



2019-2020 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 HEALTH, 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.

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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 Dependent 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
Medical Second Opinion Advice	2nd.MD
Virtual Visits - Teledoctor	BCBS with MDLive

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

The cost of a health 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 health, 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 health, prescription drug or dental expenses for each family member each year before health, drug or dental benefits are reimbursable in most cases. After you have paid 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 Spending Account.

FSA (FLEXIBLE SPENDING ACCOUNT)

An FSA is often set up through an employer plan. It lets you set aside pre-tax money for common medical costs and dependent care. FSA funds must be used by the end of the term-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 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 is the annual deductible, and the copayments and coinsurance. Once you've met the out-of-pocket maximum on yourself or a covered dependent, the plan pays 100% of most remaining expenses for you or the 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.

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 the 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 not 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

- 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 health, 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 whom you or your spouse are the legal guardian.

Examples of dependents who are not eligible for coverage include:

- A former spouse.
- 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.

Be prepared to provide proof of eligibility such as your marriage certificate, your child(ren)'s birth certificates, appropriate adoption paperwork, federal tax forms or other documents that support the dependent relationship. 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. You can upload dependent documentation in HRConnect 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 (fiscal 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:

- Texas Declaration of Informal/Common Law Marriage from the County where the marriage was recognized or recorded OR your most recent Federal Tax Return(s) showing that you are married filing jointly or separately
- 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 health 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 the Employee Benefits Manager who will approve or deny coverage based on the medical information received.

GRANDCHILD DOCUMENTATION

Tax return showing claimed grandchild.

- The tax return may be redacted of proprietary information

FOSTER CHILD DOCUMENTATION

Official Court or Agency Placement papers.

LEGAL GUARDIANSHIP DOCUMENTATION

Court order establishing guardianship of a child.

MANAGING CONSERVATORSHIP DOCUMENTATION

Court order establishing managing conservatorship of a child.

** Foreign documents other than marriage license or birth certificate should be accompanied by an English translation.*

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.

BENEFIT ENROLLMENT

ENROLLMENT

Coverage for you and your dependents can take effect either on your hire date or on your employer contribution eligibility date (the first of the month after your 60th day of employment) if you enroll before, on, or within seven days after your hire date.

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. If you want 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 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 health 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.

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.

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 the Flexible Spending Accounts and life insurance coverage reductions due

to age.

IF YOU DO NOT WANT HEALTH COVERAGE

If you do not need A&M System health coverage and you certify that you have other health 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 health plan and use the employer contribution for dental and vision coverage for you and your spouse.

You can use the 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 the policyholder of health 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 do not want the employer contribution applied to your LTD coverage, you can waive the contribution as you complete your online enrollment.

HOW TO ENROLL ONLINE

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 Change my Current Elections. You will be asked to select a Reason for the change.

Some things you may need to add:

- Enter the names and other required information for dependents you wish to add to any coverages under Dependents in the Benefits Worklet.
- 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.

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. 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 \$2,700 to a Health Care Spending Account, but the total both spouses may contribute to Dependent Day Care Spending Accounts is \$5,000.
- You can each enroll separately in health coverage and receive separate employer contributions.
- Or, one of you can enroll in health and cover the other as a dependent on health. 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 health plans, you must each enroll as employees. A spouse who is covered on health 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 Dependent 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".

PROTECTION OF PERSONAL HEALTH INFORMATION

Certain information collected by the A&M System will be sent to the insurance carriers of the plans in which you enroll. However, the A&M System and the insurance carriers will treat this information as confidential. 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 HIPAA, 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.

COSTS AND PREMIUMS

EMPLOYER CONTRIBUTION

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

Your employer contribution amount will depend on whether you are a full-time (30 hours/week) 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 you begin receiving the employer contribution.

PRETAX PREMIUMS

When you enroll in health, 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 are a new employee and your insurance coverage will not start until November 1, you not have prorated premiums during your first year of employment; you will be deducted for your summer premiums 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.

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.

Changes can be made to your benefits during the Open Enrollment period each July. Otherwise, you can only change your health, 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 health plan (health 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
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
Loss of Other Coverage	Copy of loss of coverage announcement showing effective date and corresponding coverages
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 benefit coverage due to a COBRA qualifying event, you and/or your dependents will be able to continue coverage, if already enrolled in medical, dental, vision and/or a Health Care Spending Account. COBRA coverage is the same coverage provided to all other participants, but the premiums are 102% of the total premiums.

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 health, 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. Dependents who were covered at the time of the employee's/retiree's death can receive coverage for 36 months or until age 26 for health coverage, whichever is longer. Health includes medical, dental, and vision coverage. 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.

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

The A&M Care plan is available to all benefit-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 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 health plan**, unless a spouse or dependent child works for the A&M System and chooses separate coverage.

None of the health plans have pre-existing condition limitations. All plans have a few limits on specific benefits such as home health care. You cannot change health 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 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 Life Event. You do not have to provide evidence of insurability to enroll in any of the plans.

HEALTH CARE WHILE TRAVELING

All A&M System-offered health 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 health 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 him/her for advice or to call in a prescription to a nearby pharmacy.

MDLIVE VIRTUAL VISITS WITH BLUE CROSS AND BLUE SHIELD

Virtual Visits is a feature provided by MDLive through your Blue Cross and Blue Shield health 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 \$20 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 \$20 charge. These services are not covered by Medicare and will be paid by Blue Cross Blue Shield without being submitted to Medicare. You will be asked to pay up front before you speak with the physician.

A&M CARE PLAN

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.

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 and deductible 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 your prescription history.
- Conduct a personal assessment for possible lower cost alternatives.
- Request assistance from Express Scripts in contacting your provider to request approval for changing to lower cost alternatives/equivalents
- Compare brand to generic and retail to mail costs.

