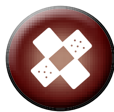
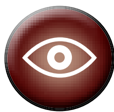
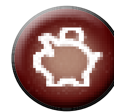
THE TEXAS A&M UNIVERSITY SYSTEM

2021-2022 Employee Benefits Guide







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, and various work-life benefits such as 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 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 programs.
- Links to sites for the insurance carriers and other benefit plan providers.
- Most forms and benefit publications, which can be downloaded and printed.
- Additional information about A&M System retirement programs.

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

Table of Contents

How Your Benefits Work

Benefits At-A-Glance 3
Understanding Benefits Lingo 4
Benefit Eligibility and Coverage Information 6
Proof of Eligibility 6
Dependent Documentation 7
Benefits Enrollment 9
Costs and Premiums 12
Qualifying Life Events 13
Qualifying for COBRA 14

Medical Plans Overview 15

A&M Care Plan 18
A&M Care 65 Plus Plan 19
J Plan 21
Graduate Student Employee Health Plan 26

Optional Plans

Retiree Medical Coverage 28
Dental 30
Vision 33
Life 34
AD&D 38
Long-Term Disability 40
Flexible Spending Accounts 42
Retirement Programs 45

Other Programs 48
Monthly Premiums 50
Premium Worksheet 54
Privacy Notices 56

Benefits At A Glance

Right for your family, right for you.

Benefit Type	Options
Medical Plans	A&M Care Plan J Plan A&M Care 65 PLUS Plan Graduate Student Employee Health Plan
Dental Plans	Delta Dental PPO DeltaCare USA HMO
Vision Plans	Superior Vision
Flexible Spending Account	Health Care Spending Account Dependent Day Care Spending Account
Life	Basic Life Alternate Basic Life Optional Life Spouse Life Child Life
AD&D (Accidental Death & Dismemberment)	AD&D Plan
Long-Term Disability	Optional Long-Term Disability
Retirement Programs	Teacher Retirement System of Texas (TRS) Optional Retirement Program (ORP) Tax-Deferred Account Program (TDA) Texa$aver Deferred Compensation Plan (DCP)
Wellness and Work/Life Solutions	ComPsych GuidanceResources Wellness Program Hinge Health Omada for Pre-diabetes and Pre-hypertension Livongo for Diabetes and Hypertension Ovia Maternity and Women's Health Wondr Health
Medical Second Opinion Advice	2nd.MD
Virtual Visits - Telemedicine	BCBS with MDLIVE AHP Live Care - Grad Plan

Understanding Benefits Lingo

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 your coverages and 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 toward an expense, 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 of money you must pay toward medical, prescription drug or dental expenses for each family member each year before some medical, drug or dental benefits are reimbursable. After you have met your deductible, future expenses are covered at the coinsurance or copayment amount. Copayments do not count toward the deductible. You can submit claims for reimbursement of deductible, coinsurance and copayment amounts through a Health Care Flexible Spending Account.

FSA (Flexible Spending Account)

A FSA is set up through an employer plan. It lets you set aside pre-tax money for most out-of-pocket medical, prescription drug, dental and vision costs and for dependent daycare. FSA funds must be used by the end of the 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.

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 spend each plan year for each covered family member. The annual deductible, copayments and coinsurance are counted towards this maximum. Once you have met 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 A&M Care and Graduate Student Health 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, pharmacist and other health professionals for effectiveness and cost effectiveness. Each plan has its own Preferred Drug List. Often, brand drugs that have generics available will not be on the formulary list to encourage individuals to purchase the less expensive generic.

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 medical 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 particular benefits package depends on the type of job you have, the percentage of time you work and the length of your appointment.

Eligibility	
Eligibility	• You work at least 50% time for at least 4 1/2 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 you are 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. Only the dependents you list in Workday will be covered. However, if you elect family AD&D coverage, all eligible dependents will automatically be covered under that plan. For more information on eligible dependents, contact your Human Resources office.

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, or a child for whom you or your spouse are the legal guardian.
- 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. In order for your dependents to have coverage, their 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. For medically incapacitated dependents, medical files documenting incapacitating condition and dependency must be submitted within 31 days of initial eligibility for enrollment of an incapacitated dependent.

Dependent Documentation

In order for your dependents to have coverage, their dependent documentation must be submitted and approved **before** their effective date of coverage. Foreign documents other than marriage license or birth certificate 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 OR legally married and 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. Recommendations include Texas Car Insurance Document, assignment of a durable property power of attorney or healthcare power of attorney, a mortgage or bank statement, or property tax bill. 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. Recommendations include Texas Car Insurance Document, assignment of a durable property power of attorney or healthcare power of attorney, a mortgage or bank statement, or property tax bill. Documents must include both the employee's name and the spouse's name.

