THE TEXAS A&M UNIVERSITY SYSTEM

2026-2027 TAMUS Employee Benefits Guide

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

TAMUS Benefits

Enrollment Guide

FOR PLAN YEAR BEGINNING SEPTEMBER 1, 2026

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

Date of hire/initial benefits eligibility date

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

My coverage is effective

My state contribution date

My universal identification number

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

Contents

How Your Benefits Work

Understanding Benefits Language 5
Benefit Eligibility and Coverage Information 6
Benefits Enrollment 9
Cost and Premiums 11
Qualifying Life Events 12
Qualifying for COBRA 13

Medical Plans Overview

A&M Care Plan 15
J Plan 17
Pharmacy Coverage (A&M Care & J Plans) 21
Graduate Student Employee Health Plan 22

Optional Plans

Dental 24
Vision 27
Life 31
Accidental Death & Dismemberment 32
Long-Term Disability 33
Flexible Spending Accounts 35
Retirement Programs 38

Health and Wellness Programs 40
Premiums 44
Premium Worksheet 48
Privacy Notices 49
Human Resources and Carrier Contact Information 55

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

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

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

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

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

Benefit Eligibility and Coverage Information

Employee Coverage

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

Eligibility

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

Dependent Coverage

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

Eligible Dependents include:

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

Examples of dependents who are not eligible for coverage include:

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

Proof of Eligibility

You must provide proof of eligibility to enroll any dependents. **Dependent documentation must be submitted and approved within 31 days of the change prior to the effective date of coverage.** This paperwork is required not only to support the coverage of eligible dependents but also to support a mid-year Qualifying Life Event such as marriage or gain/loss of other coverage. To enroll medically incapacitated dependents, medical records documenting the incapacitating condition and dependency must be submitted within 31 days of initial eligibility.

Type of Dependent	Required Documentation
Spouse	If you are legally married, even if physically separated, you will need: • IRS Transcript of your current filed Federal Tax Return from the IRS.gov website showing you are married filing jointly or married filing separately, **OR** • Valid government-issued marriage license, **AND** • Proof of joint ownership issued within the last six months. *If within two years of marriage date, proof of joint ownership is not required.*
Spouse - Common Law	If you are legally married by a Common Law Marriage, you will need: • IRS Transcript of your current filed Federal Tax Return from the IRS.gov website showing you are married filing jointly or married filing separately, **OR** • Declaration of Informal/Common Law Marriage from the County/State where the marriage was recognized/recorded, **AND** • Proof of joint ownership dated within the last six months. If within two years of marriage date, proof of joint ownership is not required.
Biological Child*	• Birth certificate of child(ren) proving relationship of child(ren) to employee/retiree, **OR** • Certification of Vital Records proving relationship of child(ren) to employee/retiree, **OR** • Verification of Birth Facts Form proving relationship of newborn child(ren) to employee/retiree (see Documentation Requirements), **OR** • Valid Medical Support Order requiring employee/retiree to provide medical coverage, **OR** • Paternity test accompanied by Court Order, Medical Support Order or reissued Birth Certificate
Stepchild*	• Birth certificate of the child(ren) showing the child(ren)'s parent is the employee's/retiree's spouse, AND • IRS Transcript of your current filed Federal Tax Return from the IRS.gov website showing you are married filing jointly or married filing separately, OR • Marriage certificate showing legal marriage between the employee/retiree and the child(ren)'s parent, AND • Proof of joint ownership dated within the last six months. *If within two years of marriage date, proof of joint ownership is not required.*
Adopted Child*	The documents will depend on the current stage of the adoption • Valid Pre-Adoption Placement Order issued by a Licensed Child Placement Agency, **OR** • Valid Court Order naming employee/retiree as Managing Conservator of Child(ren), **OR** • Valid Court Order of Adoption, **OR** • Birth Certificate of Child(ren) with Adoptive Parent(s), **OR** • Valid Medical Support Order requiring employee/retiree to provide medical coverage *Note: If you add the child during the Pre-Adoption Placement phase or the Managing Conservator stage, a copy of the Valid Court Order of Adoption will be required once adoption is finalized to continue coverage.*
Disabled/ Incapacitated Child(ren) age 26 or older	• Valid document (e.g., birth certificate, adoption papers) proving relationship to employee/retiree, **AND** • A doctor's statement regarding the physical or mental condition of the dependent, whether the dependent can maintain self-sustaining employment, and whether the condition occurred before the child(ren) reached age 26 must be submitted. If the dependent is currently enrolled, **the appropriate form must be submitted before the dependent reaches age 26:** 1. For A&M Care Plan or J Plan medical coverage plus optional coverages (if applicable) submit the BCBSTX Dependent Child's Statement of Disability form directly to BCBSTX as indicated on the form. 2. For 65 Plus Medicare Advantage Plan (PPO) medical coverage plus optional coverages (if applicable) submit the Disabled Dependent Verification form to System Benefits Administration. 3. For optional coverages only, not including medical, submit the TAMUS Dependent Child's Statement of Disability form to System Benefits Administration.

Grandchild*	• Birth Certificate of grandchild(ren) or Verification of Birth Facts form (see Documentation Requirements), **AND** • Birth Certificate of grandchild(ren)'s biological parent (i.e., child of the employee/retiree), **AND** • Dependent Grandchild Certification Form (HR 120), **AND** • IRS Transcript of your current filed Federal Tax Return from the IRS.gov website showing the grandchild(ren) as a claimed dependent of the employee/retiree (if grandchild is a newborn, tax return not required at the time of enrollment, but will be required during annual recertification process).
Foster Child	Valid Court Order establishing a parent-child relationship between the employee/retiree and foster child.
Legal Guardianship	Valid Court Order naming the employee/retiree as the legal guardian. Eligible up to age 18 unless court order defines otherwise.
Managing Conservatorship	Valid Court Order naming the employee/retiree as the managing conservator. Eligible up to age 18 unless court order defines otherwise.

**Child must be under age 26 for health insurance and can be married or unmarried. Disabled dependent children age 26 and over may be eligible for insurance. For additional information, please reach out to your benefits office.*

DOCUMENTATION REQUIREMENTS

Make sure your dependents are eligible for insurance and that you have the appropriate documentation to show eligibility before you enroll them in any coverage. You are required to provide the dependent documentation to your Human Resources office directly or by uploading the documents to HRConnect Legacy.

Important reminders for all documents

- DO NOT SEND ORIGINALS. Send copies only.
- Black out any financial information, monetary amounts and/or account numbers on all documents
- No documents will be returned.

Federal Tax Return

- Send IRS transcript of your most recent filed Federal Tax Return showing you are married filing jointly or married filing separately
- For grandchildren, the Federal Tax Return transcript must show the grandchild(ren) as a claimed dependent of the employee/retiree
- Your Federal Tax Return transcript must be downloaded from the IRS.gov website.
- Copies of mailed or e-filed tax returns will not be accepted.
- A state tax return will NOT be accepted in place of a federal tax return
- Black out any monetary amounts appearing on your federal tax return transcript.