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. You can find a list of these medications on the Benefits Administration website.

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”.

<ul style="list-style-type: none">• Cancer• Growth Hormone Deficiency• HIV• Hepatitis C• Parkinson’s Disease	<ul style="list-style-type: none">• Crohn’s Disease• Multiple Sclerosis• Pulmonary Arterial Hypertension• Hemophilia• Rheumatoid Arthritis
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You can contact Express Scripts at 1 (888) 327-9791 or by visiting www.express-scripts.com.

A&M CARE PLAN

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.

HEALTH ASSESSMENT AND WELLNESS INCENTIVE

Employees and their spouses (if covered) are eligible for the lowest health premium if they each complete a Health Assessment and an annual wellness exam. The Health Assessment can be found on MyEvoke (tamus.myevive.com). A premium differential of \$30/month is added to the monthly premium for each individual (employee and spouse). If you complete your exams, a credit will show up on your pay stub for the equivalent amount. An alternate HA is available through Well onTarget in Blue Access for Members (BAM) which will also count toward the premium credit.

Newly enrolled employees and spouses have a grace period of the current plan year plus one additional year to get their exams. 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 have your exam. We recommend completing the exam before June 30 to ensure the credit is in the Blue Cross and Blue Shield and A&M systems before the new plan year begins. More information is available online at <http://www.tamus.edu/business/benefits-administration/wellness/>. You can check your incentive status on MyEvoke.

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 (800) 441-9188 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 www.bcbs.com/already-a-member/coverage-home-and-away.html 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>.

For Davis Vision:

- Click members then in the Open Enrollment box towards the bottom center of the page, enter 2295 as your client control plan number or call 1 (800) 501-1459.

For EyeMed Vision Care:

- Click Find a Provider and begin your search. Be sure the Advantage Network is selected.

A&M CARE 65 PLUS PLAN

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 will be enrolled in the 65 PLUS plan. Under the 65 PLUS 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 no 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.

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.

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 (800) 441-9188 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 www.bcbs.com/already-a-member/coverage-home-and-away.html 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>.

For Davis Vision:

- Click members then in the Open Enrollment box towards the bottom center of the page, enter 2295 as your client control plan number or call 1 (800) 501-1459.

For EyeMed Vision Care:

- Click Find a Provider and begin your search. Be sure the Advantage Network is selected.

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 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.

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.

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 (800) 441-9188 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 www.bcbs.com/already-a-member/coverage-home-and-away.html 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>.

For Davis Vision:

- Click members then in the Open Enrollment box towards the bottom center of the page, enter 2295 as your client control plan number or call 1 (800) 501-1459.

For EyeMed Vision Care:

- Click Find a Provider and begin your search. Be sure the Advantage Network is selected.

ABOUT MEDICAL EVACUATION AND REPATRIATION

The Graduate Student Employee Health Plan exceeds the federal requirement for medical evacuation coverage and Repatriation of remains.

The J plan does not provide these benefits; however, the Basic Life coverage from Securian, provided with the J plan as a package, does provide the following required coverage:

Evacuation/Repatriation: \$150,000

Repatriation of Remains: \$150,000

Visit of Family Member or Friend: \$5,000

Return of Dependent Children: \$5,000

GRADUATE STUDENT EMPLOYEE HEALTH PLAN

The Graduate Student Employee Health Plan (GSE Plan) provides benefit-eligible 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			
No annual deductible			
Student Health Center	\$10 / \$35		
Retail Pharmacy (30-Day Supply)	\$10	\$35	\$60
Mail-Order (90-day Supply)	\$45	\$90	\$120

COMPARING THE PLANS

The charts on the following pages show your share of the cost of a health procedure or service. For example, 20% means you pay 20% (coinsurance) of the cost after any applicable deductibles up to the out-of-pocket maximum, then the plan pays 80%; \$30/visit means you pay a \$30 (copayment) for each office visit.

Provisions	A&M Care & J Plans Network/Out-of-Network Benefits		A&M Care Medicare-Primary Retirees
	Network/Brazos Valley Network (BVN)	Out-of Network	
Regions offered	BCBSTX has networks in all 50 states. These benefits apply to Active Employees and Retirees under age 65.		These benefits apply to Medicare-primary retirees not enrolled in the A&M Care 65 Plus plan.
Pre-existing condition limitations	None	None	None
Out-of-service area restrictions	Emergency care - Network benefit; must notify BCBSTX within 48 hours	Non-emergency care - Out-of-network benefit unless you go to a BCBS provider in that area	None
Deductibles	\$400/person/plan year, \$1,200/family/plan year	\$800/person/plan year; \$400/hospital	\$400/person/plan year, \$1,200/family/plan year
Out-of-pocket maximum	\$5,000 plus \$400 deductible/person/plan year; \$10,000 plus \$1,200 deductible/family/plan year	\$10,000 plus \$800/person/plan year	\$5,000 + \$400 deductible/person/plan year
In-hospital care	Network: 20% after deductible BVN: 10% after deductible	\$400/admission+ \$800 deduct., then 50%	20% after deductible
Emergency room	Network: 20% after deductible BVN: 10% after deductible	20% after deductible if emergency; otherwise 50% after deductible	20% after deductible
Office visits	Network: \$20/visit for Primary Care Physician (PCP); \$30/visit for specialists; certain in-office surgeries—20% after deductible BVN: \$5/visit for Primary Care Physician (PCP); \$15/visit for Specialists; certain in-office surgeries-10% after deductible	50% after deductible	20% after deductible
Lab/X-rays	Network: Benefit depends on setting and procedure; see plan description booklet or call BCBSTX for details	50% after deductible	20% after deductible
Surgery	Network: 20% after deductible (inpatient and outpatient) BVN: 10% after deductible	50% after deductible (inpatient and outpatient) Network and out-of-network: In physician's office, see office visit	20% after deductible
Chiropractic care	Network: \$30/visit, 30 visits/plan year BVN: \$15/visit; 30 visits/plan year	50% after deductible, 30 visits/plan year	20% after deductible; 30 visits/plan year
Provisions	A&M Care & J Plans Network/Out-of-Network Benefits		A&M Care Medicare-Primary Retirees