Biological Child Documents

Birth Certificate of Biological Child listing the employee as mother or father, OR Documentation on hospital letterhead indicating the birth date of the child or children (if under 6 months old) will be accepted as temporary enrollment and 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 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 disabled child 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 he/ she is currently covered) or when the child begins the enrollment process (if he/she is currently not covered):

1. For medical coverage: Blue Cross and Blue Shield's "Dependent Child's Statement of Disability," should be mailed to: Sr. Medical Underwriter, Blue Cross and Blue Shield of Texas, Small Group Medical Underwriting, P.O. Box 655730, Dallas, TX 75265-5730, Attn: Medical Underwriting.

2. For optional coverage only: the documentation should be sent to System Benefits Administration who will approve or deny coverage based on the medical information received.

Grandchild Documentation

Tax return showing claimed grandchild (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.

Retiree Coverage

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 service credit, or your age plus years of service equal at least 80 and you have 10 years of 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 rule.

For information on "grandfathered" retirement rules for employees working for the A&M System prior to 9/1/2003, contact your Human Resource office.

If you are in TRS, you must be receiving TRS annuity payments to be eligible for health and other benefits.

Enrollment

You must enroll in benefits within 45 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 take effect on your hire date if you enroll before, on, or within seven days after your hire 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 date, but during your 45-day enrollment period, your coverage will take effect on your employer contribution eligibility date (the first of the month after your 60th day of employment).

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)	45 days from date of hire/initial eligibility

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

You may cover your dependents beginning on your hire date if you enroll before, on, or within seven days after your hire 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 45-day enrollment period, you will automatically be enrolled in a basic package with employee-only coverage on your employer contribution eligibility date. This basic package includes the A&M Care medical plan for you, Basic Life coverage for you and any eligible dependent children and $5,000 in Accidental Death and Dismemberment (AD&D) coverage for you. 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, or if **evidence of insurability** is required and approved after September 1, the first of the month following the approval.

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 Accounts 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, A&M Dental or DeltaCare USA Dental HMO, Vision and Long-Term Disability, 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 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 $2,750 to a Health Care Flexible Spending Account, but the total both 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. To be covered under different medical plans, you must each enroll as employees. A spouse who is covered on medical as a dependent is not eligible for Basic Life coverage.
- 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 website.

How To Enroll Online

To eroll through Workday:

Log in to Single Sign On (SSO) at https://sso.tamus.edu using your Universal Identification Number (UIN) and your SSO password. Once you're logged on, click on Workday. Then:

- **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.
- **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.
- **New employees** should refer to the New Employee Booklet on the A&M System Benefits Administration website for more information about the initial enrollment process.

Additional information you need to enroll:

- If adding dependents to your coverage, before electing coverage, enter the dependent's names and other required information under Dependents in the Benefits Worklet.
- After entering dependents, you will begin the enrollment task.
- You must then add your dependents to the coverages you select.
- Designate your beneficiaries for Basic Life, Optional 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, click "submit" to submit your final choices for processing.

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 with no break in service from another Texas state agency or institution of higher education, 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.

Pretax Premiums

When you enroll in medical, dental, vision 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 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.

If you are a new employee and your insurance coverage begins after September 1, you do 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 9-11 month bi-weekly paid and/or part-time employees, and if your employer has a reasonable expectation to continue your employment in the fall, your summer premiums (June, July and August) will be deducted from your May paycheck. 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 Appointments

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 appointments are not available to graduate student employees.

Payroll Deductions

If you are paid monthly, premiums deducted from your paycheck are for your insurance 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. 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.

Qualifying Life Events

Changes can be made to your benefits during the Open Enrollment period each July. Otherwise, you can only change your medical, dental, vision or spending account coverages during the plan year within 60-days of a **Qualifying Life Event**. The changes you make to your coverage(s) must be consistent with the **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 60-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 Event Type	Documentation Required
Birth/Adoption	See Dependent Documentation on Page 7
Marriage	See Dependent Documentation on Page 7
Change due to Spouse Open Enrollment	Copy of spouse's enrollment plan notification of add or drop, showing effective date and corresponding coverages, and enrolled dependents
Dependent Daycare Provider Cost/ Hour Change	Receipt or notice of change from provider
Gain Other Coverage	Copy of enrollment confirmation showing effective date and enrolled coverages, and enrolled dependents
Loss of Other Coverage	Copy of loss of coverage announcement showing effective date and corresponding coverages, and enrolled dependents
Medicaid Change	Copy of Medicaid announcement
Medical Support Order	Copy of Medical support order
Spouse Becoming Medicare Eligible	Copy of spouse 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. The following are qualifying events:

- The death of a covered employee
- a covered enployee's termination of employment or reduction of the hours of employment
- divorce or legal separation from the covered employee, or
- a dependent child ceasing to be a dependent under the generally applicable requirements of the plan.

COBRA coverage is the same coverage provided to all other participants, but the premiums are 102% of the total premiums and there is no employer contribution.

Survivors

Survivor(s) of deceased employees or retirees may be eligible for coverage beyond the coverage extended 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 is subject to the 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. Heath includes medical, dental, and vision coverage. Dependents not covered at the time of the employee's/retiree's death cannot be added to coverage. Coverage for disabled surviving children may continue indefinitely, subject to coverage rules for disabled children.