Proof of Joint Ownership Document

Proof of joint ownership dated within the last six months. Documents for proof of joint ownership include the following and must include both the employee's/retiree's name and spouse's name as co-owners:

- Mortgage or bank statement, residential leasing agreement, property tax bill, or joint credit card statement.

If within two years of marriage date, proof of joint ownership is not required.

Proof of Marriage Document

You must provide a government-issued marriage license or certificate that includes the date of your marriage. Church-issued certificates will NOT be accepted.

Birth Certificate

You must provide a government-issued birth certificate listing the parents' names.

- Verification of birth facts or documentation on hospital letterhead indicating the birth date of the child(ren) will be accepted for temporary enrollment but must be followed by the birth certificate within 60 days from date of birth.
- Some state and county clerk offices issue the short-form certificate as standard (Iowa, New Jersey, South Carolina, among others). Please get the long form that includes the parents' names. (The long-form certificate is the same kind of document used to get a passport.)

Requestion Vital Records

In some states and county clerk offices, it can take four to eight weeks for vital records to come in. Typically, though, they are delivered within 10-14 business days. Please order your documents as soon as possible to ensure receipt by the verification deadline.

Benefits Enrollment

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

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

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

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

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

If you do not enroll in medical coverage and do not waive medical coverage by the end of your 31 day enrollment period, you will automatically be enrolled in a basic package on your employer contribution eligibility date. This basic package includes the A&M Care medical plan and $50,000 in Accidental Death and Dismemberment (AD&D) coverage for you only and $50,000 Basic Life coverage for you and any eligible dependent children. You pay any cost that is greater than the employer contribution.

Current Employee

Open Enrollment is held each year from July 10 through July 31. During this time you may add, change, or drop coverage for yourself and/or your dependents using Workday. Elections and/or changes made during this time will be effective the following September 1. If Optional Life or Spouse Life insurance changes are made during Open Enrollment and Evidence of Insurability (EOI) is required, the change will be effective on the first of the month following approval if approved after September 1.

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

IF YOU DO NOT NEED MEDICAL COVERAGE

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

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

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

IF YOU BOTH WORK FOR THE A&M SYSTEM

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

- You can be covered as an employee on some coverages and as a dependent on others but you cannot be covered as an employee and a dependent on the same coverages, except on AD&D.
- Children can be covered as dependents by either spouse, but not by both, except on AD&D.
- Both spouses may set up Flexible Spending Accounts and use them to pay dependent expenses. Each spouse may contribute up to $3,400 to a Health Care Flexible Spending Account, but the combined maximum spouses may contribute to Dependent Day Care Flexible Spending Accounts is $7,500.
- You can each enroll separately in medical coverage and receive separate employer contributions.
- Or, one of you can enroll in medical and cover the other as a dependent on medical. If you do this, the employee covered as a dependent will receive half of the employee-only employer contribution, which can be used to purchase other coverages for the employee, spouse and/or family. A spouse who is covered on medical as a dependent is not eligible for Basic Life coverage. To be covered under different medical plans, you must each enroll as employees.
- If you elect Alternate Basic Life or Optional Life on yourself, you may not be covered by your spouse on Spouse Life.
- You may elect employee coverage for AD&D and be covered as a dependent on your spouse's family AD&D coverage, but your benefit will not be more than the maximum for which you are eligible under employee coverage. If both you and your spouse elect family AD&D coverage, your children may be covered under both plans. However, you will not receive more than $25,000 total benefit for each child.

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

How To Enroll Online

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

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

How To Enroll Dependents

Adding dependents to your coverage is a 3-step process.

- **Step 1:** From your Worker Profile, select **Actions** > **Benefits** >**View Dependents**. Enter the dependent's name and **required information**.
- **Step 2:** Provide dependent documentation. Once you have created the dependent profile in Workday. Upload dependent documentation to HRConnect Legacy or provide it to your Benefits Office for review and approval.
- **Step 3:** Add dependents to coverage. After entering your dependents in Workday, you will begin the enrollment task. You must click on each benefit coverage tile and select the dependent(s) to add to that specific coverage. Repeat for each benefit plan.

Other Enrollment Tasks

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

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

Costs and Premiums

Employer Contribution

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

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

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

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

Pretax Premiums

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

Summer Premiums

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

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

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

For employees holding 9-11 month positions, if there is a reasonable expectation that you will be in a benefit-eligible position the upcoming fall semester, your summer premiums (June, July, August) will be deducted from your May paycheck, unless you are eligible for 12 over 9 premiums. You will receive the employer contribution for these months unless you terminate employment before September 1. You will receive more information about this in April, if applicable.

12 Over 9 Premiums

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

Payroll Deductions

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

Billing or Bank draft

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

Tobacco User Premium

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

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

Qualifying Life Events

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

Changes can be made to your benefits during the Open Enrollment period each July. During the plan year, you can only change your medical, dental, vision, AD&D, or flexible spending account coverage within **31 days of a Qualifying Life Event**. For example, if you have a new baby, you can add the baby to your medical coverage, but you cannot drop your spouse from health coverage. **You have 60 days from the date of birth to add a newborn to coverages.**

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

Qualifying Life Events include:

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

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

Qualifying for COBRA

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

Cobra Qualifying Events

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

Survivors

Survivor(s) of deceased employees may be eligible for coverage beyond the time period allowed through COBRA regulations. Coverage in all cases depends on the survivor having been covered at the time of the employee's/retiree's death. Survivors of A&M System employees or retirees may continue medical, dental and/or vision coverage only.

The total premium for survivors is the same as those for active employees, but survivors are not eligible for the employer contribution. Indefinite coverage for survivor(s) is available if the deceased was 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.

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

Medical Plan Overview

Plan Choices

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

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

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

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

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

Enrollment Rules

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

Prescription Drugs

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

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

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

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

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

A&M Care Plan

Vendor: Blue Cross Blue Shield of Texas (BCBSTX)

Member Services Contact Information:

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

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

Website: bcbstx.com/tamus

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

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

	Network Provider	Non-Network
A&M Care Plan Information (cont)		
Preventive exam:	100% covered	Not covered
Lab/X-rays:	Benefit depends on setting & procedure	50% after deductible
Skilled nursing facility (not custodial care):	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Home health care:	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Other Healthcare Benefits		
*Chiropractic care:	$30/visit; 30 visits/plan year	50% after deductible; 30 visits/plan year
Durable medical equipment:	20% after deductible	50% after deductible
*Maternity care:	Hospital: 20% after deductible; Doctor: $20 initial visit only	Hospital: 50% after deductible Doctor: 50% after deductible
*Mental health:	Inpatient: 20% after deductible Outpatient: $20/visit	Inpatient: 50% after deductible Outpatient: 50% after deductible
*Physical therapy:	$30/visit	50% after deductible
*Vision:	$30/visit	Routine preventive eye exams not covered
Hearing:	Illness/accident coverage; 20% coinsurance, one hearing aid per ear, every 36 months	Illness/accident coverage; 20% coinsurance
Prescription Drug Vendor: Express Scripts		
Member Services Contact Information: (866) 544-6970 | express-scripts.com After you meet the $50/person/plan year prescription drug deductible (three-person maximum): • 30-day supply: $10/generic, $35/brand-name formulary, $60/brand-name non-formulary; brand-name copayment + difference between brand name and generic when available • 90-day supply: Three copayments required if purchased by mail-order, or eligible retail pharmacies		

