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.

### Table of Contents

#### How Your Benefits Work

- Benefits At-A-Glance
- Understanding Benefits Lingo
- Benefit Eligibility and Coverage Information
- Proof of Eligibility
- Dependent Documentation
- Benefit Enrollment
- Costs and Premiums
- Qualifying Life Events
- Qualifying for COBRA

#### Health Plans Overview

- A&M Care Plan
- J Plan
- Graduate Student Employee Health Plan
- Comparing the Plans

#### Optional Plans

- A&M Care Special Programs
- Retiree Health Coverage
- Dental
- Vision
- Life
- AD&D
- Long-Term Disability
- Flexible Spending Accounts
- Retirement Programs

- Other Plans
- Monthly Premiums
- Premium Worksheet
- Protection of Personal Health Information
- Appendix

#### Benefit Type Options

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plans</td>
<td>A&amp;M Care Plan</td>
</tr>
<tr>
<td></td>
<td>J Plan</td>
</tr>
<tr>
<td></td>
<td>A&amp;M Care 65 PLUS Plan</td>
</tr>
<tr>
<td></td>
<td>Graduate Student Employee Health Plan</td>
</tr>
<tr>
<td>Dental Plans</td>
<td>Delta Dental PPO</td>
</tr>
<tr>
<td></td>
<td>DeltaCare USA HMO</td>
</tr>
<tr>
<td>Vision Plans</td>
<td>Superior Vision</td>
</tr>
<tr>
<td>Flexible Spending Account</td>
<td>Health Care Spending Account</td>
</tr>
<tr>
<td></td>
<td>Dependent Day Care Spending Account</td>
</tr>
<tr>
<td>Life</td>
<td>Basic Life</td>
</tr>
<tr>
<td></td>
<td>Alternate Basic Life</td>
</tr>
<tr>
<td></td>
<td>Optional Life</td>
</tr>
<tr>
<td></td>
<td>Dependent Life</td>
</tr>
<tr>
<td>AD&amp;D (Accidental Death &amp; Dismemberment)</td>
<td>AD&amp;D Plan</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Optional Long-Term Disability</td>
</tr>
<tr>
<td>Retirement Programs</td>
<td>Teacher Retirement System of Texas (TRS)</td>
</tr>
<tr>
<td></td>
<td>Optional Retirement Program</td>
</tr>
<tr>
<td></td>
<td>Tax-Deferred Account Program (TDA)</td>
</tr>
<tr>
<td></td>
<td>Texa$aver Deferred Compensation Plan (DCP)</td>
</tr>
<tr>
<td>Wellness and Work-Life</td>
<td>Deer Oaks Employee Assistance Programs</td>
</tr>
<tr>
<td></td>
<td>Wellness Incentives</td>
</tr>
<tr>
<td>Relocation Services</td>
<td>Daryl Flood relocation &amp; Logistics</td>
</tr>
<tr>
<td>Medical Second Opinion Advice</td>
<td>2nd.MD</td>
</tr>
</tbody>
</table>
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 of Formulary Drugs
A list of drugs that are periodically reviewed and updated by a committee of physicians, pharmacists and other health professionals for effectiveness and cost effectiveness. Each plan has its own Preferred Drug List. Often, brand 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
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.
**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.

<table>
<thead>
<tr>
<th>FULL-TIME ELIGIBILITY</th>
<th>PART-TIME ELIGIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You work at least 30 hours a week, and</td>
<td>• You work at least 20 hours a week, and</td>
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<tr>
<td>• Your appointment is expected to continue for at least 90 days</td>
<td>• Your appointment is expected to continue for a term of at least 4½ months, and</td>
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<td></td>
<td>• You are eligible for retirement benefits as a member of the Teacher Retirement System of Texas (TRS) or you are enrolled in graduate student-level classes at an A&amp;M System institution as a condition of employment.</td>
</tr>
</tbody>
</table>

**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 on your enrollment form or on the online system 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 in the household, 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 iBenefits during enrollment, 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 crossed out) OR “Marriage Certificate AND Proof of Joint Ownership.
- A mortgage or bank statement or property tax bill which must be dated within the previous six months and 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.

**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).

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

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 60-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.

Annual 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 the online iBenefits system. 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.
How To Enroll Online
Through iBenefits:
Login 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 iBenefits. Then:

- Complete the employee information section.
- Enter the names and other required information for dependents you wish to add to any coverages.
- Enroll in any of the coverages listed.
- 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.

While you are making your elections, you can check them on the screen to make sure you clicked the correct buttons for the choices you want. You may correct any errors immediately. Before exiting the system, click “sign and submit” to submit your final choices for processing.

How to Enroll on Paper
You can enroll using a New Employee Benefit Enrollment Form. Complete this form and return it to your Human Resources office. You will need to complete a Beneficiary Designation Form and, if you enroll dependents, a Dependent Enrollment/Change Form.

After you begin employment, you can also log on to HRConnect (https://sso.tamus.edu) to find:

- Employment and payroll information specific to you.
- Links to calculators that can help you plan for retirement or determine how your net pay will be affected if you change your benefit coverages.

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 $2,600 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 HRConnect 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.
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

If you work fewer than 12 months (for example, if you are budgeted to work nine or 10½-months) and 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.

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.

Changes can be made to your benefits during the Annual 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 Annual 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 annual 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.
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.

Survivors

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.

Qualifying For COBRA

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 her/him for advice or to call in a prescription to a nearby pharmacy.

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. Your A&M Care ID card has a toll-free telephone number you can call to locate BCBSTX network providers outside Texas.

If you need treatment while traveling outside the United States, call 1 (800) 810-BLUE or visit BCBS online at http://www.bcbs.com/already-a-member/traveling-outside-of-the.html. 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
- 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.