Medical Plans Overview

A&M Care Plan	65 Plus Plan	J Plan	Graduate Student Employee Plan
Available to all Employees and Retirees	Retirees not working and enrolled in Medicare A & B	Employees enrolled under a J1 or J2 Visa	Graduate Student Employees

Plan Choices: A&M Care and 65 Plus Plan

The A&M Care plan is available to all benefits-eligible employees and retirees. If you are a graduate student employee, the Graduate Student Plan is also an option. If you are working for the A&M System under a J1 or J2 Visa, you must be must be enrolled in a plan that meets the requirements of your visa. These include the J Plan or the Graduate Student Plan if you are a graduate student. If you and all of your covered dependents are enrolled in Medicare Parts A & B, and you are not working, you should enroll in the 65 PLUS Plan. 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 carriers during the plan year and you cannot add or drop coverage for yourself or any dependents during the plan year unless you have a certain 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 certain Qualifying Life Event. You do not have to provide evidence of insurability to enroll in any of the plans.

Prescription Drugs

Each A&M System health 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 health 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 health plan has a Preferred or Formulary list. This list can change during the year due to pharmaceutical review. Check your health plan's preferred/formulary drug list to determine your medication cost. For the A&M Care 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.

2021-2022 Plan: A&M Care Information				
Vendor: Blue Cross and Blue Shield of Texas (BCBSTX) 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.*** **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: http://www.bcbstx.com/tamus				
	Network	**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	$5,000 + the $400 medical deductible above $10,000 + $1,200 family	$5,000 + the $400 medical deductible above $10,000 + $1,200 family	$10,000 + $800 deductible per person $20,000 + $2,400 family
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/adm + deduct, 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

2021-2022 Plan: A&M Care Information				
Preventive exam:	100% covered	100% covered	100% covered	Not covered
Lab/X-rays:	Benefit depends on setting & procedure	Benefit depends on setting and procedure	Benefit depends on setting and 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 visits/plan year	20% after deductible; 60 days/plan year	20% after deductible; 60 days/plan year	50% after deductible; 60 visits/plan year
Other Healthcare Benefits				
***Chiropractic care:**	$30/visit; 30 visits/ plan year	$15 visit	$15 visit	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: $30 initial visit only	Hospital: 10% after deductible Doctor: $15 initial visit only	Hospital: 10% after deductible Doctor: $15 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: $5/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 $1000 per ear, every 3 years	Illness/accident coverage; 20% coinsurance, hearing aid up to $1000 per ear, every 3 years	Illness/accident coverage; 20% coinsurance	Illness/accident coverage; 20% coinsurance

Prescription Drug Vendor: Express Scripts

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

Member Services Contact Information: ExpressScripts: 1 (866) 544-6970 | Website: http://www.express-scripts.com

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 A&M Care 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. Out-of-network hospital deductibles do not count toward the annual health 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 Health Coverage if your primary carrier is Medicare.

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

- You are not eligible for a $20 or $30 copayment.
- You must 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.

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 percent reduction in primary care copays, a 50 percent reduction in specialty care copays and a 50 percent reduction in co-insurance costs at all of CHI St. Joseph Health's locations throughout the Brazos Valley. This translates to employee out-of-pocket costs for physicians and facilities contracted with CHI St. Joseph and Texas A&M of a $5 copay for a primary care physician, a $15 copay for a specialist and a 10% coinsurance for other costs such as a 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 the Brazos Valley area. Use the Blue Cross and Blue Shield Provider Finder to find eligible Brazos Valley Network physicians.

Blue Distinction Centers

With the Blue Distinction Centers (BDCs) and Blue Distinction Centers+ (BDC+) designation, you have access to specialty care facilities that have met 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 https://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. Blue Distinction Centers are paid at 10% coinsurance for inpatient services.

Two-Step Wellness Incentive Program

Employees and their spouses (if covered) enrolled in the A&M Care Plan are eligible for the lowest health premium if they each complete two steps from their MyEvive Personalized Checklist found on MyEvive (tamus.myevive.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. An alternate Health Assessment is available through Well onTarget in Blue Access for Members (BAM) which will also count toward the premium credit when paired with your annual wellness exam.

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, 2018, you will have until the end of the following plan year June 30, 2019, to complete your two tasks. 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 wellness program. More information is available online at http://www.tamus.edu/business/benefits-administration/wellness/. You can check your incentive status at any time on MyEvive, 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 https://www.bcbs.com/member-services or by calling 1 (800) 810 - BLUE.

Coordination of Benefits

If you or another family member has other health 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 does provide 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 http://www.davisvision.com or http://eyemedexchange.com/blue365.

A&M Care 65 PLUS Plan

Vendor: Blue Cross and Blue Shield of Texas (BCBSTX)
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 4 months. All covered dependents must also be enrolled in Medicare Parts A&B.