For more information

Medical Summary Plan Description Booklet:

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

J Plan

Vendor: Blue Cross Blue Shield of Texas (BCBSTX)

Member Services Contact Information:

Blue Cross and Blue Shield of Texas: (866) 295-1212
Information about networks outside of Texas: (800) 810-BLUE (2583)
Website: bcbstx.com/tamus

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

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

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

J Plan Information (cont)		
Preventive exam:	100% covered	Not covered
Lab/X-rays:	Benefit depends on setting & procedure	50% after deductible
Skilled nursing facility (not custodial care):	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Home health care:	20% after deductible; 60 days/plan year	50% after deductible; 60 days/plan year
Other Healthcare Benefits		
Chiropractic care:	$30/visit; 30 visits/plan year	50% after deductible; 30 visits/plan year
Durable medical equipment:	20% after deductible	50% after deductible
Maternity care:	Hospital: 20% after deductible; Doctor: $20 initial visit only	Hospital: 50% after deductible Doctor: 50% after deductible
Mental health:	Inpatient: 20% after deductible Outpatient: $20/visit	Inpatient: 50% after deductible Outpatient: 50% after deductible
Physical therapy:	$30/visit	50% after deductible
Vision:	$30/visit	Routine preventive eye exams not covered
Hearing:	Illness/accident coverage; 20% coinsurance, one hearing aid per ear, every 36 months	Illness/accident coverage; 20% coinsurance
Prescription Drug Vendor: Express Scripts		
Member Services Contact Information: (866) 544-6970 | express-scripts.com/ After you meet the $50/person/plan year prescription drug deductible (three-person maximum): • 30-day supply: $10/generic, $35/brand-name formulary, $60/brand-name non-formulary; brand-name copayment + difference between brand name and generic when available • 90-day supply: Three copayments required if purchased by mail-order, or by eligible retail pharmacies		

About Medical Evacuation and Repatriation

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

GeoBlue includes the following required coverage:

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

For more information

Medical Summary Plan Description Booklet:

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

Plan Administration

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

How the Plan Works

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

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

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

You receive network benefits if you use an **in-network provider**. You receive out-of-network benefits if you use a **provider not in the network**.

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

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

Blue Distinction Centers

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

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

Two-Step Wellness Incentive Program

Employees and covered spouses enrolled in the A&M Care Plan are eligible for the lowest medical premium if they complete the annual wellness exam and one other activity from their WebMD ONE Personalized Checklist found at webmdhealth.com/tamus. A premium differential of $30/month is added to the monthly premium for each individual (employee and spouse). If you or your spouse complete your annual wellness exam and one other wellness activity in the current plan year, a $30 credit for each of you will be applied to your pay stub in Workday for the following plan year. You must complete the tasks between September 1 and June 30 each year. Newly enrolled employees and spouses have a grace period of the current plan year plus one additional year to complete their two steps. For example, if you enroll in the plan on March 1, 2026, you must complete your two tasks between September 1, 2026 and August 31, 2027. We recommend completing both tasks before June 30 to ensure the claims are processed and the credit is recorded before the plan year begins. Employees enrolled in the J Plan, graduate student employees enrolled in the Grad Plan, and retirees already receive the lowest premium and are not eligible to participate in the Two-Step Wellness Program. More information is available online at tamus.edu/benefits/wellness. You can check your incentive status at any time on WebMD ONE.

Emergency Admissions

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

This number is also on the back of your BCBSTX ID card for easy reference.

International Claims

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

Coordination of Benefits

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

Vision Benefits

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

Medical Care While Traveling

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

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

MDLive Virtual Visits with Blue Cross and Blue Shield

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

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

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

Pharmacy Coverage

The A&M Care and J Plan Pharmacy benefit is managed by Express Scripts. You will receive a separate ID card from Express Scripts. This benefit allows you to use both retail and home delivery pharmacy. Participating retail pharmacy information and formulary information is available at express-scripts.com.

A&M Care and J Plan Pharmacy Benefit

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

- Prior Authorization
- Step Therapy
- Drug Quantity Management

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

Prior authorization

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

Step Therapy

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

Drug Quantity management

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

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

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

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

Specialty Medicines

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

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

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

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

Rx Savings Solutions

Through your prescription plan you have access to Rx Saving Solutions (RxSS). RxSS has a team of certified pharmacy technicians ready to explain all your options. They can help answer your questions and find ways to save money on your medications.

Know your options - see options for lower-cost medications and compare prices between pharmacies.

Simple Switches - switch to a lower-cost prescription with one click. RxSS will work with you doctor to get it approved.

Activate your account to make sure you are getting the best price for your medications. To activate your account, visit the RxSS website or call 800-492-1051 to speak with someone today.

Rx Savings Solutions is available to all employees and retirees and their covered dependents who are enrolled in the A&M Care, 65 Plus Medicare Advantage (PPO) and J plans.

Graduate Student Employee Health Plan

Vendor: Blue Cross Blue Shield of Texas (BCBSTX)

Member Services Contact Information:

Academic Health Plans (AHP)
Phone: (877) 624-7911
Website: tamus.myahpcare.com

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

	Network	Non-Network
Limitations and Restrictions		
Pre-existing condition limitations:	None	n/a
Out-of-service area restrictions:	None	n/a
Maximums and Deductibles		
Benefit maximum:	No annual/lifetime maximums	No annual/lifetime maximums
Deductibles:	$350/$1,050	$1,000/$3,000
Out-of-pocket maximum: Individual/Family	$7,900/$15,800	$15,800/$31,600
Hospital Benefits		
In-Hospital care:	20% after deductible	40% after deductible
Emergency Room: Emergency Room Physician:	20% after $150 copayment 20% after deductible	20% after $150 copayment 20% after deductible
Surgery:	20% after deductible	40% after deductible
Non-Hospital Visits		
Office visits:	$25 copay	40% after $25 copayment
Preventive exam:	100% covered (deductible waived)	40% after deductible
Lab/X-rays:	20% after deductible	20% after deductible
Skilled nursing facility (not including custodial care):	20% after deductible; 25 days/plan year	40% after deductible; 25 days/plan year
Home health care:	20% after deductible; 60 visits/plan year	40% after deductible; 60 visits/plan year
Other Healthcare Benefits		
Chiropractic care:	$25/visit; 35 visits/person per year	40% after $25 copay; 35 visits/person per year
Durable medical equipment:	20% after deductible	40% after deductible
Mental health:	Inpatient - 20% after deductible Outpatient - $25/visit	40% after deductible 40% after $25 copay
Physical therapy:	$25/visit; 35 visits/person per year	40% after $25 copay; 35 visits/person per year
Vision/Hearing:	20% after deductible One preventive vision exam/per plan year	40% after deductible