	Network/Brazos Valley Network (BVN)	Out-of-Network	
Vision/Hearing	Vision - Network: \$30/visit, One routine preventive vision exam/per person/per plan year Hearing—Illness/accident coverage; Hearing aid 20% up to \$1000, every 3 years, deductible does not apply	Routine preventive vision exams not covered Hearing—Illness/accident coverage; Hearing aid 20% up to \$1000, every 3 years, deductible does not apply	Vision - Network: 20% after deductible Vision - Out-of-Network: Routine preventive vision exams not covered Hearing—Illness/accident coverage; Hearing aid 20% up to \$1000, every 3 years
Maternity care	Network: Hospital—20% after deductible; Doctor-\$20 initial visit BVN: Hospital-10% after deductible; Doctor-\$5 initial visit	Hospital—50% after deductible; Doctor - 50% after deductible	20% after deductible
Physical therapy	Network: \$30/office-visit setting; Deductible and Coinsurance Outpatient or hospital-related facility setting BVN: \$15/office visit; Deductible and Coinsurance Outpatient or hospital-related facility setting	50% after deductible	20% after deductible
Durable medical equipment	Network: 20% after deductible BVN: 10% after deductible	50% after deductible	20% after deductible
Home health care	Network: 20% after deductible; 60 visits/person/plan year BVN: 10% after deductible; 60 visits/person/plan year	50% after deductible; 60 visits/person/plan year	20% after deductible 60 visits/person/plan year
Skilled nursing facility (not including custodial care)	Network: 20% after deductible; 60 days/person/plan year BVN: 10% after deductible; 60 days/person/plan year	50% after deductible; 60 days/person/plan year	20% after deductible 60 days/person/plan year
Mental Health Inpatient Outpatient	Network: Inpatient—20% after deductible; Outpatient—\$20/visit BVN: 10% after deductible; Outpatient-\$15/visit	Inpatient—\$400 admission + \$800 deductible, then 50% after deductible Outpatient—50% after deductible	Inpatient - 20% after deductible Outpatient - 20% after deductible
Prescription drugs	After you meet the \$50/person/plan year prescription drug deductible (three-person maximum): 30-day supply: \$10/generic, \$35/brand-name preferred, \$60/brand-name non-preferred; brand-name copayment + difference between brand-name and generic when generic is available 90-day supply: Two copayments required if purchased by mail-order; Three if purchased through certain retail pharmacies.		
How does this health plan work?	This plan is a preferred provider organization (PPO). To receive the highest level of coverage, choose a Blue Cross and Blue Shield network provider. You can use a out-of-network provider, but your benefits are usually paid at a lower level.		
Customer Service phone number/ website	Blue Cross and Blue Shield of Texas—1 (866) 295-1212; Networks outside Texas—1 (800) 810-BLUE (2583) http://www.bcbstx.com/tamus		

Provisions	A&M Care 65 PLUS
Regions offered	Available everywhere. Policy holder must be retired, not working in an A&M System benefits-eligible position, and enrolled in Medicare Parts A & B. All covered dependents must also be enrolled in Medicare Parts A & B.
Pre-existing condition limitations	None
Out-of-service area restrictions	None
Deductibles	\$400/person/plan year
Out-of-pocket maximum	Medical: \$1,000 plus \$400 deductible/person/plan year (9-1 to 8-31) RX: \$400 (1-1 to 12-31)
In-hospital care	20% after deductible
Emergency room	20% after deductible
Office visits	20% after deductible
Lab/X-rays	20% after deductible
High Technology Radiology (MRI, CT and pet scans, stress test, Angiogram and myelography)	20% after deductible
Surgery	Inpatient, Outpatient and in physician's office - 20% after deductible
Chiropractic care	20% after deductible, 30 visits/plan year
Vision/Hearing	Vision - Network: 20% after deductible, One routine preventive vision exam/per person/per plan year Vision - Out-of-Network: Routine preventive vision exams not covered Hearing— Illness/accident coverage; Hearing aid 20% up to \$1000, every 3 years, deductible does not apply
Physical therapy	20% after deductible
Durable medical equipment	20% after deductible
Home health care	Network: 20% after deductible; 60 visits/person/plan year Out-of-network: 50% after deductible; 60 visits/person/plan year
Skilled nursing facility (not including custodial care)	Network: 20% after deductible; 60 days/person/plan year Out-of-network: 50% after deductible; 60 days/person/plan year
Mental Health - Inpatient/Outpatient	Inpatient - 20% after deductible Outpatient - 20% after deductible
Prescription drugs	30-day supply: \$10/generic, \$35/brand-name preferred, \$60/brand-name non-preferred; brand-name copayment + difference between brand-name and generic when generic is available 90-day supply: Two copayments required if purchased by mail-order; Three if purchased through certain retail pharmacies.
How does this health plan work?	This plan pays secondary to Medicare.
Customer Service phone number/ website	BCBSTX—1 (866) 295-1212; Networks outside Texas—1 (800) 810-BLUE (2583) http://www.bcbstx.com/tamus