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<thead>
<tr>
<th>A&amp;M Care Plan</th>
<th>65 Plus Plan</th>
<th>J Plan</th>
<th>Graduate Student Employee Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available to all Employees and Retirees</td>
<td>Retirees not working and enrolled in Medicare A &amp; B</td>
<td>Employees enrolled under a J1 or J2 Visa</td>
<td>Graduate Student Employees enrolled under a J1 or J2 Visa</td>
</tr>
</tbody>
</table>

Plan Choices

The A&M Care plan is available to all benefit-eligible employees and retirees. If you are a graduate student, 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 may also be eligible for 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 Annual 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.
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, 65 PLUS 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.

<table>
<thead>
<tr>
<th>Generic Drug Copayment</th>
<th>Brand Name Preferred Drug Copayment</th>
<th>Brand Name Non-Preferred Drug Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy – 30-day supply</td>
<td>$10</td>
<td>$35</td>
</tr>
<tr>
<td>Retail Pharmacy – 90-day supply</td>
<td>$30</td>
<td>$105</td>
</tr>
<tr>
<td>Express Scripts Home Delivery - 90-Day Supply</td>
<td>$20</td>
<td>$70</td>
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</tbody>
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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 by clicking here.

Prior Authorization

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

Step Therapy

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

DRUG QUANTITY MANAGEMENT

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

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

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

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

SPECIALTY MEDICINES

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

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

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

You can contact Express Scripts at 1 888 327-9791 or by visiting www.express-scripts.com.
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, 2016, you will have until the end of the following plan year June 30, 2017, 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/.

DEDUCTIBLE CREDITS
If you take a Health Assessment (HA), available on the Blue Cross and Blue Shield website, your annual deductible will be credited $50 (i.e., you will have a $350 deductible rather than a $400). Your spouse and dependent children, age 18 or older, are also eligible for a $50 deductible credit as each completes the online HA.

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) 810-180.

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/blues365.

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.

Deductible Credits

If you take a Health Assessment (HA), available on the Blue Cross and Blue Shield website, your annual deductible will be credited $50 (i.e., you will have a $350 deductible rather than a $400.) Your spouse and dependent children, age 18 or older, are also eligible for a $50 deductible credit as each completes the online HA.

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

Repatriation of remains of at least $7,500 and medical evacuation coverage of at least $10,000 are also required of those on a J-1 or J-2 visa. The Graduate Student Employee Health Plan exceeds this federal requirement.

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
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 info@ahpcare.com.

GSE Plan Pharmacy Benefit - Prime Therapeutics

<table>
<thead>
<tr>
<th>No annual deductible</th>
<th>A&amp;M Care &amp; J Plans</th>
<th>A&amp;M Care Medicare-Primary Retirees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regions offered</td>
<td>BCBS TX has networks in all 50 states. These benefits apply to Active Employees and Retirees under age 65.</td>
<td>These benefits apply to Medicare-primary retirees not enrolled in the A&amp;M Care 65 Plus plan.</td>
</tr>
<tr>
<td>Pre-existing condition limitations</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Out-of-service area restrictions</td>
<td>Emergency care - Network benefit; must notify BCBS TX within 48 hours; Non-emergency care - Out-of-network benefit unless you go to a BCBS provider in that area</td>
<td>None</td>
</tr>
<tr>
<td>Deductibles</td>
<td>Network: $400/person/plan year, $1,200/family/plan year</td>
<td>$400/person/plan year, $1,200/family/plan year</td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
<td>Network: $5,000 plus $400 deductible/person/plan year; $10,000 plus $1,200 deductible/family/plan year</td>
<td>$5,000 + $400 deductible/person/plan year</td>
</tr>
<tr>
<td>In-hospital care</td>
<td>Network: 20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Emergency room</td>
<td>Network: 20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Office visits</td>
<td>Network: $20/visit for Primary Care Physician (PCP) visits; $30 for specialists; certain in-office surgeries—20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Lab/X-rays</td>
<td>Network: Benefit depends on setting and procedure; see plan description booklet or call BCBS TX for details</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Surgery</td>
<td>Network: 20% after deductible (inpatient and outpatient)</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>Network: $30/visit, 30 visits/plan year</td>
<td>20% after deductible; 30 visits/plan year</td>
</tr>
<tr>
<td>Vision/Hearing</td>
<td>Vision - Network: $30/visit, One routine preventive vision exam per person/plan year</td>
<td>Vision - Network: 20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Hearing — Illness/accident coverage only</td>
<td>Hearing — Illness/accident coverage only</td>
</tr>
</tbody>
</table>