For more information

Student Health Insurance Master Policy

Graduate Student Employee Health Plan

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

GSE Plan Pharmacy Benefits

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

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

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

GSE Plan Pharmacy Benefit - Prime Therapeutics			
	Generic	**Brand Formulary**	**Brand Non-Formulary**
No annual deductible			
Student Health Center	$10	$35	
Retail Pharmacy (30-Day Supply)	$10	$35	$60
Mail-Order (90-day Supply)	$30	$105	$180

AcademicLiveCare for Graduate Student Employees

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

Academic Emergency Services

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

Dental Coverage

Plan Choices

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

Enrollment Rules

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

Benefits

A&M Dental PPO

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

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

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

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

DeltaCare USA Dental HMO

The DeltaCare USA plan is not available in all parts of Texas. **The plan is only available in Texas, Tennessee, Florida, Georgia, California, Washington, D.C., Maryland, Minnesota, Colorado, New York and Utah.**

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

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

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

Delta Dental PPO

Vendor: Delta Dental

Member Services Contact Information:

Delta Dental: (800) 422-4234
Website: deltadentalins.com/tamus

Provisions	
Deductible	$75/person/plan year; $225 family/plan year
Maximum benefit	Regular: $2,000/person/plan year (not including preventive care); Orthodontia: $2,000/person/ lifetime
Your cost for preventive care	$0 (if you use a network provider). The plan covers three regular or periodontal cleanings per plan year at 100% up to the maximum allowable charges. Deductible and maximum benefit do not apply.
Your cost for basic care	You pay the deductible plus 20% of the maximum allowable charges for fillings, root canals, extractions and periodontics. Once you reach your maximum annual benefit of $2,000, you pay 100%.
Your cost for major restorative care	After you meet your deductible, you pay 50% of the maximum allowable charges for crowns, dentures and bridges. Once you reach your maximum annual benefit of $2,000, you pay 100%.
Your cost for orthodontics	After you meet your deductible, you pay 50% until you reach your maximum lifetime benefit of $2,000, then you pay 100%.
Filing Claims	PPO and Premier dentists file claims for you.
Alternate benefit provision	When more than one procedure could provide suitable treatment, the plan will pay for the least expensive procedure. You may apply this benefit to whichever procedure you wish to have.

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

Procedure: Crown	Delta Dental PPO Network Dentist	Delta Dental Premier Network Dentist	Non-Delta Dental Dentist
Dentist bills	$800.00	$800.00	$800.00
Dentist accepts as payment in full	$548.00 (Delta Dental's allowed amount)	$688.00 (Delta Dental's allowed amount)	$800 (No fee agreement with Delta Dental)
Delta Dental's payment Major benefit paid at 50%	$274.00	$344.00	$344.00
Patient share*	$274.00	$344.00	$456.00
Patient savings	$252.00	$112.00	$0.00
**Patient's share is the coinsurance, any remaining deductible, any amount over the annual maximum and any services your plan does not cover. However, when visiting a non-Delta Dental dentist, the patient share also includes the difference between the allowed amount and the dentist's submitted charge.*			

For More Information

Dental Summary Plan Description Booklet:
assets.system.tamus.edu/files/benefits/website/SPDs/SPDDental.pdf

Delta Dental HMO

Vendor: Delta Dental

Member Services Contact Information:

Delta Dental: (800) 422-4234
Website: deltadentalins.com/tamus

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

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

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

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

For More Information

Delta Dental HMO Benefits Highlights

Vision Coverage

Plan

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

Enrollment Rules

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

Benefits

The plan covers exams for a $10 copayment and has a $15 copayment for materials if you use an in-network provider. If you use a non-network provider, 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 by MetLife for reimbursement of the covered amount. If you have receipts for services and materials purchased on different dates, you must submit the receipts at the same time and within 12 months of the date of service.

	Network Benefit	Non-Network Benefit
Eye exam (one per plan year)	100% after $10 copayment.	Up to $50. Copayment doesn't apply
Materials	100% after $15 copayment for: • Frames - every plan year, up to $200. • Eyeglass lenses - 100% after $15 copay for standard single vision; standard lined trifocal, standard lined bifocal, standard lenticular and standard progressive.	Copayment doesn't apply. • Frames: Up to $120. • Lenses: $50 to $100, depending on type of lenses.
Contact lenses (once every plan year in place of eyeglass benefit)	Conventional/Disposable - $200 allowance; Medically Necessary - Covered in Full up to the Allowable Amount	Conventional/Disposable - $200 allowance; Medically Necessary - $210 Allowance
Refractive eye surgery	15% off reasonable and customary cost, or 5% off promotional price	Not applicable

For More Information

Superior Vision website:
metlife.com/info/TAMUS

Customer service: (844) 549-2603

Life Coverage

Plan Choices

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

Enrollment Rules

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

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

Benefits

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

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

Premiums

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

Accelerated Death Benefit

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

Evidence of Insurability

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

EOI is required to:

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

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

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

Once Enrolled in coverages, you have access to MetLife Advantages℠ Services

Grief Counseling (Applies to enrollees in all Plans)

To help you, your dependents, and your beneficiaries cope with loss

You, your dependents, and your beneficiaries have access to grief counseling sessions and funeral related concierge services to help cope with a loss — at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. At your time of need, you and your dependents have 24/7 access to a work/life counselor. You simply call a dedicated 24/7 toll-free number to speak with a licensed professional experienced in helping individuals who have suffered a loss. Sessions can either take place in-person or by phone. You can have up to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to death, bankruptcy, divorce, terminal illness, or losing a pet. In addition, you have access to funeral assistance for locating funeral homes and cemetery options, obtaining funeral cost estimates and comparisons, and more. You can access these services by calling 888.319.7819 or log on to one.telushealth.com (Username: metlifeassist; Password: support). Download this helpful Funeral Planning Guide at metlife.com/funeralplanning/funeral-guide/.

Funeral Discounts and Planning Services (Applies to enrollees in all Plans)

Ensuring your final wishes are honored

As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life — at no additional cost to you. Dignity Memorial provides you and your loved ones access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States.

When using a Dignity Memorial Network you have access to convenient planning services — either online at www.finalwishesplanning.com, by phone 866.853.0954, or by paper — to help make final wishes easier to manage. You also have access to assistance from compassionate funeral planning experts to help guide you.