Provisions	Graduate Student Employee Health Plan
Regions offered	Available worldwide
Pre-existing condition limitations	No waiting period
Benefit maximum	Unlimited per person/year
Out-of-service area restrictions	None
Deductibles	Network: \$500/person/year; \$1,500/family; Out-of-Network: \$700/person/year; \$2,100/family; waived at student health center
Out-of-pocket maximum	Network: \$7,900 individual/\$15,800 family; Out-of-Network: \$12,700 individual/\$25,400 family;
In-hospital care	Network: 20% after deductible, Out-of-Network: 40% after deductible
Emergency room	Facility - Network & Out-of-Network: 20% after \$150 copayment Physician - Network & Out-of-Network - 20% after deductible
Office visits	Network: \$35 copay; Out-of-Network - 40% after \$35 copay
Preventive Services	Network: No cost; Out-of-Network: 40% after deductible and coinsurance
Diagnostic Lab/X-rays	Network: 20% after deductible Out-of-Network: 40% after deductible
Surgery	Network: 20% after deductible, Out-of-Network: 40% after deductible
Chiropractic care	Network: \$35/visit; 35 visits/person/plan year Out-of-Network: 40% after \$35 copay; 35 visits/person/plan year
Vision/Hearing	Network: 20% after deductible, Out-of-Network: 40% after deductible
Physical therapy	Network: \$35/visit; 35 visits/person/plan year Out-of-Network: 40% after \$35 copay; 35 visits/person/plan year
Durable medical equipment	Network: 20% after deductible, Out-of-Network: 40% after deductible
Home health care	Network: 20% after deductible, 60 visits/person/plan year Out-of-Network: 40% after deductible, 60 visits/person/plan year
Skilled nursing facility (not including custodial care)	Network: 20% after deductible, 25 visits/person/plan year Out-of-Network: 40% after deductible, 25 visits/person/plan year
Mental Health - Inpatient/Outpatient	Network: Inpatient - 20% after deductible, Out-of-Network: 40% after deductible Network: Outpatient - \$35/visit, Out-of-Network: 40% after deductible
Prescription drugs	\$10/\$35 at student health center; Prime Therapeutics RX drug card \$10/generic, \$35/preferred brand-name, \$40/non-preferred brand-name
How does this health plan work?	This plan is for benefit-eligible graduate student employees only. Students must be taking at least six credit hours or otherwise be working toward a degree. It is a preferred provider organization (PPO). To receive the highest level of coverage, choose a Blue Cross and Blue Shield network provider. You can use a out-of-network provider, but your benefits are usually paid at a lower level.
Member Services phone number/ website	1 (877) 624-7911 or https://tamus.myahpcare.com/

RETIREE HEALTH COVERAGE

MEDICARE-ELIGIBLE RETIREES

If you are retired, not working for the A&M System at 50% effort or more for at least 4½ consecutive months in a budgeted position and eligible for Medicare, you are considered Medicare-Primary for Coordination of Benefits (COB). That means all A&M plans pay benefits as if you are enrolled in Medicare Parts A and B, regardless of whether or not you have enrolled. In addition, you will not be eligible for co-payments.

You should enroll in the 65 Plus Plan if both you and your spouse are aged 65 and over. 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 BCBS 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 \$193 doctor's office visit:

	Medicare Primary (A&M Care Secondary)	A&M Care Primary (Medicare Secondary)
Primary Payer	Cost: \$193 Medicare Deductible: \$183 Remainder: \$10 Medicare pays 80%: \$8 Retiree pays 20%: \$2 Cost for retiree (deductible + 20%): \$185 <i>Once your Medicare deductible has been met for the plan year, you will just be responsible for the 20% coinsurance.</i>	\$20 or \$30 copayment, depending on the provider
Secondary Payer	\$193 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 \$185.	\$183 is applied to the Medicare deductible.
	*Deductible begins in January	*Deductible begins in September

MEDICARE-ELIGIBLE WORKING RETIREES

If you are a working retiree in a budgeted position at 50% effort or more for at least 4 ½ consecutive months, your A&M Care plan is primary and you will be eligible for office visit copayments.

If you are a working retiree in a budgeted position at 50% effort or more for at least 4 ½ consecutive months, your A&M Care plan is primary and you will be eligible for office visit copayments. When your employment ends, you can retain your retire coverage in A&M Care or, if you do not intend to return to A&M System employment, and you and all covered members are age 65 or older, you should move to the 65 PLUS plan.

COORDINATION OF BENEFITS

The chart on the next page 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's Status	Dependent's Status	Eligible for the 65+ plan?	Plan considered Primary for Retiree	Plan considered Primary for Dependents
<i>If you are retired and not working for the TAMU System for 50% time or more for at least 4 ½ months (benefits-eligible position).</i>				
Retiree is 65 or older or otherwise eligible for Medicare	Spouse/dependents are over 65 or otherwise eligible for Medicare	Yes	Medicare	Medicare
Retiree is 65 or older or otherwise eligible for Medicare	Spouse/dependents are under 65 or otherwise not eligible for Medicare	No	Medicare	A&M Care
Retiree is under 65 or otherwise not eligible for Medicare	Spouse/dependents are over 65 or otherwise eligible for Medicare	No	A&M Care	Medicare
Retiree is under 65 or otherwise not eligible for Medicare	Spouse/dependents are under 65 or otherwise not eligible for Medicare	No	A&M Care	A&M Care
<i>If you are working for the TAMU System for 50% time or more for at least 4 ½ months (benefits-eligible position).</i>				
Retiree*	Spouse/dependents	No	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 may 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).

NOTICE OF CREDITABLE COVERAGE FOR MEDICARE PART D

All A&M System health plan prescription drug benefits have been certified to be comparable to or better than those provided by the Medicare Part D prescription drug plan. When you, your spouse or other dependents become eligible for Medicare (by turning age 65 or by approval from Social Security to receive disability benefits), it is important to investigate enrollment in Medicare Parts A and B. In most cases, if you do not enroll in Medicare when you're first eligible, you will have to pay a late enrollment penalty to Medicare for as long as you have Part B.

