	Participant & Spouse	Participant & Child(ren)	Participant & Family
A&M Care	\$815.28	\$1,377.36	\$1,205.80	\$1,606.28
A&M Care 65 PLUS	\$729.67	\$1,231.22	\$1,078.08	\$1,435.59
A&M Dental PPO	\$ 30.00	\$ 60.00	\$ 63.00	\$ 96.00
DeltaCare USA Dental	\$ 21.08	\$ 37.48	\$ 37.76	\$ 58.66
Vision	\$ 7.60	\$ 16.12	\$ 12.46	\$ 22.22

Premium Worksheet

1. Medical

Enter your cost. Subtract 30\$ for yourself and \$30 for your enrolled spouse if you have completed your wellness incentive. Add \$30 if you or your spouse use tobacco products.

\$ _____

2. Dental

Enter premium amount.

\$ _____

3. Vision

Enter premium amount.

\$ _____

4. Optional Life *

Take your annualized salary, multiply by your coverage amount (½, 1, 2, 3, 4, 5 or 6), and round down to the nearest thousand (maximum is \$1,000,000).

Divide by 1,000: _____ × your age-based premium of _____ =

\$ _____

5. Dependent Life

Plan A Premium: Your spouse's age-based premium of _____ × (spouse coverage amount/1000) + (child coverage amount/1000 × .06) = _____

Plan B Premium: \$1.37/month (flat rate)

Plan C Premium: ½ your Alternate Basic Life premium

\$ _____

6. Accidental Death and Dismemberment

Choose your coverage amount and divide by 10,000: _____ ×

your premium of _____ = (Max coverage is the greater of \$250,000 or 10 times your annual salary, not to exceed coverage of \$800,000.)

\$ _____

7. Long-Term Disability *

Enter your annual salary = _____. Divide by 12 to get your monthly salary.

Take the lower of that number or \$12,307 (the maximum monthly salary for benefit purposes) and divide by 100. Multiply that number by your premium to get the monthly premium.

\$ _____

8. Spending Accounts

Enter your Health Care Account monthly contribution

Enter your Dependent Day Care Account monthly contribution

Your total montly cost (add 1-8)

\$ _____

Complete this section if you do not have A&M System health coverage, but certify that you have other health coverage:

Alternate Basic Life: \$.626 per \$1,000 of coverage

\$ _____

Enter the total of your premiums shown above for Dental (line 2), Vision (line 3), AD&D(line 6) and Long-Term Disability (line 7)**

\$ _____

Subtract the state contribution: full-time: \$410.00; part-time: \$205.00

\$ _____

Your total montly cost

\$ _____

* THE PREMIUMS MAY INCREASE BASED ON YOUR SALARY.

** INCLUDE LINE 7 ONLY IF YOU CHOOSE TO USE THE EMPLOYER CONTRIBUTION TO PAY FOR THIS COVERAGE.

Effective as of September 1, 2021

THE TEXAS A&M UNIVERSITY SYSTEM BENEFITS ADMINISTRATION

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Benefits Administration's Responsibilities.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Commitment to Protecting Health Information About You

This Notice of Privacy Practices describes the privacy practices of Benefits Administration at The Texas A&M University System (Benefits Administration) with respect to The Texas A&M University System Group Health Plan (Plan), which is a "group health plan" (as defined in the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder) and funded by The Texas A&M University System (Plan Sponsor). Federal law requires Benefits Administration to protect the privacy of health information of individuals who participate in the Plan. It also requires Benefits Administration to give you this notice of Benefits Administration's legal duties and privacy practices with respect to your health information.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask Benefits Administration to limit the information it shares
- Get a list of those with whom your information has been shared
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that Benefits Administration uses and shares information as it answers coverage questions from your family and friends and provides emergency disaster relief.

Uses and Disclosures

Benefits Administration may use and share your information to:

- Pay for your health services
- Administer the Plan
- Help manage the health care treatment you receive
- Run its organization
- Help with public health and safety issues
- Provide data for research purposes under certain limited circumstances
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government inquiries
- Respond to lawsuits and legal actions

These are explained further on the following pages.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of Benefits Administration's responsibilities to help you.

Get a copy of health and claims records. You can ask to see or get a copy of your health and claims records and other health information that Benefits Administration has about you. Ask Benefits Administration how to do this. Benefits Administration may direct you to the third-party administrator to provide a copy or a summary of your health and claims records, usually within 30 days of your request. You may be charged a reasonable, cost-based fee.

Ask to correct health and claims records. You can ask to correct your health and claims records if you think they are incorrect or incomplete. Ask Benefits Administration how to do this. It may say "no" to your request, but will tell you why in writing within 60 days.