Beneficiary Claim Assistance (Applies to enrollees in all Plans)

For support when beneficiaries need it most

This program is designed to help beneficiaries sort through the details and serious questions about claims and financial needs during a difficult time. MetLife has arranged for specially trained third party financial professionals to be available for assistance in-person or by telephone to help with filing life insurance claims, government benefits and help with financial questions.

Total Control Account (Applies to enrollees in all Plans)

For immediate access to death proceeds

The Total Control Account® (TCA) settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life or accidental death and dismemberment claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. TCA death claim payments relieve beneficiaries of the need to make immediate decisions about what to do with a lump-sum check and enable them to have the flexibility to access funds as needed while earning a guaranteed minimum interest rate on the proceeds as they assess their financial situations. Call 800.638.7283 for more information about options available to you.

Travel Assistance (Applies to enrollees in all plans)

A travel assistance benefit is available when you enroll in MetLife's Voluntary AD&D coverage

Travel assistance services, offered on Voluntary AD&D coverage, offers you and your family access to emergency services while you travel, plus the advantage of concierge assistance for personal and work-related travel and entertainment requests. This service provides you and your dependents with medical, legal, transportation and financial assistance 24 hours a day, 365 days a year when you are more than 100 miles away from home. Our travel assistance program offers worldwide telemedicine consultations when nonurgent medical care is needed. It also offers a dedicated travel portal – making it easy to connect when it matters most. You also have access to political and natural disaster evacuation services. Please visit the AXA website for more information.

Estate Planning Services (Applies to enrollees in Optional Life)

To help ensure your decisions are carried out

When you enroll for optional term life coverage, you will automatically receive access to Estate Planning Services at no extra cost to you. Estate Planning Services offers unlimited access to Digital Estate Planning services to complete wills and other important estate planning documents quickly and easily online with access to online notary services, and Will Preparation Services to work one-on-one with a MetLife Legal Plans' attorney, in-person or on the phone, to prepare or update a will, living will, or power of attorney. When you use a participating plan attorney, there will be no charge for the services.

- A will lets you define your most important decisions, such as who will care for your children or inherit your property.
- A living will ensures your wishes are carried out and protects your loved ones from having to make very difficult and personalmedical decisions by themselves. Also called an "advanced directive," it is a docment authorized by statutes in all states that allows you to provide written instructions regarding use of extraordinary life-support measures and to appoint someone as your proxy or representative to make decisions on maintaining extraordinary life-support if you should become incapacitated and unable to communicate your wishes.
- Powers of attorney allow you to plan ahead by designating someone you know and trust to act on your behalf in the event of unexpected occurrences or if you become incapacitated

Visit www.legalplans.com/estateplanning to get started. You also have the flexibility of using an attorney who is not participating in the MetLife Legal Plans, Inc.network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney's fees that exceed the reimbursed amount.

Digital Estate Planning (Applies to enrollees in all Plans)

Estate planning made easy

You have access to Digital Estate Planning services to create key estate planning documents online in as little as 15 minutes by answering a few simple questions. Documents include Last Will and Testament, Advance Healthcare Directive (Living Will), and Durable Financial Power of Attorney. Visit www.willscenter.com to get started.

Estate Resolution Services (ERS) (Applies to enrollees in Optional Life)

Personal service and compassion assistance to help probate your and your spouse's estates. MetLife Estate Resolution Services℠ provides probate services in person or over the phone to the representative (executor or administrator) of the deceased employee's estate and the estate of the employee's spouse. Estate Resolution Services include preparation of documents and representation at court proceedings needed to transfer the probate assets from the estate to the heirs and completion of correspondence necessary to transfer non-probate assets. ERS covers participating plan attorneys' fees for telephone and face-to-face consultations or for the administrator or executor to discuss general questions about the probate process.

Life Coverage	
Basic Life/Basic AD&D Coverage for you: Child Coverage:	You are automatically covered if you are enrolled in an A&M System medical plan. $50,000 in life insurance and $50,000 in AD&D coverage $5,000 in life insurance on each eligible dependent child.
Alternate Basic Life/ Basic AD&D Coverage for you: Child Coverage:	If you are not enrolled in A&M System medical coverage, but certify that you have other medical coverage, you can pay for Alternate Basic Life using the employer contribution. If you select this coverage, you cannot enroll in Optional Life. $50,000 and $5,000 in Basic AD&D 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.
Dependent Life Plan A Spouse Coverage: Child 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. Coverage over $50,000 requires EOI within initial 31 day enrollment period or within 31 days of marriage. Enrollments outside of those time periods require EOI for all coverage amounts. The spouse coverage amount may not be greater than the employee coverage amount. $10,000 per child.
Dependent Life Plan B Spouse coverage: Child Coverage:	 $5,000 in life and $5,000 in AD&D coverage; if spouse is enrolled. $5,000 in life insurance on each eligible enrolled dependent child.
Dependent Life Plan C Spouse coverage: Child Coverage:	You can enroll your dependents if you have **Alternate Basic Life** coverage. You pay for the coverage yourself. 50% of your Alternate Basic Life coverage amount, if spouse is enrolled. $5,000 on each enrolled child.

- If you had coverage prior to September 1, 2009 your dependent coverage amount(s) may be greater than the above referenced maximums.
- You must provide evidence of insurability to enroll in or increase Life insurance coverage for you or your spouse.

Naming a Beneficiary

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

For more information

MetLife microsite: metlife.com/info/TAMUS

Accidental Death and Dismemberment

Plan Choices

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

If your annual pay is $25,000 or less, you can buy coverage of up to $250,000 in multiples of $10,000. If your annual salary is more than $25,000, you can buy up to 10 times your salary with a maximum coverage amount of $800,000.

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

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

Enrollment Rules

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

Benefits

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

Coma Benefit

The AD&D plan will pay a coma benefit if you or a covered family member lapses into a coma as a result of and within 365 days of a covered accidental injury if the coma lasts for a minimum of 31 days. A monthly benefit is equal to a percentage of your amount of AD&D insurance will be paid for up to 11 months or until the person recovers, whichever occurs earlier.