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. The plan year is 9-01-17 through 8-31-18.
<table>
<thead>
<tr>
<th>Provisions</th>
<th>A&amp;M Care &amp; J Plans Network/Out-of-Network Benefits</th>
<th>A&amp;M Care Medicare-Primary Retiree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity care</td>
<td>In Network: Hospital—20% of charges after deductible; Doctor-$20 initial visit only</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: Hospital—50% after deductible; Doctor - 50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Physical therapy</td>
<td>Network: $30/office-visit setting; Deductible and Coinsurance Outpatient or hospital-related facility setting</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Network: 20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>Network: 20% after deductible; 60 visits/person/plan year</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 50% after deductible; 60 visits/person/plan year</td>
<td>60 visits/person/plan year</td>
</tr>
<tr>
<td>Skilled nursing facility (not including custodial care)</td>
<td>Network: 20% after deductible; 60 days/person/plan year</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 50% after deductible; 60 days/person/plan year</td>
<td>60 days/person/plan year</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Network: Inpatient—20% after deductible; Outpatient—$20/visit</td>
<td>Inpatient - 20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: Inpatient—$400 admission + $800 deductible, then 50% after deductible</td>
<td>Outpatient - 20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Outpatient—50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>After you meet the $50/person/plan year prescription drug deductible (three-person maximum):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90-day supply: Two copayments required if purchased by mail-order; Three if purchased through certain retail pharmacies.</td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Graduate Student Employee Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regions offered</strong></td>
</tr>
<tr>
<td><strong>Pre-existing condition limitations</strong></td>
</tr>
<tr>
<td><strong>Benefit maximum</strong></td>
</tr>
<tr>
<td><strong>Out-of-service area restrictions</strong></td>
</tr>
<tr>
<td><strong>Deductibles</strong></td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
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<td><strong>In-hospital care</strong></td>
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<tr>
<td><strong>Office visits</strong></td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
</tr>
<tr>
<td><strong>Diagnostic Lab/X-rays</strong></td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
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<td><strong>Chiropractic care</strong></td>
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<td><strong>Home health care</strong></td>
</tr>
<tr>
<td><strong>Skilled nursing facility</strong> (not including custodial care)</td>
</tr>
<tr>
<td><strong>Mental Health - Inpatient/Outpatient</strong></td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
</tr>
<tr>
<td><strong>How does this health plan work?</strong></td>
</tr>
<tr>
<td><strong>Member Services phone number/website</strong></td>
</tr>
</tbody>
</table>

**Well on Target**

Well on Target is a resource consisting of online tools and information to help you make informed health care decisions and improve your health in a variety of ways. From the Well on Target home page, you can:

- Take a Health Assessment
- Talk with a Nurse Trainer, Dietitian or Life Coach
- Use the Interactive Symptom Checker
- Explore topics in the Health Information and Care Center

**Benefits Value Advisors**

BCBS Benefits Value Advisors can help you get cost estimates on healthcare services, pre-certifications, and find in-network providers for services like CT scans, MRIs, endoscopy/colonoscopy procedures, and surgeries (back, spinal, knee, shoulder, and hip or joint replacement). You can reach them by calling customer service at (866) 295-1212.

**Blue Points**

Blue Points can help motivate you to maintain a healthy lifestyle. Earn points for engaging in daily physical activity, downloading healthy recipes, and completing other healthy tasks. Redeem points in the online shopping mall. For more information, log in to your MyEvive account or visit Well on Target.

**NurseLine**

NurseLine is there 24/7 for medical advice by phone on health conditions like asthma, back pain, diabetes, dizziness, severe headaches, high fever, cuts, bruises, sore throats, and much more. You can reach the NurseLine at (800) 581-0368. For medical emergencies, call 911.

**Special Beginnings**

The Special Beginnings maternity program is a free, easy, and confidential program for pregnancy support and education. They can help identify pregnancy risks and provide ongoing communication and monitoring from early pregnancy to six weeks after delivery. Available from 8 AM to 6:30 PM CT, call (888) 421-7781.

**Blue Care Connection**

This program offers education, coaching, and helps with condition management from registered nurses and other healthcare professionals for those who have or are at risk for a chronic health issue such as asthma, diabetes, coronary artery disease (CAD) or other acute/complex conditions. You can reach Blue Care Connection at (866) 412-8795.
Retiree Health Coverage

Medicare-Eligible Retirees

If you are retired, not working for the TAMU 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 may enroll in A&M Care or the 65 Plus Plan and use any provider. 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:

<table>
<thead>
<tr>
<th>Medicare Primary (A&amp;M Care Secondary)</th>
<th>A&amp;M Care Primary (Medicare Secondary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Payer</td>
<td></td>
</tr>
<tr>
<td>Cost: $193</td>
<td>$20 or $30 copayment, depending on the provider</td>
</tr>
<tr>
<td>Medicare Deductible: $183</td>
<td></td>
</tr>
<tr>
<td>Remainder: $10</td>
<td></td>
</tr>
<tr>
<td>Medicare pays 80%: $5</td>
<td></td>
</tr>
<tr>
<td>Retiree pays 20%: $2</td>
<td></td>
</tr>
<tr>
<td>Cost for retiree (deductible + 20%): $185</td>
<td></td>
</tr>
<tr>
<td>Once your Medicare deductible has been met for the plan year, you will just be responsible for the 20% coinsurance.</td>
<td></td>
</tr>
<tr>
<td>Secondary Payer</td>
<td></td>
</tr>
<tr>
<td>$193 is applied toward your $400 A&amp;M Care deductible.</td>
<td>$183 is applied to the Medicare deductible.</td>
</tr>
<tr>
<td>If the A&amp;M Care deductible has already been met, A&amp;M Care will pay the $185.</td>
<td></td>
</tr>
</tbody>
</table>

Medicare-Eligible Working Retirees

If you are a working retiree in a budgeted position at 50% effort or more for at least 4½ consecutive months, your A&M Care plan is primary and you will be eligible for office visit copayments.

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.

If you are retired and not working for the TAMU System for 50% time or more for at least 4½ months (benefits-eligible position).

If you are working for the TAMU System for 50% time or more for at least 4½ months (benefits-eligible position).

Medicare-Eligible Working Retirees

If you are a working retiree in a budgeted position at 50% effort or more for at least 4½ consecutive months, your A&M Care plan is primary and you will be eligible for office visit copayments.

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.

If you are retired and not working for the TAMU System for 50% time or more for at least 4½ months (benefits-eligible position).

If you are working for the TAMU System for 50% time or more for at least 4½ months (benefits-eligible position).