Member Services: 1 (866) 295-1212 | Outside of Texas: 1 (800) 810-BLUE (2583)
https://www.bcbstx.com/tamus

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 **Formulary** **Non-Formulary**	$10 $35 $60	$30 $105 $180
Mail-Order Prescription Copays:	**1-90 Day**	
Generic **Formulary** **Non-Formulary**	$20 $70 $120	

Member Services: Express Scripts: 1 (855) 895-4647 | Website: http://www.express-scripts.com

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 are a retiree age 65 and over, you should enroll in the 65 PLUS plan. Under the 65 PLUS plan, you may use any doctor, hospital or other provider and receive benefits.

You do not need a referral to see a specialist. The plan has no prescription drug deductible per and has a $400 out-of-pocket maximum for drug copayments, per calendar year.

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.

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, and Livongo for diabetes and hypertentsion. 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 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

To file international claims, you will need to complete an international claim form and submit it to the address printed on the form. The plan covers you overseas even though Medicare does not. 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 https://www.bcbs.com/member-services or by calling 1 (800) 810 - BLUE.

Coordination of Benefits

If you or another family member has other health 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 does provide 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 http://www.davisvision.com or http://eyemedexchange.com/blue365.

2021-2022 Plan: J Plan Health Care Information

Vendor: Blue Cross and Blue Shield of Texas (BCBSTX)

The Texas A&M University Care 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 differences found 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.

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: https://www.bcbstx.com/tamus

	Network; includes Brazos Valley Network (BVN)	Non-Network
Limitations and Restrictions		
Pre-existing condition limitations:	None	
Out-of-service area restrictions:	Emergency care- must notify BCBSTX within 48 hours	Emergency care
Maximums and Deductibles		
Deductibles:	$400 Medical/$50 Rx	$800 Medical/$400 hospitalization
Out-of-pocket maximum:	$5,000 + the $400 *medical deductible above* $10,000 + $1,200 family	$10,000 + $800 deductible per person $20,000 + $2,400 family
Benefit maximum:	No annual/lifetime maximums Except those listed below	
Hospital Benefits		
In-Hospital care:	20% after deductible; BVN-10% after deductible	$400/adm. + deduct., then 50%
Emergency Room:	20% after deductible; BVN-10% after deductible	20% after deductible if emergency; otherwise 50% after deductible
Surgery:	20% after deductible; BVN-10% after deductible In-physician's office, See office visit	50% after deductible 50% after deductible
Non-Hospital Visits		
Office visits:	Primary Care Physician-$20/visit; BVN-$5/visit Specialist-$30/visit; BVN-$15/visit Certain surgeries—20% after deductible	50% after deductible
Preventive exam:	100% covered	Not covered
Lab/X-rays:	Benefit depends on setting & procedure; See plan book or call BCBSTX	50% after deductible
Skilled nursing facility (not including custodial care):	20% after deductible; 60-days/plan year	50% after deductible; 60-days/plan year
Home health care:	20% after deductible; 60-visits/plan year	50% after deductible; 60-visits/plan year

Vendor: ExpressScripts
Prescription drugs: 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

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

Plan Administration

The J plan is administered by Blue Cross and Blue Shield of Texas (BCBSTX), with Express Scripts administering the prescription drug portion. The J plan is only available to employees on a J-1 or J-2 visa and their eligible family members. If you fall into this group, your visa requires you to have a plan with a maximum deductible of $500 and a maximum coinsurance amount of 20%. The benefits are the same as those in the A&M Care plan, including the Blue Cross and Blue Shield in-network and out-of-network benefits.

Since this coverage is a requirement of your visa, if you are working for the A&M System on a J-1 or J-2 visa, the J plan will be your default plan.

How the J Plan Works

Under the J 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. Out-of-network hospital deductibles do not count toward the annual health 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 Health Coverage if your primary carrier is Medicare.

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

- You are not eligible for a $20 or $30 copayment.
- You must 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.

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 https://www.bcbs.com/member-services or by calling 1 (800) 810 - BLUE.

Coordination of Benefits

If you or another family member has other health coverage that is primary, the J 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 J plan will pay no benefits.

Vision Benefits

The J plan does provide coverage for one preventive eye exam per person, per year (copayment, if in-network, will apply). Additionally, J Plan 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 BCBSTX ID card. For provider information, visit http://www.davisvision.com or http://eyemedexchange.com/blue365.

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. The student insurance plan for graduate and international students exceeds this federal requirement.

GeoBlue, provided with the J plan, 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

Pharmacy Coverage Review

A&M Care and J Plan Pharmacy Benefit - Express Scripts			
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 http://www.express-scripts.com.			
	Generic Drug Copayment	Brand Name Preferred Drug Copayment	Brand Name Non-Preferred Drug Copayment
Retail Pharmacy – 30-day supply	$10	$35	$60
*Retail Pharmacy – 90-day supply	$30	$105	$180
Express Scripts Home Delivery - 90-Day Supply	$20	$70	$120

65 Plus (Medicare Part D) Plan Pharmacy Benefit - Express Scripts			
	Generic Drug Copayment	Brand Name Preferred Drug Copayment	Brand Name Non-Preferred Drug Copayment
Retail Pharmacy – 31-day supply	$10	$35	$60
Retail Pharmacy – 32-90-day supply	$30	$105	$180
Express Scripts Home Delivery - 90-Day Supply	$20	$70	$120

*The Smart90 Network requires purchase from Walgreens, Home-Delivery, or certain non-chain retail pharmacies.