Felonious Assault Benefit

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

Child Care Benefit

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

COBRA Benefit (Medical Continuation)

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

Education Benefit

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

Seat Belt and Air Bag Benefit

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

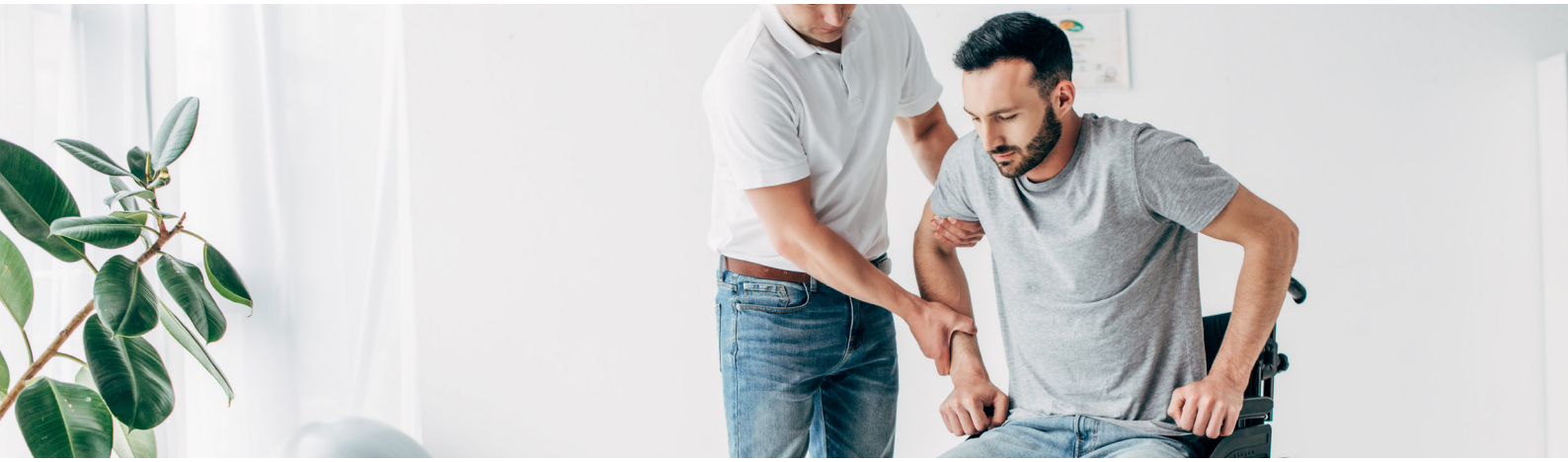
Naming a Beneficiary

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

For more information

AD&D Summary Plan Description:
assets.system.tamus.edu/files/benefits/website/SPDs/SPDADD.pdf

Long Term Disability



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

Enrollment Rules

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

Benefits

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

Definition of Disability

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

Monthly Benefit Limits

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

Elimination Period

90 days from onset of continuous disability

Pre-Existing Condition

We will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condtion" means any injury or sickness for which you incurred expenses, received medical treatment, care or services including diganostic measures, or took prescribed drugs or medicines within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective dae of any added or increased benefits.

Non-organic Mental Impairments

Maximum benefit period of 24 months.

Reducing Benefit Duration

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

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

Catastrophic Disability

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

For More Information

LTD Plan Description Booklet:
assets.system.tamus.edu/files/benefits/website/SPDs/SPDLTD.pdf

New York Life website:
mynylgbs.com

New York Life claim office:
(800) 362-4462

Flexible Spending Accounts

Plan Choices

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

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

Health Care Spending Account:

- Maximum contribution: $3,400/year

Dependent Day Care Spending Account:

- Maximum contribution: $7,500/year ($3,750 if married and filing a separate income tax return)

Enrollment Rules

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

Changing your elections

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

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

Benefits

Health Care Account

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

Dependent Day Care Account

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

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

You can use the spending account for the same day care expenses that are eligible for a tax credit. However, you cannot use both the account and the tax credit for the same expense. Consult your tax advisor or visit Naviabenefits.com to determine which works best for you.

Restrictions

Both types of accounts carry certain restrictions.

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

Using the Spending Accounts

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

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

Health Care Spending Account	
Covered Expenses	**Non-Covered Expenses**
• Copayments and deductibles • Orthodontia • Glasses, contact lenses and supplies (such as saline solution and enzyme cleaner) • LASIK surgery • Smoking cessation programs • Dental care • Hearing aids *For a list of eligible and ineligible expenses, visit* naviabenefits.com/participants/resources/expenses/?benefit=health-care-fsa	• Health insurance premiums • Nicotine patches or diet pills* • Exercise programs and equipment* • Medical or dental cosmetic surgery or drugs* **Unless prescribed for treatment of an illness or injury.*

Dependent Day Care Spending Account	
Covered Expenses	**Non-Covered Expenses**
• Day care fees for children 12 or younger or older disabled dependents • Babysitting fees (work-related only)	• Tuition and fees for private school, grades kindergarten through 12th • Overnight camps and extracurricular lessons • Supply fees • Club or organization membership fees

Debit Card

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

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

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

PIN

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

Grace Period

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

Paper Claims

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

Filing Deadline

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

For More Information

FSA Plan Description Booklet:
assets.system.tamus.edu/files/benefits/website/SPDs/SPDFSA.pdf

Navia website:
naviabenefits.com

Customer Service:
(800) 669-3539

Retirement Programs

Mandatory Plan Choices

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

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

Contribution Rules

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

Teacher Retirement System of Texas (TRS)

You contribute 8.25% of your pay to TRS on a before-tax basis and the A&M System contributes a legislated amount.

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

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

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

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

Optional Retirement Program (ORP)

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

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

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

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

No loans or hardship withdrawals are permitted under ORP.

Retiree Insurance Eligibility

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

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

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

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

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

**An intact ORP account is a 403(b) account containing funds that can be tied to a Texas ORP account. An IRA is not an intact ORP account.*

Voluntary Plan Choices

Tax-Deferred Accounts and Deferred Compensation Plans

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

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

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

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

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

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

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

Enrollment Rules

Tax Deferred Accounts

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

Texa$aver DCP

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

Beneficiary Designation

You must add beneficiaries to your retirement accounts. Your beneficiary election in Workday does not pertain to your mandatory or voluntary retirement plans. If you do not designate a beneficiary for each account, in the event of your death, benefits would be paid according to plan rules, which might differ from the designation you would choose. Visit your vendor to find out how to designate your beneficiar(ies)

Important things to remember:

The **Primary Beneficiary** is your first choice to receive the value of your account.

The **Contingent Beneficiary** is your second choice to receive the value of your account if the beneficiary(ies) are not living at the time of your passing. Do not enter the same name(s) you have entered as primary beneficiary(ies).

A list of approved ORP/TDA vendors can be found at tamus.edu/benefits/retirement-programs/orptda-approved-vendors/. For the TRS website visit, trs.texas.gov.

Health and Wellness Programs

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

WebMD ONE

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

WebMD ONE offers variety of benefit resources:

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

To register, go online to webmdhealth.com/tamus and enter your UIN and information from your BCBSTX insurance card. Graduate Student Employees enrolled in the Grad Plan are not eligible for the wellness premium credit because they are already receiving the lower premium. If you are new employee, WebMD ONE is available 3-4 weeks after your coverage start date. Newly enrolled employees and spouses have a grace period of the current plan year plus one additional year to complete their two steps.

2nd.MD

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

Accolade Care

With Accolade Care, you can see and speak with a board-certified doctor or therapist right from your phone, tablet or computer. You have access to doctors who have trained at the top 50 U.S. medical schools, same-day virtual visits, physical and mental health support, and 24/7 support from your care team.