Request confidential communications. You can ask Benefits Administration to contact you in a specific way (for example, home or office phone) or to send mail to a different address. It will consider all reasonable requests, and must say "yes" if you tell Benefits Administration you would be in danger if it does not.

Ask Benefits Administration to limit what it uses or shares. You can ask Benefits Administration not to use or share certain health information for treatment, payment, or its operations. Benefits Administration is not required to agree to your request and may say "no" if it would affect your care.

Get a list of those with whom Benefits Administration has shared information. You can ask for a list (accounting) of the times Benefits Administration has shared your health information for six years prior to the date you ask, who Benefits Administration shared it with, and why. Benefits Administration will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked it to make). Benefits Administration will provide one accounting a year for free but a charge will be assessed for additional requests if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. Benefits Administration will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Benefits Administration will confirm that person has this authority and can act for you before it takes any action.

File a complaint if you feel your rights are violated. You can complain if you feel Benefits Administration has violated your rights by contacting Benefits Administration at the email below. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. Benefits Administration will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell Benefits Administration your choices about what it shares. If you have a clear preference for how your information is shared in the situations described below, tell Benefits Administration what you want it to do, and it will follow your instructions.

You have both the right and choice to tell Benefits Administration to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell Benefits Administration your preference, for example if you are unconscious, it may go ahead and share your information if it believes it is in your best interest. Benefits Administration may also share your information when needed to lessen a serious and imminent threat to health or safety.

Benefits Administration does not share your information for marketing purposes, although it may contact you about health-related benefits and services provided in connection with the Plan, treatment plans and alternatives, and for other purposes related to your treatment and its health care operations. It does not sell your information.

Uses and Disclosures

How does Benefits Administration typically use or share your health information?

Benefits Administration typically uses or shares your health information in the following ways:

Pay for your health services. Benefits Administration can use and disclose your health information as it pays for your health services. Example: It may share information about you with your dental plan to coordinate payment for your dental work.

Administer the Plan. Benefits Administration may disclose your information to the Plan Sponsor to permit employees of the Plan Sponsor to perform plan administration functions on behalf the Plan. When Benefits Administration discloses your information to the Plan Sponsor, the Plan documents restrict the Plan Sponsor's uses and disclosures of your information, and Plan Sponsor certifies that your information will not be used or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor. Benefits Administration may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests such information for purposes of obtaining premium bids for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan. Benefits Administration may also disclose to the Plan Sponsor information on whether you are participating in the Plan or enrolled in, or have dis-enrolled from, health insurance coverage offered by the Plan.

Benefits Administration may also disclose your health information to third-party administrative services providers for plan administration on behalf of the Plan. Example: The administrative services provider needs to know your information in order to pay your medical claims.

Help manage the health care treatment you receive. Benefits Administration can use your health information and share it with professionals who are treating you. Example: A doctor sends information about your diagnosis and treatment plan to arrange additional services.

Run its organization. Benefits Administration can use and disclose your information to run its organization and contact you when necessary. Example: Benefits Administration uses health information about you to develop better services for you.

How else can Benefits Administration use or share your health information?

Benefits Administration is allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. It must meet many conditions in the law before it can share your information for these purposes. For more information see: <https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>.

Help with public health and safety issues. Benefits Administration can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research. Benefits Administration can use or share your information for health research under certain limited circumstances.

Comply with the law. Benefits Administration will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that Benefits Administration is complying with federal privacy requirements.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director. Benefits Administration can share health information about you with organ procurement organizations. It can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Act in response to workers' compensation, law enforcement, and other government requests. Benefits Administration can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions. Benefits Administration can share health information about you in response to a court or administrative order, or in response to a subpoena.

Benefits Administration Responsibilities

- Benefits Administration is required by law to maintain the privacy and security of your protected health information.
- Benefits Administration will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Benefits Administration must follow the duties and privacy practices described in this notice and give you a copy.
- Benefits Administration will not use or share your information other than as described in this notice unless you permit it in writing. If you permit it, you may change your mind at any time. Let Benefits Administration know in writing if you change your mind.

For more information, visit <https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html>.

Changes to this Notice

Benefits Administration reserves the right to make changes to this notice and to make such changes effective for all information it may already have about you. If and when this notice is changed, it will post this information on its website and provide you with a copy of the revised notice upon your request.

Privacy Official

You can contact the Plan's Privacy Official at:

Judy Cato
Director of Benefits Administration
The Texas A&M University System Connally/Moore Building
301 Tarrow, 5th Floor College Station, TX 77840-7896
Phone: (979) 458-6330
employeebenefits@tamus.edu

Protection of Personal Health Information

The A&M System is committed to protecting your personal health information. The System's Notice of Privacy Practices explains the circumstances under which this type of information can be disclosed, and it explains the rights you have regarding how the information is used. This document is available in this publication and online at <https://www.tamus.edu/business/benefits-administration/booklets-brochures>, or from your Human Resources office.