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

- **Prior Authorization**
- **Step Therapy**
- **Drug Quantity Management**

These are in place to ensure that medications are taken safely and appropriately. If you or a covered member in your family is taking 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 based on 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 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 below. 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".

• Cancer • Growth Hormone Deficiency • HIV • Hepatitis C • Parkinson's Disease	• Crohn's Disease • Multiple Sclerosis • Pulmonary Arterial Hypertension • Hemophilia • Rheumatoid Arthritis

You can contact Express Scripts at 1 (866) 544-6970 or by visiting www.express-scripts.com.

Medical Care While Traveling

All A&M System-offered 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, call your network or primary care doctor and ask for advice or to call in a prescription to a nearby pharmacy. You can call 1 (800) 810-BLUE 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 65PLUS 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.

2021-2022 Plan: Graduate Student Health Plan (SHP) Information		
Vendor: Blue Cross and Blue Shield of Texas (BCBSTX) Any registered and enrolled A&M System graduate student employed by the System is eligible to 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. Academic HealthPlans (AHP): 1 (877) 624-7911; Website: https://tamus.myahpcare.com/		
	Network	**Non-Network**
Limitations and Restrictions		
Pre-existing condition limitations:	None	n/a
Out-of-service area restrictions:	None	n/a
Maximums and Deductibles		
Deductibles:	$500 Medical/waived student health center	$700; waived student health center
Out-of-pocket maximum:	$7,900/person (includes all copayments)	$12,700/person (includes all copayments)
Benefit maximum:	No annual/lifetime maximums	
Hospital Benefits		
In-Hospital care:	20% after deductible	40% after deductible
Emergency Room: **Emergency Room Physician:**	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	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

The Graduate Student Employee Health Plan (GSE Plan) provides benefits-eligbile graduate students with comprehensive benefits at a lower premium than other 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 http://www.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 www.tamus.myahpcare.com or the Prime Therapeutics website at www.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 HealthPlan 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	$35	$60
Mail-Order (90-day Supply)	$45	$90	$120

AHP Live Care for Graduate Student Employees

Download the iOS or Android mobile app OR visit ahplivecare.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.

Medicare Coordination of Benefits

Medicare-Eligible Retirees

You are considered Medicare-Primary if you are:

- retired;
- eligible for Medicare; 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 COB 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: $213 Medicare Deductible: $203 Remainder: $10 Medicare pays 80%: $8	$20 or $30 copayment, depending on the provider. If using a PPO provider, claim is paid with PPO benefits. If not, paid as traditional deductible and co-insurance.
Secondary Payer	$213 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 $205. Retiree pays 20%: $2 Cost for retiree (deductible + 20%): $205	$203 is applied to the Medicare deductible.

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
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)				
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
If you ARE working for the TAMU System for 50% time or more for at least 4 1/2 months (benefits-eligible position)				
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: http://www.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

• "Medicare & You 2020" handbook (available from Medicare), which contains detailed information about Medicare plans that offer prescription drug coverage.

• Medicare website https://www.medicare.gov/default.aspx

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

• State Health Insurance Assistance Program (SHIP)

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 certain 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. 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 groups of providers have agreed to specific fee schedules, and you are not liable for any costs over Delta's allowable amount. You can also use a non-network provider and receive the regular plan benefits shown in the chart based on the provider's full fees, but your out-of-pocket costs may be higher. To find a network dentist in your area, go to https://www.deltadentalins.com/tamus.

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. 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 general dentist listed on your ID card*.

The plan also has networks in Texas, Tennessee, Florida, Georgia, California, Washington, D.C., Maryland, Colorado, New York and Utah. You must use a network general dentist 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 dentist, go to https://www.deltadentalins.com/tamus. Contact Delta Dental directly for information about specialists.

A&M Dental PPO

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 online at: https://assets.system.tamus.edu/files/benefits/pdf/spddental.pdf.
- Delta Dental Online at http://www.deltadentalins.com/tamus
- Customer Service: 1 (800) 336-8264

DeltaCare USA Dental HMO

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 a complete listing of copayments, go to https://assets.system.tamus.edu/files/benefits/pdf/programs/DHMO15B.pdf	

Plan Choices

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 or non-covered benefit-eligible dependents during your initial enrollment, Annual 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: • 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. • 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 online at: https://assets.system.tamus.edu/files/benefits/pdf/spdvision.pdf
- Superior Vision online at https://superiorvision.com
- Customer service: 1 (800) 507-3800

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 health coverage through the A&M System. The plan you select for yourself can affect eligibility for the dependent life plans.