Accolade Care will support you and your family with:

- Urgent medical issues: cold and flu, urinary tract infections, sinus and baterial infections and rashes.
- Ongoing Conditions: diabetes, high blood pressure, asthma, thyroid disorders.
- Everyday care: prescription and refills, birth control, HIV Prevention (PrEP).
- Mental Health: anxiety, depression, sleep disorders, grief and loss, trauma.

Accolade Care will provide you access to: doctors trained at the top 50 U.S medical schools, same day virtual primary care appointments, and physical and mental health support, 24/7 support from your care team. You can book your appointment at AccoladeCare.com.

Accolade Care is available to employee, spouses, and dependents enrolled in the A&M Care or J Medical Plan. Graduate student employees in the Graduate Student Plan and retirees enrolled in the A&M Care Plan that are Medicare Primary or the 65 Plus Medicare Advantage Plan (PPO) are not eligible.

Work/Life Solutions by GuidanceResources

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

Hinge Health

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

The program includes:

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

For more information, visit hingehealth.com/tamus.

Wondr

Wondr is a 100% digital weight-loss program that will teach you clinically proven skills through weekly master classes. You will learn how to eat your favorite foods and still lose weight, increase energy, stress less, and so much more. Wondr is not a diet, it's a program that works for everyone without points, plans, or calories to count.

There is no cost to use the program. In order to participate in Wondr, you must be an employee, spouse, or dependent who is 18 years or older enrolled in the A&M Care Plan or J Plan. For more information and eligibilty information, visit wonderhealth.com/tamus.

Teladoc Health for Diabetes

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

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

For more information on Teladoc Health for Diabetes or to register, visit teladochealth.com/register/tamus.
You may also register by phone at 800-835-2362. The registration code is **TAMUS**.

Cylinder

Cylinder is a benefit to help you maintain a healthy gut. A healthy gut helps maintain overall health, weight management, sleep quality, joint health, how we manage stress and anxiety, and more.

What can Cylinder do for you:

Provide relief from common digestive issues. Do you experience gas? Bloating? Heartburn? The Cylinder app, together with a dedicated Cylinder Dietitian, can help you ease common symptoms without giving up all the foods you love.

At-home gut microbiome kit and analysis ($150 value at no cost to you). Discover which bacteria are living in your gut, and work with a dedicated Dietitian to understand what that means for your health, based on the latest science.

Relief from stress and anxiety. Your gut is where 95% of serotonin is produced – commonly known as the happiness hormone. Cylinder includes direct access to a Care Team who will share proven tools for managing stress and anxiety.

Virtual visits with physicians. No co-pays, no commute, no waiting rooms. Complete care for digestive health symptoms and conditions. Access to physicians including internists and gastroenterologists, all through the app.

Open to employees and covered dependents (age 18+) enrolled in the A&M Care Plan or J Plan.
For more information visit, https://go.cylinderhealth.com/tamus.

Hello Heart

The Hello Heart app lets you track your blood pressure and easily manage your heart health all in one place. This benefit is offered at no cost to eligible members and includes a free Hello Heart monitor that pairs directly with your smartphone.

What do you get with Hello Heart?

- An app to help you track blood pressure, cholesterol, medication, and more.
- Clear explanations of what your numbers mean.
- Personalized tips that make it simple to maintain a healthy heart.
- Progress reports that are easy to review or share with your physician.
- Assistance from our support team via phone or email.

For more information or to register, visit join.helloheart.com/TAMUS. Hello Heart is available to all employees and their covered dependents who are enrolled in the A&M Care, or J plans. Retirees enrolled in the 65 Plus Medicare Advantage Plan (PPO) are not eligible.

Virta Health

Virta is a virtual clinic that helps members create plans for better health with support from health care clinicians, coaches, and digital health tools. With Virta, you may reverse type 2 diabetes, lose weight, reduce medications, and save money.

What Virta members receive:

- A nutrition therapy plan backed by clinical research
- Tips to make meals tasty and healthier
- Personalized clinician care and coaching
- Daily support via mobile/desktop app
- Meter, scale, and testing supplies

Virta is available to A&M System employees, spouses, or dependents with Type 2 diabetes (ages 18+) who are enrolled in the A&M Care or J Plan. There are some medical conditions that would exclude patients from the Virta treatment. To check for eligibility and learn more, visit virtahealth.com/join/tamus.

Maven Women's Health and Family Planning (available Sept 1)

Maven is the virtual clinic that understands your world, and brings you closer to a happy, healthy future. Our specialists are here to support you, day and night, with answers you can trust. Same-day video visits, 24/7 (no cost to you, no long waits). You and your partner will have unlimited access to Maven as your virtual health benefit for pregnancy, postpartum, parenting, pediatrics, menopause and midlife support.

Maven can help you:

- Through pregnancy and birth of your child
- Navigating parenthood
- Managing menopause and midlife

Available to all employees, retirees and their covered dependents enrolled in the A&M Care Plan or J Plan. Graduate student employees in the Graduate Student Plan and retirees enrolled in the 65 Plus Medicare Advantage Plan (PPO) are not eligible.

Learn more at mavenclinic.com/lp/maven-benefits-signup

WIN Fertility

WINFertility is a fertility solution to help you navigate your journey with compassion, education, guidance and emotional support. WINFertility provides individualized support including:

- 24/7 nurse care advocate support assistance selecting an in-network provider
- Expertise in understanding complex information
- Convenient nurse access through the WINFertility Companion app

Fertility Benefit: A lifetime maximum of 2 cycles toward eligible expenses related to fertility treatment with unlimited coverage for related fertility medications.

Coverage Requirement: 12-months of enrollment in the A&M Care plan or J Plan is required for the individual receiving treatment.

Download the WINFertility Companion App to take advantage of your benefits on the go! Use the **TAMUS23** employer code when creating your account. This benefit is available to employees and eligible dependents enrolled in the A&M Care or J Plan. For additional information, please visit managed.winfertility.com/tamus or contact customer support at (866) 898-1458.

ID Protection

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

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

Blue Points

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

Inside Rx Pets

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

Inside Rx Pets provides you with:

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

For more information, visit insiderxpets.com.

Learn to Live

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

Fitness Program

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

SAVI provided through TIAA

Reducing your monthly student loan payment and working toward loan forgiveness could be getting much easier. You and your family members have access to Savi, a robust tool that helps you find the best federal repayment and forgiveness programs for your financial situation. Borrowers working with Savi can save an average of $187 on their student loan payments.

Employees can unlock a world of options with Savi’s three distinct plan levels.

- **DIY:** Dive in with totally free access to a personalized repayment calculator, forgiveness detection, and SAVI workshops.
- **Essential:** Step up to a premium tier! Have access to digitized applications and enjoy the comfort of one-on-one customer support.
- **Pro:** Elevate your experience with a personalized onboarding session and dedicated SAVI phone support.

For more information, visit tiaa.org/tamus/student for more information.