When you are retired, become eligible for Medicare, and are not working for the A&M System, and your spouse, if covered, is also eligible for Medicare, you should take the opportunity to enroll in the 65+ plan. The 65+ plan covers the same services as the A&M Care plan at the same benefit level.

Your prescription drug coverage will change to Express Scripts Medicare® Prescription Drug Plan through the Texas A&M University System. This is a Medicare Part D plan. It has no drug deductible and will offer the same coverage as the prescription drug benefit through the A&M Care plan. It is considered creditable coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare or from Oct. 15 to Dec. 7 of any later year. 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.

Financial assistance is available to Medicare beneficiaries with incomes up to 150% of the Federal Poverty Level and limited resources. To determine if you qualify for financial assistance with Medicare Part D, you can contact the Social Security Administration (SSA) at 1 (800) 772-1213 (TTY 800-325-0778) or visit SSA online at <http://www.socialsecurity.gov>.

Medicare Part D is offered through private, Medicare-approved prescription drug plans. All Medicare drug plans will offer a standard level of coverage set by Medicare.

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

FOR MORE INFORMATION ABOUT MEDICARE

- “Medicare & You 2019” handbook (available from Medicare), which contains detailed information about Medicare plans that offer prescription drug coverage.
- Medicare website <http://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)

DENTAL

PLAN CHOICES

If you enroll in dental, you may have a choice between the A&M Dental PPO and the DeltaCare USA Dental HMO. If you enroll yourself in a plan, you may also enroll some or all eligible family members in that plan.

ENROLLMENT RULES

- Everyone is eligible for the PPO plan. Eligibility for the HMO depends on where you live and whether there are HMO dentists in the area.
- If you do not enroll during your initial enrollment period, you can enroll yourself and dependents only during annual enrollment or if you have a certain 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 <http://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 enroll by submitting a Benefit Enrollment form to 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 <http://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: <http://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 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 http://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 **Life Event**.
- You do not have to provide evidence of insurability to enroll.
- The plan has no pre-existing condition limitations.

BENEFITS

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

	Network Benefit	Non-Network Benefit
Eye exam (one per plan year)	100% after \$10 copayment.	Up to \$50. Copayment doesn't apply
Materials	100% after \$15 copayment for: <ul style="list-style-type: none"> • Frames - every plan year, up to \$150. • Eyeglass lenses - one standard pair every plan year Standard single vision; standard lined trifocal, standard lined bifocal, standard lenticular and standard progressive.	Copayment doesn't apply. <ul style="list-style-type: none"> • Frames: Up to \$90. • Lenses: \$50 to \$100, depending on type of lenses.
Contact lenses (once every plan year in place of eyeglass benefit)	Conventional/Disposable - \$150 Allowance; Medically Necessary - Covered in Full	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: <http://assets.system.tamus.edu/files/benefits/pdf/spdvision.pdf>
- Superior Vision online at 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 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 specified 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 list are covered under Dependent Life.
- After your initial enrollment period, you may:
- Enroll in coverage at any time by providing E of I.
- Enroll in Optional Life coverage of ½ or one times salary within 60-days of a **Life Event** without providing E of I.
- Increase Optional Life coverage by one increment up to three times salary within 60-days of a **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.

BENEFITS

Life Insurance pays benefits to your beneficiaries if you die or to you if a covered family member dies, if you covered that dependent. 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 annual enrollment, or as a result of a Life Event, you may make a change to your dependent life coverage, but it must be to one of the amounts available. 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 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 to dependents covered under Dependent Life.

ADDITIONAL BENEFITS

Travel Assistance provided by RedpointWTP LLC - covers employees and dependents traveling 100 miles or more when traveling for business or pleasure. Features include a repatriation benefit, access to emergency medical assistance, emergency travel arrangements and pre-trip resources.

Legal Services provided by Ceridian Life Works - offers employees, retirees and their families a free 30 minute initial consultation with an attorney, drafting of wills and other legal documents.

Beneficiary Financial Counseling Services through PricewaterhouseCoopers - provides assistance with estate planning, budgeting, taxes, etc., for beneficiaries receiving a benefit of \$25,000 or more.

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	
<p>Basic Life/Basic AD&D</p> <p><i>Coverage for you:</i></p> <p><i>Child Coverage:</i></p>	<p>You are automatically covered if you are enrolled in an A&M System health plan.</p> <p>\$7,500 in life insurance and \$5,000 in AD&D coverage</p> <p>\$5,000 in life insurance on each eligible dependent child.</p>
<p>Alternate Basic Life/Basic AD&D</p> <p><i>Coverage for you:</i></p> <p><i>Child Coverage:</i></p>	<p>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.</p> <p>\$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</p> <p>\$5,000 in life insurance on each eligible dependent child.</p>
<p>Optional Life</p>	<p>Employee: ½ to 6x salary with a maximum coverage amount of \$1,000,000. Coverage will automatically reduce to \$100,000 at retirement if under age 70 and \$60,000 if age 70 or older.</p> <p>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.</p>
<p>Dependent Life Plan A</p> <p><i>Spouse coverage:</i></p> <p><i>Child Coverage:</i></p>	<p>You can enroll your dependents if you have Optional Life coverage. You pay for the coverage yourself.</p> <p>Coverage amounts are: \$25,000, \$50,000, \$75,000, \$100,000, \$150,000 or \$200,000. Any amount over \$50,000 requires evidence of good health. The spouse coverage amount may not be greater than the employee coverage amount.</p> <p>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.</p> <p>\$10,000 per child.</p>
<p>Dependent Life Plan B</p> <p><i>Spouse coverage:</i></p> <p><i>Child Coverage:</i></p>	<p>5,000 in life and \$5,000 in AD&D coverage; if spouse is enrolled.</p> <p>5,000 in life insurance on each eligible enrolled dependent child.</p>
<p>Dependent Life Plan C</p> <p><i>Spouse coverage:</i></p> <p><i>Child Coverage:</i></p>	<p>You can enroll your dependents if you have Alternate Basic Life coverage. You pay for the coverage yourself.</p> <p>50% of your Alternate Basic Life coverage amount, if spouse is enrolled.</p> <p>\$5,000 on each enrolled child.</p> <p>Retiree: 10% of your Alternate Basic Life coverage amount on each enrolled child.</p>
<ul style="list-style-type: none"> • 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. A medical questionnaire is available from your Human Resources office. 	