Enrollment Rules

Coverage for life insurance is effective on the date you elect for coverage for yourself and your dependents to begin, within your initial enrollment period, 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 (E of I).
  - Enroll in Optional Life coverage of ½ or one times salary within 60-days of a **Qualifying Life Event** without providing E of I.
  - Increase Optional Life coverage by one increment up to three times salary within 60-days of a **Qualifying Life Event** without providing E of I, or
  - Enroll **new** dependents within 60 days of acquiring them without providing E of I. Spouses must always provide E of I 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 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 E of I, 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 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 www.everestfuneral.com/hartford to access this service.

EstateGuidance Will Services

This service helps you protect your family's future by creating 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 www.estateguidance.com/wills 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 servce.

Life Benefit Guidance

The Hartford partners with OG Benefits to provide additional guidance on the life insurance plans.

Contact 1 (833) 867-5300, Monday-Friday 8 AM to 5 PM, or Saturday 8 AM to 12 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 lowered 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

Life	
Basic Life/Basic AD&D	You are automatically covered if you are enrolled in an A&M System health 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 System health coverage, but certify that you have other health 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 E of I within initial 45 day enrollment period or within 60 days of marriage. Enrollments outside of those time periods require E of I for all coverage amounts. The spouse coverage amount may not be greater than the employee coverage amount. Retiree: 25,000 or $50,000, if retiree is younger than 70. Maximum spouse coverage is $30,000 for retirees ages 70–79 and $15,000 if retiree is age 80 or older.
Child Coverage:	$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. Retiree: 10% of your Alternate Basic Life coverage amount on each enrolled child.
• If you had coverage prior to 09-01-09, your dependent coverage amount(s) may be greater than the above maximums. • You must provide evidence of insurability to enroll in or increase Life insurance coverage for you or your spouse.	

Evidence of Insurability

After your initial enrollment period has ended, you must provide Evidence of Insurability (E of I), to enroll in or increase Life Insurance coverage. Providing E of I involves answering questions about your health.

E of I is required to:

- Add Optional Life of more than three times your annual salary during your initial 45-day enrollment period, or for any amount after your initial 45-day enrollment period.
- Add Spousal-Dependent Life over $50,000 within your initial 45-day enrollment period.
- Add or increase Spousal-Dependent Life more than $50,000 any time after your initial 45-day enrollment period or within 60 days of your marriage.
- Increase Optional Life one increment up to 3X salary within 60 days of a commensurate Qualifying Life Event.

As a new employee or during Open Enrollment, you can complete the E of I information on The Hartford's website, which is accessible through Workday, or Optional/Dependent Life E of I 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. You will be notified 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.

For More Information

Life Summary Plan Description Booklet, online at: https://assets.system.tamus.edu/files/benefits/pdf/spdlife.pdf or from your Human Resources office.

Accidental Death & 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%, and 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 or during future Open Enrollment periods.
- Evidence of Insurability (E of I) is not required for AD&D because the policy pays only for accidents.
- Once you enroll in the AD&D plan, you can reduce or drop your coverage at any time. You can enroll in or increase coverage only during Open Enrollment. You can change from individual to family coverage or family coverage to individual coverage only during Open Enrollment or within 60 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 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 any time by logging into Workday at https://sso.tamus.edu.

For More Information

AD&D Plan Description Booklet, online at http://assets.system.tamus.edu/files/benefits/pdf/spdadd.pdf.

Long-Term Disability

Long-Term Disability (LTD) provides income if you cannot work due to a 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 (E of I) to enroll in LTD.
- If you do not elect coverage during your initial enrollment period, you may enroll during Open Enrollment without E of I. 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, online at https://assets.system.tamus.edu/files/benefits/pdf/spdltd.pdf

LTD claim office: Cigna 1-800-362-4462 or https://www.cigna.com.

Plan Choices

Flexible Spending Accounts (FSAs) allow you to set money aside to use 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: $2,750/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 45 days of employment, within 60 days of certain Qualifying Life Events, or during open enrollment.

Changing your elections

After enrolling, your elections remain in effect through August 31. You may change your elections only if you have certain Qualifying Life Events. You may change your elections within 60 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 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 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. Please consult your tax advisor or visit the Navia website, https://www.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**
• 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 **Guidance on covered and non-covered medications can be found online at www.naviabenefits.com*	• Health insurance premiums • Nicotine patches or diet pills* • Exercise programs and equipment* • Medical or dental cosmetic surgery or drugs* **Unless prescribed for treatment of an illness or injury.*

Dependent Day Care Spending Account	
Covered Expenses	**Non-Covered Expenses**
• Day care fees for children 12 or younger or older disabled dependents • Babysitting fees (work-related only)	• 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) and dependent daycare 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.

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 online https://www.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 on-line Express claim, uploading, faxing, or mailing your claim to Navia.

When you file a claim, you may receive a reimbursement check, or you may have your reimbursement directly deposited in the account in which your paycheck is deposited. If you want to have your reimbursement deposited into a different account, you can complete a Direct Deposit Authorization Form and submit it directly to Navia. The form is available on the Navia website, https://www.naviabenefits.com/.