A Word About Security

Single Sign On (SSO) and Workday provide personal and confidential information. By asking you to provide a UIN and a password, the site provides two levels of security. However, do not share this information with anyone, because anyone who has it can access your information. If you believe someone has learned your password, select a new one through the "Profile" screen in SSO.

Medicare Part D Notice of Creditable Coverage

This notice has information about your current prescription drug coverage with The Texas A&M University System and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering enrolling in a Medicare Part D plan or an Advantage Plan with prescription drug coverage that is not affiliated with the A&M System, you should compare your current coverage through the A&M System, including which drugs are covered at what cost, with the coverage and costs of the Medicare plans available to you. Information about where you can get help with making decisions about your prescription drug coverage is included at the end of this notice.

You should know:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Texas A&M University System has determined that the prescription drug coverage offered by the A&M Care 65 Plus Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join when you first become eligible for Medicare, and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Non-A&M System Medicare Drug Plan?

If you are enrolled in the A&M Care Plan and choose to join an outside Medicare Part D plan, you are not required to drop your medical and prescription drug coverage. Your A&M System prescription drug benefits will coordinate with your outside Part D coverage.

However, if you are enrolled in the A&M Care 65 Plus Plan you cannot also be enrolled in an outside Part D or Advantage plan.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

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

For more information about this notice or your current prescription drug coverage:

Contact your Human Resource Office listed at the back of this booklet for further information. You'll get this notice each year. You may request a copy of this notice at any time from your Human Resources office.

For more information about your options under Medicare prescription drug coverage:

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

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

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Human Resources Offices

Texas A&M University	(979) 862-1718	benefits@tamu.edu
Texas A&M Health Science Center	(979) 436-9207	hschr@tamu.edu
Prairie View A&M University	(936) 261-1730	benefitsteam@pvamu.edu
Tarleton State University	(254) 968-9128	benefits@tarleton.edu
Texas A&M University-Central Texas	(254) 519-8015	hr@tamuct.edu
Texas A&M International University	(956) 326-2365	hr@tamiu.edu
Texas A&M University-Commerce	(903) 886-5049	hr.benefits@tamuc.edu
Texas A&M University-Corpus Christi	(361) 825-2630	benefits@tamucc.edu
Texas A&M University at Galveston	(409) 740-4534	penningt@tamug.edu
Texas A&M University-Kingsville	(361) 593-3398	theresa.perez@tamuk.edu
Texas A&M University-Texarkana	(903) 223-3113	hr@tamut.edu
Texas A&M Transportation Institute	(979) 845-9668	employment@tti.tamu.edu
Texas A&M University-San Antonio	(210) 784-2058	benefits@tamusa.edu
Texas A&M Forest Service	(979) 845-9337	agrilifebenefits@ag.tamu.edu
Texas A&M AgriLife	(979) 845-2423	agrilifebenefits@ag.tamu.edu
Texas A&M Engineering	(979) 458-7699	engrbenefits@tamu.edu
Texas A&M Engineering Extension Service	(979) 458-6801	HR@teex.tamu.edu
Texas Department of Emergency Management	(979) 458-6417	employeebenefits@tamus.edu
West Texas A&M University	(806) 651-2117	hr@wtamu.edu
System Offices	(979) 458-6417	employeebenefits@tamus.edu

Carrier Phone Numbers and Websites

Blue Cross and Blue Shield of Texas: A&M Care, 65 Plus	(866) 295-1212	bcbstx.com/tamus
Delta Dental - A&M Dental PPO	(800) 336-8264	deltadentalins.com/tamus
DeltaCare USA Dental HMO	(800) 422-4234	deltadentalins.com/tamus
Superior Vision	(844) 549-2603	microsite.superiorvision.com/tamus
Express Scripts - A&M Care Drug Program	(866) 544-6970	express-scripts.com
Express Scripts: A&M Care 65 Plus Medicare Part D Program	(855) 895-4647	express-scripts.com
The Hartford	(833) 867-5300	thehartford.com/learn/tamus
New York Life Long-Term Disability	(800) 362-4462	mynylgbs.com
Academic Health Plan - GSE Plan	(877) 624-7911	tamus.myahpcare.com
Prime Therapeutics - GSE Plan Prescriptions	(800) 423-1973	primetherapeutics.com
Navia - Flexible Spending Accounts	(800) 669-3539	naviabenefits.com
GuidanceResources	(866) 301-9623	guidanceresources.com
2nd.MD	(866) 841-2575	2nd.md/activate/step1/tamus

Information on benefits and human resource programs can be found on the Benefit Administration website at tamus.edu/benefits.

Texas A&M System Benefits

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