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. This means that if you have A&M System health coverage and become eligible for Medicare Part D but decide to enroll at a later date, you will not have to pay a higher premium than you would have paid if you’d enrolled when you first became eligible. You may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium.

Medicare Part D is available if you qualify for Medicare Part A and/or Part B. Enrolling or not enrolling in Medicare Part D will not change your enrollment in Parts A and/or B and will not impact the non-prescription drug part of your A&M System health 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 A&M System health coverage and don’t enroll in Medicare Part D within 63 days after your coverage ends, you may be required to pay more to enroll in Medicare Part D later. In this case, you may enroll as soon as you drop or lose A&M System coverage and become eligible for Medicare Part D, which could mean you would benefit from Part D. 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, you will save on Part D premiums, copayments and coinsurance.

Because A&M System health plans usually provide better drug benefits at a lower cost, Medicare Part D enrollment is not necessary for most employees and retirees enrolled in A&M System health plans. However, if you qualify for financial assistance, you will save on Part D premiums, copayments and coinsurance, which could mean you would benefit from Part D. 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, you will save on Part D premiums, copayments and coinsurance.
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. Contact Delta Dental directly for information about specialists.

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. 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

<table>
<thead>
<tr>
<th>Provisions</th>
<th>Deductible</th>
<th>Maximum benefit</th>
<th>Your cost for preventive care</th>
<th>Your cost for basic care</th>
<th>Your cost for major restorative care</th>
<th>Your cost for orthodontics</th>
<th>Filing Claims</th>
<th>Alternate benefit provision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$75/person/plan year; $225 family/plan year</td>
<td>Regular: $1,500/person/plan year; Orthodontia: $1,500/person/lifetime</td>
<td>$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.</td>
<td>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%.</td>
<td>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%.</td>
<td>After you meet your deductible, you pay 50% until you reach your maximum lifetime benefit of $1,500, then you pay 100%.</td>
<td>PPO and Premier dentists file claims for you.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Procedure: Crown</th>
<th>Delta Dental PPO Network Dentist</th>
<th>Delta Dental Premier Network Dentist</th>
<th>Non-Delta Dental Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist bills</td>
<td>$800.00</td>
<td>$800.00</td>
<td>$800.00</td>
</tr>
<tr>
<td>Dentist accepts as payment in full</td>
<td>$548.00 (Delta Dental’s allowed amount)</td>
<td>$688.00 (Delta Dental’s allowed amount)</td>
<td>$800 (No fee agreement with Delta Dental)</td>
</tr>
<tr>
<td>Delta Dental’s payment Major benefit paid at 50%</td>
<td>$274.00</td>
<td>$344.00</td>
<td>$344.00</td>
</tr>
<tr>
<td>Patient share*</td>
<td>$274.00</td>
<td>$344.00</td>
<td>$456.00</td>
</tr>
<tr>
<td>Patient savings</td>
<td>$252.00</td>
<td>$112.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

*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.

### 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.

<table>
<thead>
<tr>
<th>Provisions</th>
<th>Deductible</th>
<th>Maximum benefit</th>
<th>Your cost for preventive care</th>
<th>Your cost for basic care</th>
<th>Your cost for major restorative care</th>
<th>Your cost for orthodontics</th>
<th>Filing Claims</th>
<th>Alternate benefit provision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Regular: None; Orthodontia: None</td>
<td>Comprehensive oral exam: $0; Cleaning (once each six months): $5; Panoramic X-rays (once every three years): $0</td>
<td>You pay a pre-set fee, for example: Amalgam fillings: $8-$22; Resin-based composite filling: two surfaces, posterior; permanent: $75;</td>
<td>You pay a pre-set fee, for example: Crown; porcelain/ceramic: $395; Complete denture; Maxillary: $365</td>
<td>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</td>
<td>None; you choose the procedure you want from the covered services and pay the applicable copayment.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Dental Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Oral Exam - X-rays, Cleaning</td>
<td>$5</td>
</tr>
<tr>
<td>Fluoride Treatment - child (age &lt;19)</td>
<td>$0</td>
</tr>
<tr>
<td>Filling -Amalgam, one surface</td>
<td>$8</td>
</tr>
<tr>
<td>Crown</td>
<td>$185-$395</td>
</tr>
<tr>
<td>Root Canal - molar</td>
<td>$365</td>
</tr>
<tr>
<td>Extraction - erupted tooth or exposed root</td>
<td>$14</td>
</tr>
<tr>
<td>Orthodontia (child to age 19)</td>
<td>$1,150</td>
</tr>
</tbody>
</table>


### For More Information

- [Dental Summary Plan Description Booklet online at: http://assets.system.tamus.edu/files/benefits/pdf/sppdental.pdf](http://assets.system.tamus.edu/files/benefits/pdf/sppdental.pdf)
- [Delta Dental Online at http://www.deltadentalins.com/tamus](http://www.deltadentalins.com/tamus)
- [Customer Service: 1-800-336-8264](tel:1-800-336-8264)
**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.

<table>
<thead>
<tr>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam (one per plan year)</td>
<td>100% after $10 copayment.</td>
</tr>
<tr>
<td>Materials</td>
<td>100% after $15 copayment for:</td>
</tr>
<tr>
<td></td>
<td>- Frames - every plan year, up to $150</td>
</tr>
<tr>
<td></td>
<td>- Eyeglass lenses - one standard pair every plan year</td>
</tr>
<tr>
<td></td>
<td>- Standard single vision; standard lined trifocal, standard lined bifocal, standard lenticular and standard progressive.</td>
</tr>
<tr>
<td>Contact lenses (once every plan year in place of eyeglass benefit)</td>
<td>Conventional/Disposable - $150 Allowance; Medically Necessary - Covered in Full</td>
</tr>
<tr>
<td>Refractive eye surgery</td>
<td>15% off reasonable and customary cost, or 5% off promotional price</td>
</tr>
</tbody>
</table>

**For More Information**

- Vision Summary Plan Description booklet online at: http://assets.system.tamus.edu/files/benefits/pdf/spvision.pdf
- Superior Vision online at superiorvision.com
- Customer service: (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.