Filing Deadline

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

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 have 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 7.8% 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, 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 https://www.tamus.edu/business/benefits-administration/retirement-programs/orptda-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 benefits

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 service credit, or your age plus years of service equal at least 80 and you have 10-years of 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 rule. You must also provide proof that you are receiving or have applied to receive your TRS annuity payments or have an intact ORP account (an IRA rollover is not an intact 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 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 from your Human Resources or Payroll office and online at https://www.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 https://www.texasaver.com (click on "457 Plan Information").

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, http://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 TDA Vendor New Account 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 https://www.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.

Other Programs

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

MyEvive

MyEvive is an online health and wellness application 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 MyEvive Personalized Checklist.

MyEvive 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 https://tamus.myevive.com and enter your UIN and information from your BCBSTX insurance card. You can also download the MyEvive app and use the token code: **myevivetamus** to let MyEvive 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, MyEvive is available 3-4 weeks after your coverage start date.

2nd M.D.

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. Call 1 (866) 841-2575 to schedule a consultation.

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 https://www.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 and A&M Care 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

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 and A&M Care 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

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 and A&M Care 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

Ovia for Women's Health and Family Planning

Ovia heatlh 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, J, 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.

Premiums

September 1, 2021

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

Plan	Frequency	*Employee Only* Total Cost	*Employee Only* **Your Cost**	*Employee & Spouse* Total Cost	*Employee & Spouse* **Your Cost**	*Employee & Child(ren)* Total Cost	*Employee & Child(ren)* **Your Cost**	*Employee & Family* Total Cost	*Employee & Family* **Your Cost**
A&M Care	Monthly	$706.82	$30.00	$1,298.90	$341.04	$1,097.34	$225.26	$1,527.82	$455.50
	Bi-Weekly	$706.82	$15.00	$1,298.90	$170.52	$1,097.34	$112.63	$1,527.82	$227.75
J Plan	Monthly	$676.82	$0.00	$1,238.90	$281.04	$1,067.34	$195.26	$1,467.82	$395.50
	Bi Weekly	$676.82	$0.00	$1,238.90	$140.52	$1,067.34	$97.63	$1,467.82	$197.75

Part-Time Employees (work a 20-29 hour week)

Plan	Frequency	*Employee Only* Total Cost	*Employee Only* **Your Cost**	*Employee & Spouse* Total Cost	*Employee & Spouse* **Your Cost**	*Employee & Child(ren)* Total Cost	*Employee & Child(ren)* **Your Cost**	*Employee & Family* Total Cost	*Employee & Family* **Your Cost**
A&M Care	Monthly	$706.82	$370.76	$1,298.90	$822.32	$1,097.34	$663.64	$1,527.82	$994.02
	Bi-Weekly	$706.82	$185.38	$1,298.90	$411.16	$1,097.34	$331.82	$1,527.82	$497.01
J Plan	Monthly	$676.82	$340.76	$1,238.90	$762.32	$1,067.34	$633.64	$1,467.82	$934.02
	Bi-Weekly	$676.82	$170.38	$1,238.90	$367.89	$1,067.34	$303.57	$1,467.82	$453.74
Graduate Plan	Monthly	$252.00	$0.00	$504.00	$27.42	$669.00	$235.30	$921.00	$387.20
	Bi Weekly	$252.00	$0.00	$504.00	$13.71	$669.00	$117.65	$921.00	$193.60

Dental

Plan	Frequency	*Employee Only*	*Employee & Spouse*	*Employee & Child(ren)*	*Employee & Family*
A&M Dental PPO	Monthly	$29.42	$58.82	$61.76	$94.12
	Bi-Weekly	$14.71	$29.41	$30.88	$47.06
DeltaCare USA Dental HMO	Monthly	$21.08	$37.48	$37.76	$58.66
	Bi-Weekly	$10.54	$18.74	$18.88	$29.33

Vision

	Employee Only	*Employee & Spouse*	*Employee & Child(ren)*	*Employee & Family*
Monthly	$7.60	$16.12	$12.46	$22.22
Bi-Weekly	$3.80	$8.06	$6.23	$11.11

AD&D

Rate per $10,000:

	Employee Only	*Employee and Family*
Monthly	$.10	$.24
Bi-Weekly	$.05	$.12

Long-Term Disability

Rate per $100 of monthly salary:

	Non-Tobacco Rate	*Tobacco Rate*
Monthly	$.178	$.230
Bi-Weekly	$.089	$.115

Flexible Spending Account

Maximum you can deduct from your pay:

Health Care Spending Account - $2,750
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	$1.43	$2.00
Tobacco Rate	Monthly	$.10	$.10	$.10	$.12	$.14	$.24	$.40	$.72	$1.12	$1.52	$2.86	$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	$1.27	$2.06	$2.06
Tobacco Rate	Monthly	$.060	$.072	$.096	$.108	$.120	$.180	$.276	$.516	$.792	$1.524	$2.472	$2.472