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 60-day enrollment period, or for any amount after your initial 60-day enrollment period.
- Add Spousal-Dependent Life over \$50,000 within your initial 60-day enrollment period.
- Add or increase Spousal-Dependent Life any time after your initial 60-day enrollment period or within 60 days of your marriage.

As a new employee or during Open Enrollment, you can complete the E of I information on Securian'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.

Securian 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 annual 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: <http://assets.system.tamus.edu/files/benefits/pdf/spdlife.pdf> or from your Human Resources office.

Securian customer service: 1-877-282-1752

RedPointWTP LLC: 1-855-516-5433

PLAN CHOICES

Accidental Death and Dismemberment (AD&D) 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. Family coverage will automatically cover all of your eligible family members.

All employees can choose up to \$250,000 of coverage 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.

With family coverage, 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 Annual Enrollment periods.
- Evidence of Insurability (E of I) is not required 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 Annual Enrollment. You can change from individual to family coverage or family coverage to individual coverage only during Annual 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 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 has lasted 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.

NAMING A BENEFICIARY

You are automatically the beneficiary for dismemberment benefits on yourself and all benefits payable for a covered family member. You may name a secondary beneficiary to receive benefits in case you die at the same time or as a result of the same accident as 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>.

CHANGING YOUR COVERAGE

Once you enroll in the AD&D plan, you can reduce your coverage amount or drop your coverage at any time. You can enroll in or increase coverage only during Annual Enrollment. You can change from individual to family coverage or family coverage to individual coverage only during Annual Enrollment or within 60 days of a Change in Status.

FOR MORE INFORMATION

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

LONG-TERM DISABILITY

PLAN CHOICES

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 Annual 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

Maximum \$8,000, minimum \$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.

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).

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

FOR MORE INFORMATION

LTD Plan Description Booklet, online at <http://assets.system.tamus.edu/files/benefits/pdf/spdltd.pdf>

LTD claim office: Cigna 1-800-362-4462 or 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 annual 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: \$2,700/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 Spending Account, Dependent Care Spending Account, or both, within 60 days of employment, within 60 days of certain Life Events, or during annual enrollment.

CHANGING YOUR ELECTIONS

After enrolling, your elections remain in effect through August 31. You may change your elections only if you have certain 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 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 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 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 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

The Dependent Day Care 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. 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. Visit the Navia website, <https://www.Navia.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 Account(s).

When you incur an eligible day care expense, you send a copy of the bill or receipt from the day care provider showing the period of service, provider name and type of service to PayFlex to receive reimbursement from your account.

Health Care Spending Account	
Covered Expenses	Non-Covered Expenses
<ul style="list-style-type: none"> • Copayments and deductibles • Orthodontia • Glasses, contact lenses and supplies (such as saline solution and enzyme cleaner) • LASIK surgery • Smoking cessation programs • Dental care • Hearing aids <p><i>*Guidance on covered and non-covered medications can be found online at www.naviabenefits.com</i></p>	<ul style="list-style-type: none"> • Health insurance premiums • Nicotine patches or diet pills* • Exercise programs and equipment* • Medical or dental cosmetic surgery or drugs* <p><i>*Unless prescribed for treatment of an illness or injury.</i></p>

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

DEBIT CARD

You will receive a debit card which you can use to pay for your eligible healthcare expense(s) at the point of service: the doctor’s office, a pharmacy, or other health care service provider. It can also be used to purchase eligible items at some non-healthcare related merchants such as grocery stores and discount stores. When you have a copay, the money will be taken directly from your account, so you don’t have to pay for the service and file for reimbursement. Dependent Day Care expenses cannot be paid using the debit card.

Anyone who enrolls in a Health Care 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 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.

TAX CREDIT VS. DEPENDENT DAY CARE ACCOUNT

To find out whether the Spending Account or tax credit may be best for you, login to <https://www.naviabenefits.com/>, click on Resource Center and then, Savings Calculator.

RETIREMENT PROGRAMS

MANDATORY PLAN CHOICES

If you are a benefits-eligible employee, you are automatically enrolled in the Teacher Retirement System of Texas (TRS) on your first day of work unless you are required to be a graduate student for your position. 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. Under both plans, you and the A&M System contribute toward your retirement benefit 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 benefits when you receive them.

TEACHER RETIREMENT SYSTEM OF TEXAS (TRS)

Beginning September 1, 2018, you contribute 7.7% 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 <http://www.tamus.edu/business/benefits-administration/retirement-programs/orpda-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, 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 <http://www.tamus.edu/business/benefits-administration/retirement-programs/orptda-approved-vendors/>. The DCP vendor is Great West. More information on the Texa\$aver DCP can be found at <http://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 \$25 per month to a TDA and \$20 per month to a DCP. 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 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 take a Health Assessment on MyEvive and complete your annual wellness exam. Once Blue Cross and Blue Shield processes your claim, you can track your wellness incentive status on MyEvive.