### Age Reductions

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

<table>
<thead>
<tr>
<th>Maximum Optional Life Retiree</th>
<th>Maximum Dependent Life Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree under age 70</td>
<td>$100,000</td>
</tr>
<tr>
<td>Retiree age 70 through age 79</td>
<td>$60,000</td>
</tr>
<tr>
<td>Retiree age 80 and older</td>
<td>$30,000</td>
</tr>
</tbody>
</table>

### Additional Benefits

- **Travel Assistance** provided by Redpoint WTP 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.

**Life Choices**

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.

- **Premiums**
  - Additional Benefits
  - Age Reductions
Life

Basic Life/Basic AD&D

Coverage for you:

$7,500 in life insurance and $5,000 in AD&D coverage

Child Coverage: $5,000 in life insurance on each eligible dependent child.

Alternate Basic Life/Basic AD&D

Coverage for you:

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.

$50,000 or the amount of optional life you had immediately before enrolling in this plan, whichever is less, as well as $5,000 in Basic AD&D coverage

Child Coverage: $5,000 in life insurance on each eligible dependent child.

Optional Life

Employee: ½ to 6x salary with a maximum coverage amount of $1,000,000. Coverage will automatically reduce to $100,000 at retirement if under age 70 and $60,000 if age 70 or older.

Retiree: Maximum of $100,000 if younger than 70. Coverage will automatically be reduced to $60,000 at age 70 and $30,000 at age 80.

Dependent Life Plan

Spouse coverage:

You can enroll your dependents if you have Optional Life coverage. You pay for the coverage yourself.

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.

Retiree: 25,000 or $50,000, if retiree is younger than 70. Maximum spouse coverage is $30,000 for retirees ages 70–79 and $15,000 if retiree is age 80 or older.

Child Coverage: $10,000 per child.

Dependent Life Plan B

Spouse coverage: 5,000 in life and $5,000 in AD&D coverage, if spouse is enrolled.

Child Coverage: 5,000 in life insurance on each eligible enrolled dependent child.

Dependent Life Plan C

Spouse coverage: 50% of your Alternate Basic Life coverage amount, if spouse is enrolled.

Child Coverage: $5,000 on each enrolled child.

Retiree: 10% of your Alternate Basic Life coverage amount on each enrolled child.

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 Annual Enrollment, you can complete the E of I information on Securian’s website, which is accessible through iBenefits, 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 the paper forms.
AD&D

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

<table>
<thead>
<tr>
<th>For Loss Of</th>
<th>Percentage of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Both Hands</td>
<td>100%</td>
</tr>
<tr>
<td>Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Entire Sight of Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand</td>
<td>50%</td>
</tr>
<tr>
<td>One Foot</td>
<td>50%</td>
</tr>
<tr>
<td>Entire Sight of One Eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech</td>
<td>50%</td>
</tr>
<tr>
<td>Hearing</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and Index Finger on Same Hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

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.

Felony Assault Benefit
If you die, or suffer a covered dismemberment as a result of a covered accident caused by a felony 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. 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. 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 iBenefits 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/spddad.
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 disability benefit before deduction of expenses, 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

<table>
<thead>
<tr>
<th>Age at time of disability</th>
<th>Benefit duration</th>
<th>Birthdate</th>
<th>SSN Normal Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 60</td>
<td>Benefit duration</td>
<td>Birthdate</td>
<td>SSN Normal Retirement Age</td>
</tr>
<tr>
<td></td>
<td>Your choice</td>
<td>Birthdate</td>
<td>SSN Normal Retirement Age</td>
</tr>
<tr>
<td>60</td>
<td>60 months</td>
<td>1938</td>
<td>65+2 months</td>
</tr>
<tr>
<td>61</td>
<td>48 months</td>
<td>1939</td>
<td>65+4 months</td>
</tr>
<tr>
<td>62</td>
<td>42 months</td>
<td>1940</td>
<td>65+6 months</td>
</tr>
<tr>
<td>63</td>
<td>36 months</td>
<td>1941</td>
<td>65+8 months</td>
</tr>
<tr>
<td>64</td>
<td>30 months</td>
<td>1942</td>
<td>65+10 months</td>
</tr>
<tr>
<td>65</td>
<td>24 months</td>
<td>1943-1954</td>
<td>66</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
<td>1955</td>
<td>66+2 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
<td>1956</td>
<td>66+4 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
<td>1957</td>
<td>66+6 months</td>
</tr>
<tr>
<td>69+</td>
<td>12 months</td>
<td>1958</td>
<td>66+8 months</td>
</tr>
<tr>
<td>70</td>
<td>9 months</td>
<td>1959</td>
<td>66+10 months</td>
</tr>
<tr>
<td>71</td>
<td>6 months</td>
<td>1960</td>
<td>67</td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION
LTD Plan Description Booklet, online at http://assets.system.tamus.edu/files/benefits/pdf/spldtd.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:
• Minimum contribution: $20/month;
• Maximum contribution: $2,600/year

Dependent Day Care Spending Account:
• Minimum contribution: $40/month
• 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 Day 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, 2018. 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 PayFlex 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, 2017, and August 31, 2018 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, 2017, and August 31, 2018, as long as you have an account balance.

BENEFITS
Flexible Spending Accounts (FSAs) allow 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.