Premiums – 9 Month Full-Time Employee

September 1, 2021

*For 9-month, full-time, monthly paid positions, premiums are prorated so that you pay **12 months of premiums over 9 months**. This means that you pay a full year of premiums by May 31. You do not have to pay premiums during the summer and you will have coverage, unless you are ending employment. Health premiums for the A&M Care plan below **include** a $40 wellness premium for you and for your spouse, if enrolled, in the appropriate column. If you have completed your two-step wellness activities or are waived because you are newly enrolled, you will see a credit in Workday that will reduce your premium. Premiums increase by a prorated $40 tobacco premium 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	9-Months	$942.43	$40.00	$1,731.87	$454.72	$1,463.12	$300.35	$2,037.09	$607.33
J Plan	9-Months	$902.43	$0.00	$1,651.87	$374.72	$1,423.12	$260.35	$1,957.09	$527.33

Dental

		Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
A&M Dental PPO	9-Months	$39.23	$78.43	$82.35	$125.49
DeltaCare USA Dental HMO	9-Months	$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:

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

Long-Term Disability

Rate per $100 of monthly salary:

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

Flexible Spending Account

Maximum you can deduct from your pay:

Health Care Spending Account - $2,750
Dependent Daycare Spending Account

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		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	$.05	$.05	$.06	$.07	$.12	$.20	$.36	$.56	$.76	$1.43	$2.00
Tobacco Rate	Monthly*	$.10	$.10	$.10	$.12	$.14	$.24	$.40	$.72	$1.12	$1.52	$2.86	$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	$1.27	$2.06	$2.06
Tobacco Rate	Monthly*	$.060	$.072	$.096	$.108	$.120	$.180	$.276	$.516	$.792	$1.524	$2.472	$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, 2021

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	$676.82	$ 0.00	$1,238.90	$281.04	$1,067.34	$195.26	$1,467.82	$395.50
A&M Care 65 PLUS	$605.75	$ 0.00	$1,107.45	$149.59	$954.29	$82.21	$1,311.84	$239.52

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	$29.42	$58.82	$61.76	$94.12
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	$.40
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	$.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*	*Retiree & Family*
	$.28	$.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	$623.76	$1,185.82	$1,014.29	$1,414.76
A&M Care 65 PLUS	$558.26	$1,060.00	$906.86	$1,246.42
A&M Dental PPO	$ 29.42	$ 58.82	$ 61.76	$ 94.12
DeltaCare USA Dental	$ 21.08	$ 37.48	$ 37.76	$ 58.66
Vision	$ 7.60	$ 16.12	$ 12.46	$ 22.22

PREMIUM WORKSHEET

Updated June 2021

1.	Health: 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 ____________= *(Maximum 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 **monthly** salary =______________. Multiply the lower of that number or $8,000 (the maximum benefit) × your premium of_________ =	$___________*
8.	Spending Accounts: Enter your Health Care Account monthly contribution	$_____________
	Enter your Dependent Day Care Account monthly contribution	$_____________
9.	YOUR TOTAL MONTHLY COST (Add 1 through 8) =	$_____________
----	--	--------------------
	Complete this section if you do not have A&M System health coverage but certify thatyou have other health coverage:	- $_____________
	Alternate Basic Life: $.626 per $1,000 of coverage	$_____________
	10. State Contribution: Full-time: $314.23; Part-time: $157.12	
	11: 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)**	
12.	YOUR TOTAL MONTHLY OUT-OF-POCKET COST (Subtract line 11 from line 10) =	$_____________

* 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: 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: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.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 at the end of this publication, 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) 593-4998	kucmh008@tamuk.edu
Texas A&M University-Texarkana	(903) 223-3113	ayla.baldwin@tamut.edu
Texas A&M Transportation Institute	(979) 845-9668	employment@tti.tamu.edu
Texas A&M University-San Antonio	(210) 784-2059	francy.leal@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 Experiment Station	(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 A&M Care; 65 PLUS	(866) 295-1212	http://www.bcbstx.com/tamus
Delta Dental - A&M Dental PPO	(800) 336-8264	http://www.deltadentalins.com/tamus/
DeltaCare USA Dental HMO	(800) 422-4234	http://www.deltadentalins.com/tamus/
Superior Vision	(844) 549-2603	http://www.superiorvision.com
Express Scripts - A&M Care Drug Program	(866) 544-6970	http://www.express-scripts.com/
Express Scripts - A&M Care 65PLUS Medicare Part D Program	(855) 895-4647	http://www.express-scripts.com/
The Hartford		https://thehartford.com
Cigna Long-Term Disability	(800) 362-4462	http://cigna.com/
Academic Health Plan - GSE Plan	(877) 624-7911	https://tamus.myahpcare.com/
Prime Therapeutics - GSE Plan Prescriptions	(800) 423-1973	http://primetherapeutics.com
Navia - Flexible Spending Accounts	(800) 669-3539	https://www.naviabenefits.com/
GuidanceResources	(866)301-9623	https://guidanceresources.com
2nd MD	(866) 841-2575	http://2nd.md/

Information on benefits and human resource programs can be found on the Benefit Administration website, located at http://www.tamus.edu/business/benefits-administration/.