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
- 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 are not eligible for the wellness premium credit because they are already receiving the lower premium.

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 www.guidanceresources.com.

Premiums

September 1, 2019

Health rates include the \$30 wellness premium for you and your spouse. Only the A&M Care Plan is eligible for the wellness premium. If you have completed your wellness activities or are waived, you will see a \$30 credit in Workday that will reduce this premium. Premiums increase by \$30/month if you or your spouse is a tobacco user:

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	Monthly \$623.77	\$30.00	\$1,215.88	\$341.05	\$1,014.27	\$225.25	\$1,444.71	\$455.47
	Bi-Weekly \$623.77	\$15.00	\$1,215.88	\$170.53	\$1,014.27	\$112.63	\$1,444.71	\$227.74
J Plan	Monthly \$593.77	\$0.00	\$1,155.88	\$281.05	\$984.27	\$195.25	\$1,384.71	\$395.47
	Bi-Weekly \$593.77	\$0.00	\$1,155.88	\$140.53	\$984.27	\$97.63	\$1,384.71	\$197.74

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	Monthly \$623.77	\$330.18	\$1,215.88	\$781.76	\$1,014.27	\$623.05	\$1,444.71	\$953.38
	Bi-Weekly \$623.77	\$165.09	\$1,215.88	\$390.88	\$1,014.27	\$311.53	\$1,444.71	\$476.69
J Plan	Monthly \$593.77	\$300.18	\$1,155.88	\$721.76	\$984.27	\$593.05	\$1,384.71	\$893.38
	Bi-Weekly \$593.77	\$150.09	\$1,155.88	\$360.88	\$984.27	\$296.53	\$1,384.71	\$446.69
Graduate Plan	Monthly \$219.50	\$48.50	\$439.00	\$97.00	\$582.50	\$191.28	\$802.00	\$310.67
	Bi-Weekly \$219.50	\$24.25	\$439.00	\$48.50	\$582.50	\$95.64	\$802.00	\$154.34

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

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Dental PPO	Monthly \$29.41	\$0.00	\$58.82	\$0.00	\$61.76	\$0.00	\$94.11	\$0.00
	Bi-Weekly \$14.71	\$0.00	\$29.41	\$0.00	\$30.88	\$0.00	\$47.06	\$0.00
DeltaCare USA	Monthly \$21.07	\$0.00	\$37.47	\$0.00	\$37.76	\$0.00	\$58.66	\$0.00
	Bi-Weekly \$10.54	\$0.00	\$18.74	\$0.00	\$18.88	\$0.00	\$29.33	\$0.00

Vision

	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Monthly	\$7.00	\$14.88	\$11.50	\$20.50
Bi-Weekly	\$3.50	\$7.44	\$5.75	\$10.25

AD&D

Rate per \$10,000:	Employee Only	Employee and Family
Monthly	\$0.14	\$0.24
Bi-Weekly	\$0.07	\$0.12

Long-Term Disability

	Non-Tobacco Rate	Tobacco Rate
Monthly	\$0.178	\$0.230
Bi-Weekly	\$0.089	\$0.115

Rate per \$100 of monthly salary:

Flexible Spending Account

Maximum you can deduct from your pay:

Health Care Spending Account - \$2,700
 Dependent Daycare Spending Account - \$5,000

Basic Life

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

Basic Life: \$6.59

Alternate Basic Life: \$.878 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

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

Plan C: 1/2 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, 2019

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

	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
Health								
A&M Care 9-Months	\$831.69	\$40.00	\$1,621.17	\$454.73	\$1,352.36	\$300.33	\$1,926.28	\$607.29
J Plan 9-Months	\$791.69	\$40.00	\$1,621.17	\$454.73	\$1,352.36	\$300.33	\$1,352.36	\$607.29
Dental								
A&M Dental PPO 9-Months		\$39.21		\$78.43		\$82.35		\$125.48
DeltaCare USA Dental HMO 9-Months		\$28.09		\$49.96		\$50.35		\$78.21
Vision								
9-Months	\$9.33		\$19.84		\$15.33			\$27.33
AD&D								
Rate per \$10,000: Monthly*			Employee Only \$.14		Employee and Family \$.24			
Long-Term Disability								
Rate per \$100 of monthly salary: Monthly*			Non-Tobacco Rate \$.178		Tobacco Rate \$.230			
Flexible Spending Account								

Maximum you can deduct from your pay: Health Care Spending Account - \$2,700
Dependent Daycare Spending Account - \$5,000

Basic Life

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

Basic Life: \$6.59

Alternate Basic Life: \$.878 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	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

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

Plan C: 1/2 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

Effective September 1, 2019

Basic Life

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

Basic Life \$6.59

Alternate Basic Life \$.878 per \$1,000 of coverage

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	\$593.77	\$ 0.00	\$1,155.88	\$281.05	\$984.27	\$195.25	\$1,384.71	\$395.47
A&M Care 65 PLUS	\$531.42	\$ 0.00	\$1,033.24	\$158.41	\$880.02	\$91.00	\$1,237.56	\$248.32

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	\$29.41		\$58.82		\$61.76		\$94.11
DeltaCare USA Dental HMO	\$21.07		\$37.47		\$37.76		\$58.66	

Vision	Retiree Only	Retiree & Spouse	Retiree & Child(ren)	Retiree & Family
	\$7.00	\$14.88	\$11.50	\$20.50

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

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

Plan C: 1/2 Alternate Basic Life premium; 1/10 if no spouse is covered

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

AD&D

Monthly rate per \$10,000

Retiree Only \$.28

Retiree & Family \$.46

Survivor Rates

Survivors are eligible only for Health, Dental & Vision coverage.