DEPARTMENTAL 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 PayFlex website, https://www.payflex.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**

<table>
<thead>
<tr>
<th>Covered Expenses</th>
<th>Non-Covered Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Copayments and deductibles</td>
<td>• Health insurance premiums</td>
</tr>
<tr>
<td>• Orthodontia</td>
<td>• Nicotine patches or diet pills*</td>
</tr>
<tr>
<td>• Glasses, contact lenses and supplies (such as saline solution and enzyme cleaner)</td>
<td>• Exercise programs and equipment*</td>
</tr>
<tr>
<td>• LASIK surgery</td>
<td>• Medical or dental cosmetic surgery or drugs*</td>
</tr>
<tr>
<td>• Smoking cessation programs</td>
<td>*Unless prescribed for treatment of an illness or injury.</td>
</tr>
<tr>
<td>• Dental care</td>
<td></td>
</tr>
<tr>
<td>• Hearing aids</td>
<td></td>
</tr>
</tbody>
</table>

*Guidance on covered and non-covered medications can be found online at [www.payflex.com](http://www.payflex.com).

**Dependent Day Care Spending Account**

<table>
<thead>
<tr>
<th>Covered Expenses</th>
<th>Non-Covered Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Day care fees for children 12 or younger or older disabled dependents</td>
<td>• Tuition and fees for private school, grades kindergarten through 12th</td>
</tr>
<tr>
<td>• Babysitting fees (work-related only)</td>
<td>• Overnight camps and extracurricular lessons</td>
</tr>
<tr>
<td></td>
<td>• Supply fees</td>
</tr>
<tr>
<td></td>
<td>• Club or organization membership fees</td>
</tr>
</tbody>
</table>

**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 Omaha, NE.
- The card is good for FIVE 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 PayFlex at 1 (800) 284-4885 or order online [https://www.payflex.com/](http://www.payflex.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 PayFlex. If you receive a request for documentation from PayFlex, you must return the requested documentation within 21 days of the date of the letter to ensure your PayFlex 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 PayFlex 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 online Express claim, uploading, faxing, or mailing your claim to PayFlex.

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 PayFlex. The form is available at [http://assets.system.tamus.edu/files/benefits/pdf/programs/DirectDepositAuthForm.pdf](http://assets.system.tamus.edu/files/benefits/pdf/programs/DirectDepositAuthForm.pdf) or on the PayFlex website, [https://www.payflex.com/](https://www.payflex.com/).

**FILING DEADLINE**

Claims against your 2017-2018 account must be filed by December 31, 2018.

**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.payflex.com/](http://www.payflex.com/), click on Resource Center and then, Savings Calculator.
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 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-Deducted Accounts and Deferred Compensation Plans

All System employees are eligible to participate in the Tax-Deducted Account (TDA) program and the TexasSaver 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 TexasSaver 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/retirementDeferralLimitsChart.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 Salary Reduction Agreement (HR 17), and a TDA Vendor New Account Application and turn it in to your Human Resources or Payroll office. Your investment vendor may be able to help you complete these forms. You may also use the HR 17 form to change your vendor at any time.

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 PLANS

DARYL FLOOD RELOCATION & LOGISTICS:
Daryl Flood Relocation & Logistics is the relocation provider for The Texas A&M University System. Daryl Flood offers a wide variety of in-house relocation solutions and options based on any need. They can assist with school search and area orientation before an interview. Daryl Flood can provide a full service relocation quote for moving household goods, and help existing employees and retirees connect with realtors and moving services when moving throughout the US or locally. As the official relocation provider for the A&M System, Daryl Flood can provide services paid for by an A&M System agency or university, as well as those paid for by an individual.

A few of their solutions include:

- Domestic & International Household Goods Relocation
- Realtor & Mortgage Assistance
- Home Sale & Purchase Programs
- Temporary Housing (furnished homes or apartments)
- Automobile Transport
- Destination Services (Home Finding, School Search, Place of Worship)

A Daryl Flood relocation consultant is available to ensure each relocation goes smoothly. Services offered include planning the move, helping sell your home, selecting movers, helping find housing that meets your needs and is within your budget, and pre-qualifying you for a mortgage. To initiate a relocation request, please contact 1 (844) 722-TAMU (8268) or email tamus@darylflood.com. For more information, visit http://www.tamus.edu/business/benefits-administration/employee-retiree-benefits/relocation/.

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.

EMPLOYEE ASSISTANCE PROGRAMS (EAP) - DEER OAKS
EAP programs offer 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. Deer Oaks EAP Services is the EAP provider for the A&M System. These services are completely confidential and can be easily accessed by calling the toll-free Helpline at (888) 993-7650 or by visiting www.deeroaks.com.
Monthly Premiums - Active Employees

Effective September 1, 2017

Basic Life

<table>
<thead>
<tr>
<th>Basic Life</th>
<th>Alternate Basic Life</th>
<th>$6.59</th>
<th>$8.78 per $1,000 of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;M Care</td>
<td>$955.77</td>
<td>$0.00</td>
<td>$1,155.88</td>
</tr>
<tr>
<td>J Plan</td>
<td>$955.77</td>
<td>$0.00</td>
<td>$1,155.88</td>
</tr>
</tbody>
</table>

Health

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

The A&M Care Plan premium increases by $30/month each year if you enroll your covered spouse and meet an annual wellness exam.

The following chart applies to you if you are a full-time employee (work at least 10 hours per week):

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Basic Life</th>
<th>Alternate Basic Life</th>
<th>$6.59</th>
<th>$8.78 per $1,000 of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;M Care</td>
<td>$933.77</td>
<td>$0.00</td>
<td>$1,155.88</td>
<td>$281.05</td>
</tr>
<tr>
<td>A&amp;M Care 65 PLUS</td>
<td>$531.42</td>
<td>$0.00</td>
<td>$1,033.24</td>
<td>$158.41</td>
</tr>
</tbody>
</table>

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

Dental

<table>
<thead>
<tr>
<th>Dental Plan</th>
<th>A&amp;M Dental PPO</th>
<th>$29.41</th>
<th>$58.82</th>
<th>$14.88</th>
<th>$28.41</th>
<th>$8.76</th>
<th>$34.25</th>
<th>$53.21</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeltaCare USA Dental HMO</td>
<td>$11.11</td>
<td>$33.98</td>
<td>$34.25</td>
<td>$34.25</td>
<td>$34.25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vision

<table>
<thead>
<tr>
<th>Vision Plan</th>
<th>A&amp;M Vision Plan</th>
<th>$7.00</th>
<th>$14.88</th>
<th>$11.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeltaCare USA Vision HMO</td>
<td>$10.00</td>
<td>$40.00</td>
<td>$30.00</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Optional Life</th>
<th>A&amp;M Vision Plan</th>
<th>$7.00</th>
<th>$14.88</th>
<th>$11.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeltaCare USA Vision HMO</td>
<td>$10.00</td>
<td>$40.00</td>
<td>$30.00</td>
<td></td>
</tr>
</tbody>
</table>

Dependent Life

Plan A: Spouse age-based rate per $1,000 of coverage; Child $0.06 per $1,000 of coverage

<table>
<thead>
<tr>
<th>Dependent Life</th>
<th>A&amp;M Vision Plan</th>
<th>$7.00</th>
<th>$14.88</th>
<th>$11.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeltaCare USA Vision HMO</td>
<td>$10.00</td>
<td>$40.00</td>
<td>$30.00</td>
<td></td>
</tr>
</tbody>
</table>

AD&D

Monthly rate per $10,000

<table>
<thead>
<tr>
<th>AD&amp;D</th>
<th>Monthly rate per $10,000</th>
<th>$6.28</th>
<th>$10.47</th>
</tr>
</thead>
</table>

Long-Term Disability

Monthly rate per $100,000

<table>
<thead>
<tr>
<th>Long-Term Disability</th>
<th>Monthly rate per $100,000</th>
<th>$1.14</th>
<th>$2.34</th>
</tr>
</thead>
</table>

Flexible Spending Account Debit Card (Health Care Account only)

Maximum Annual Election $2,600

No Cost

49
Leave Without Pay

The premiums shown below are your monthly health and Basic Life premiums because you are not eligible for the employer contribution. If you are on a Family and Medical Leave Act leave without pay, you are eligible to receive the employer contribution and pay the premiums shown on page 46.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Employee Only</th>
<th>Employee &amp; Spouse</th>
<th>Employee &amp; Child(ren)</th>
<th>Employee &amp; Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;M Care Plan</td>
<td>$600.36</td>
<td>$1,162.47</td>
<td>$990.86</td>
<td>$1,391.30</td>
</tr>
<tr>
<td>J Plan</td>
<td>$600.36</td>
<td>$1,162.47</td>
<td>$990.86</td>
<td>$1,391.30</td>
</tr>
<tr>
<td>Graduate Student Employee Health Plan</td>
<td>$177.59</td>
<td>$348.59</td>
<td>$457.59</td>
<td>$628.59</td>
</tr>
</tbody>
</table>

Survivor Rates

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Participant Only</th>
<th>Participant &amp; Spouse</th>
<th>Participant &amp; Child(ren)</th>
<th>Participant &amp; Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;M Care</td>
<td>$593.77</td>
<td>$1,155.88</td>
<td>$984.27</td>
<td>$1,384.71</td>
</tr>
<tr>
<td>A&amp;M Care 6PLUS</td>
<td>$531.42</td>
<td>$1,033.24</td>
<td>$880.02</td>
<td>$1,237.56</td>
</tr>
<tr>
<td>J Plan</td>
<td>$593.77</td>
<td>$1,155.88</td>
<td>$984.27</td>
<td>$1,384.71</td>
</tr>
<tr>
<td>A&amp;M Dental PPO</td>
<td>$29.41</td>
<td>$38.82</td>
<td>$61.76</td>
<td>$94.11</td>
</tr>
<tr>
<td>DeltaCare USA Dental HMO</td>
<td>$7.00</td>
<td>$14.88</td>
<td>$11.50</td>
<td>$20.50</td>
</tr>
</tbody>
</table>

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 (1/4, 1, 3, 4, or 5), and round down to the nearest thousand (maximum is $1,000,000). Divide by 1,000: $_____.

5. Alternate Basic Life: Divide your coverage amount by 1,000: _______ × .878 = $_____.

6. Dependent Life:
   - Plan A Premium: Your spouse's age-based premium of _______ × (spouse coverage amount/1000) + (child coverage amount/1000 × .06) = _______.
   - Plan B Premium: $1.37/month (flat rate) $_____.
   - Plan C Premium: 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: _______ × _______ = $_____.

8. Long-Term Disability: Divide your annual salary by 12. Divide the lesser of that number or $12,307 by 100: _______ × _______ = $_____.