	Participant Only	Participant & Spouse	Participant & Child(ren)	Participant & Family
A&M Care	\$593.77	\$1,155.88	\$984.27	\$1,384.71
A&M Care 65 PLUS	\$531.42	\$1,033.24	\$880.02	\$1,237.56
A&M Dental PPO	\$ 29.41	\$ 58.82	\$ 61.76	\$ 94.11
DeltaCare USA Dental HMO	\$ 21.07	\$ 37.47	\$ 37.76	\$ 58.66
Vision	\$ 7.00	\$ 14.88	\$ 11.50	\$ 20.50

Premium Worksheet

1.	Health: Enter premium amount. The employer contribution has already been deducted. Add \$30 if you or your spouse use tobacco products. Add \$30 each if your A&M System Medical coverage began prior to September 1, 2016 and if you or your spouse have not had a preventive wellness exam processed through BlueCross BlueShield.	\$ _____
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.	Alternate Basic Life: Divide your coverage amount by 1,000: _____ × .878 =	\$ _____ *
6.	Dependent Life: <i>Plan A Premium:</i> Your spouse's age-based premium of _____ × (spouse coverage amount/1000) + (child coverage amount/1000 × .06) = _____ <i>Plan B Premium:</i> \$1.37/month (flat rate) <i>Plan C Premium:</i> Your Alternate Basic Life premium (see #5) _____ × .5 (.1 if covering children only) =	\$ _____ \$ _____ * \$ _____
7.	Accidental Death and Dismemberment: Choose your coverage amount and divide by 10,000: _____ × your premium of _____ = <i>(Maximum coverage is the greater of \$250,000 or 10 times your annual salary, not to exceed coverage of \$800,000.)</i>	\$ _____
8.	Long-Term Disability: Divide your annual salary by 12. Divide the lesser of that number or \$12,307 by 100: _____ × your premium of _____ =	\$ _____ *
9.	Spending Accounts: Enter Health Care Account monthly contribution \$ _____ + Dependent Day Care Account monthly contribution _____ =	\$ _____ \$ _____
10.	YOUR TOTAL MONTHLY COST (Add 1 through 9) =	\$ _____
<i>Complete items 11 and 12 if you do not have A&M System health coverage but certify that you have other health coverage:</i>		
11.	Employer Contribution: Enter the total of your premiums shown above for Dental (line 2), Vision (line 3), Alternate Basic Life (line 5), AD&D (line 7) and Long-Term Disability (line 8)** or \$300.18 (\$150.09 if part-time), whichever is less.	- \$ _____
12.	YOUR TOTAL MONTHLY OUT-OF-POCKET COST (Subtract line 11 from line 10) =	\$ _____

* The premiums may increase based on your salary.

** Include only premiums you choose to pay using the employer contribution.

THE TEXAS A&M UNIVERSITY SYSTEM NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our 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.

Our Commitment to Protecting Health Information About You

The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies an individual or where there is a reasonable basis to believe the information can be used to identify an individual. This information is called "Protected Health Information" (PHI).

We are required by law to:

- Maintain the privacy of PHI about you;
- Give you this notice of our legal duties and privacy practices with respect to PHI; and
- Comply with the terms of our notice of privacy practices that is currently in effect.

Your Rights

You have the right to:

- Get a copy of your health and claims records and correct your health and claims records (these normally do not involve The Texas A&M University System)
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- 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 we use and share information as we answer coverage questions from your family and friends and provide emergency disaster relief.

Our Uses and Disclosures

We may use and share your information as we:

- Pay for your health services
- Administer your health plan
- Help manage the health care treatment you receive (these normally do not involve The Texas A&M University System)
- 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 our responsibilities to help you.

Get a copy of health and claims records or ask for corrections to health or claim records. It is anticipated that this will take place between you and your health provider or the plan administrator, not through our office.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information. You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll 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. We 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. We will confirm that person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us 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/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, tell us what you want us to do, and we will follow your instructions.

You have both the right and choice to tell us 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 us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We do not share, sell, nor do we use, your information for marketing purposes.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Pay for your health services. We can use and disclose your health information as we pay for your health services. Example: We may share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan. We may disclose your health information to our administrative services provider for plan administration; however, this normally does not involve The Texas A&M University System. Example: The services provider (claims payer) needs to know your diagnosis in order to determine the best physician to put you in contact with to meet your needs.

How else can we use or share your health information?

We are allowed or required to share your information in other ways—ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues. We 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. We can use or share your information for health research under certain limited circumstances.

Comply with the law. We 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 we're complying with federal requirements.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director.

We can share health information about you with organ procurement organizations. We 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. We 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. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to this Notice

We reserve the right to make changes to this notice and to make such changes effective for all PHI we may already have about you. If and when this notice is changed, we will post this information on our 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:

Ellen Gerescher
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

Human Resources Offices		
Texas A&M University	(979) 862-1718	benefits@tamu.edu
Texas A&M Health Science Center	(979) 436-9207	benefits@tamhsc.edu
Prairie View A&M University	(936) 261-1730	benefitsteam@pvamu.edu
Tarleton State University	(254) 968-9128	employeeservices@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	human.resources@tamucc.edu
Texas A&M University at Galveston	(409) 740-4534	penningt@tamug.edu
Texas A&M University-Kingsville	(361) 593-4998	christina.rangel@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	engineeringhr@tamu.edu
Texas A&M Engineering Extension Service	(979) 458-6801	HR@teex.tamu.edu
West Texas A&M University	(806) 651-2117	hr@wtamu.edu
System Offices	(979) 458-6181	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/
Securian Life Insurance/AD&D	(877) 443-5854	http://www.lifebenefits.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.naviabenefitsolutions.com/
GuidanceResources		
2nd MD	(866) 841-2575	http://2nd.md/

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