9. Spending Accounts: Enter Health Care Account monthly contribution $______ + $______ = $______.

10. YOUR TOTAL MONTHLY COST (Add 1 through 9) = $______.

11. Employer Contribution: Enter the total of your premiums shown above for Dental (line 2), Vision (line 3), Alternate Basic Life (line 5), ADD & LTD (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:

Mr. Kevin P. McGinnis
Executive Director of Risk Management and 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

<table>
<thead>
<tr>
<th>Institution</th>
<th>Phone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas A&amp;M University</td>
<td>(979) 862-1718</td>
<td><a href="mailto:benefits@tamu.edu">benefits@tamu.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M Health Science Center</td>
<td>(979) 436-9207</td>
<td><a href="mailto:benefits@tamhsc.edu">benefits@tamhsc.edu</a></td>
</tr>
<tr>
<td>Prairie View A&amp;M University</td>
<td>(936) 281-1730</td>
<td><a href="mailto:benefitsteam@gpamvu.edu">benefitsteam@gpamvu.edu</a></td>
</tr>
<tr>
<td>Tarleton State University</td>
<td>(254) 968-9128</td>
<td><a href="mailto:employment@tarleton.edu">employment@tarleton.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M University-Central Texas</td>
<td>(254) 519-8015</td>
<td><a href="mailto:t.flores@tamuct.edu">t.flores@tamuct.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M University-Commerce</td>
<td>(903) 886-5049</td>
<td><a href="mailto:cynthia.todhunter@tamuc.edu">cynthia.todhunter@tamuc.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M International University</td>
<td>(956) 326-2365</td>
<td><a href="mailto:hr@tamiu.edu">hr@tamiu.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M University at Galveston</td>
<td>(409) 740-4534</td>
<td><a href="mailto:penningt@tamug.edu">penningt@tamug.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M University-Kingsville</td>
<td>(361) 593-4998</td>
<td><a href="mailto:matthew.garza@tamuk.edu">matthew.garza@tamuk.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M University-Texarkana</td>
<td>(903) 223-3113</td>
<td><a href="mailto:ayla.baldwin@tamut.edu">ayla.baldwin@tamut.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M Transportation Institute</td>
<td>(979) 845-9668</td>
<td><a href="mailto:ttithr@ttimail.tamu.edu">ttithr@ttimail.tamu.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M University-San Antonio</td>
<td>(210) 784-2059</td>
<td><a href="mailto:francy.leal@tamusa.edu">francy.leal@tamusa.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M Forest Service</td>
<td>(979) 845-9337</td>
<td><a href="mailto:dorthie.thomas@ag.tamu.edu">dorthie.thomas@ag.tamu.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M AgriLife</td>
<td>(979) 845-2423</td>
<td><a href="mailto:dana.dewveall@ag.tamu.edu">dana.dewveall@ag.tamu.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M Engineering Experiment Station</td>
<td>(979) 458-7699</td>
<td><a href="mailto:engineeringhr@tamu.edu">engineeringhr@tamu.edu</a></td>
</tr>
<tr>
<td>Texas A&amp;M Engineering Extension Service</td>
<td>(979) 458-6801</td>
<td><a href="mailto:HR@teex.tamu.edu">HR@teex.tamu.edu</a></td>
</tr>
<tr>
<td>West Texas A&amp;M University</td>
<td>(806) 651-2117</td>
<td><a href="mailto:hr@wtamu.edu">hr@wtamu.edu</a></td>
</tr>
<tr>
<td>System Offices</td>
<td>(979) 862-1718</td>
<td><a href="mailto:employeebenefits@tamus.edu">employeebenefits@tamus.edu</a></td>
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</table>

### Carrier Phone Numbers and Websites

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross and Blue Shield A&amp;M Care; 65 PLUS</td>
<td>(866) 295-1212</td>
<td><a href="http://www.bcbstx.com/tamus">http://www.bcbstx.com/tamus</a></td>
</tr>
<tr>
<td>Delta Dental - A&amp;M Dental</td>
<td>(800) 336-8264</td>
<td><a href="http://www.deltadentalins.com/tamus/">http://www.deltadentalins.com/tamus/</a></td>
</tr>
<tr>
<td>DeltaCare USA Dental HMO</td>
<td>(800) 422-4234</td>
<td><a href="http://www.deltadentalins.com/tamus/">http://www.deltadentalins.com/tamus/</a></td>
</tr>
<tr>
<td>Superior Vision</td>
<td>(844) 549-2603</td>
<td><a href="http://www.superiorvision.com">http://www.superiorvision.com</a></td>
</tr>
<tr>
<td>Express Scripts - A&amp;M Care Drug Program</td>
<td>(866) 544-6970</td>
<td><a href="http://www.express-scripts.com/">http://www.express-scripts.com/</a></td>
</tr>
<tr>
<td>Securian Life Insurance/AD&amp;D</td>
<td>(877) 443-5854</td>
<td><a href="http://www.lifebenefits.com/">http://www.lifebenefits.com/</a></td>
</tr>
<tr>
<td>Cigna Long-Term Disability</td>
<td>(800) 362-4462</td>
<td><a href="http://cigna.com">http://cigna.com</a></td>
</tr>
<tr>
<td>Academic Health Plan - GSE Plan</td>
<td>(877) 624-7911</td>
<td><a href="https://tamus.myahpcare.com/">https://tamus.myahpcare.com/</a></td>
</tr>
<tr>
<td>Prime Therapeutics - GSE Plan Prescriptions</td>
<td>(800) 423-1973</td>
<td></td>
</tr>
<tr>
<td>PayFlex - Flexible Spending Accounts</td>
<td>(800) 284-4885</td>
<td><a href="https://www.payflex.com/">https://www.payflex.com/</a></td>
</tr>
<tr>
<td>Deer Oaks - EAP</td>
<td>(888) 993-7650</td>
<td><a href="http://www.deeroaks.com">http://www.deeroaks.com</a></td>
</tr>
<tr>
<td>2nd MD</td>
<td>(866) 841-2575</td>
<td></td>
</tr>
</tbody>
</table>

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