Premiums

September 1, 2026

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

Health

		Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
		Total Cost	**Your Cost**	Total Cost	**Your Cost**	Total Cost	**Your Cost**	Total Cost	**Your Cost**
A&M Care	Monthly	$1,150.00	$30.00	$1,800.44	$370.22	$1,581.08	$245.54	$2,053.14	$496.58
	Bi-Weekly	$1,150.00	$15.00	$1,800.44	$185.11	$1,581.08	$122.77	$2,053.14	$248.29
J Plan	Monthly	$1,120.00	$0.00	$1,740.44	$310.22	$1,551.08	$215.54	$1,993.14	$436.58
	Bi Weekly	$1,120.00	$0.00	$1,740.44	$155.11	$1,551.08	$107.77	$1,993.14	$218.29

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

		Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
		Total Cost	**Your Cost**	Total Cost	**Your Cost**	Total Cost	**Your Cost**	Total Cost	**Your Cost**
A&M Care	Monthly	$1,150.00	$593.14	$1,800.44	$1088.46	$1,581.08	$916.44	$2,053.14	$1,277.98
	Bi-Weekly	$1,150.00	$296.57	$1,800.44	$544.23	$1,581.08	$458.22	$2,053.14	$638.99
J Plan	Monthly	$1,120.00	$563.14	$1,740.44	$1,028.46	$1,551.08	$886.44	$1,993.14	$1,217.98
	Bi-Weekly	$1,120.00	$281.57	$1,740.44	$514.23	$1,551.08	$443.22	$1,993.14	$608.99
Graduate Plan	Monthly	$262.50	$0.00	$525.00	$0.00	$696.00	$31.36	$958.50	$183.34
	Bi Weekly	$262.50	$0.00	$525.00	$0.00	$696.00	$15.68	$958.50	$91.67

Dental

		Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
A&M Dental PPO	Monthly	$32.54	$65.04	$68.30	$104.06
	Bi-Weekly	$16.27	$32.52	$34.15	$52.03
DeltaCare USA Dental HMO	Monthly	$21.72	$38.60	$38.90	$60.42
	Bi-Weekly	$10.86	$19.30	$19.45	$30.21

Vision

	Employee Only	***Employee & Spouse***	***Employee & Child(ren)***	***Employee & Family***
Monthly	$8.36	$17.72	$13.70	$24.44
Bi-Weekly	$4.18	$8.86	$6.85	$12.22

AD&D

Rate per $10,000:

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

Long-Term Disability

Rate per $100 of monthly salary:

	Non-Tobacco Rate	*Tobacco Rate*
Monthly	$.163	$.210
Bi-Weekly	$.0815	$.105

Flexible Spending Account

Maximum you can deduct from your pay:

Health Care Spending Account - $3,400
Dependent Daycare Spending Account - $7,500

Basic Life

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

Basic Life: $6.27

Alternate Basic Life: $.70 per $1,000 of coverage

Optional Life

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

	Age =	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Non-Tobacco Rate	Monthly	$.036	$.036	$.036	$.043	$.050	$.102	$.170	$.306	$.476	$.646	$1.216	$1.700
Tobacco Rate	Monthly	$.085	$.085	$.085	$.102	$.119	$.204	$.340	$.612	$.952	$1.292	$2.431	$3.400

Dependent Life

Plan A: Spouse Age-based rate per $1,000 of coverage; Child: $.051 per $1,000 of coverage Spouse Plan B: $.895/month (flat rate) for $5,000 in DL and AD&D
Child Plan B: $0.270/month (flat rate) for $5,000 in DL and AD&D
Plan C: ½ Alternate Basic Life premium; 1/10 if no spouse is covered

	Age =	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Non-Tobacco Rate	Monthly	$.043	$.051	$.068	$.077	$.085	$.128	$.196	$.366	$.561	$1.080	$1.751	$1.751
Tobacco Rate	Monthly	$.051	$.061	$.082	$.092	$.102	$.153	$.235	$.439	$.673	$1.295	$2.101	$2.101

Premiums – 9 Month Full-Time Employee

September 1, 2026

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

Health

		Employee Only		***Employee & Spouse***		***Employee & Child(ren)***		***Employee & Family***	
		Total Cost	**Your Cost**	*Total Cost*	**Your Cost**	*Total Cost*	**Your Cost**	*Total Cost*	**Your Cost**
A&M Care	9-Months	$1,533.33	$40.00	$2,400.59	$493.63	$2,108.11	$327.39	$2,737.52	$662.11
J Plan	9-Months	$1,493.33	$0.00	$2,320.59	$413.63	$2,068.11	$287.39	$2,657.52	$582.11

Dental

		Employee Only	***Employee & Spouse***	***Employee & Child(ren)***	***Employee & Family***
A&M Dental PPO	9-Months	$43.39	$86.72	$91.07	$138.75
DeltaCare USA Dental HMO	9-Months	$28.96	$51.47	$51.87	$80.56

Vision

	Employee Only	***Employee & Spouse***	***Employee & Child(ren)***	***Employee & Family***
9-Months	$11.15	$23.63	$18.27	$32.59

AD&D

Rate per $10,000:

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

Long-Term Disability

Rate per $100 of monthly salary:

	Non-Tobacco Rate	***Tobacco Rate***
Monthly*	$.163	$.210

Flexible Spending Account

Maximum you can deduct from your pay:

Health Care Spending Account - $3,400
Dependent Daycare Spending Account - $7,500

Basic Life

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

Basic Life: $6.27

Alternate Basic Life: $.70 per $1,000 of coverage

Optional Life

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

	Age =	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Non-Tobacco Rate	Monthly	$.036	$.036	$.036	$.043	$.050	$.102	$.170	$.306	$.476	$.646	$1.216	$1.700
Tobacco Rate	Monthly	$.085	$.085	$.085	$.102	$.119	$.204	$.340	$.612	$.952	$1.292	$2.431	$3.400

Dependent Life

Plan A: Spouse Age-based rate per $1,000 of coverage; Child: $.051 per $1,000 of coverage Spouse Plan B: $.895/month (flat rate) for $5,000 in DL and AD&D
Child Plan B: $0.270/month (flat rate) for $5,000 in DL and AD&D
Plan C: ½ Alternate Basic Life premium; 1/10 if no spouse is covered

	Age =	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Non-Tobacco Rate	Monthly	$.043	$.051	$.068	$.077	$.085	$.128	$.196	$.366	$.561	$1.080	$1.751	$1.751
Tobacco Rate	Monthly	$.051	$.061	$.082	$.092	$.102	$.153	$.235	$.439	$.673	$1.295	$2.101	$2.101

Premium Worksheet

1. Medical

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

$_____

2. Dental

Enter premium amount.

$_____

3. Vision

Enter premium amount.

$_____

4. Optional Life *

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

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

$_____

5. Dependent Life

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

Plan B Premium: $.895 spouse/$.27 child

Plan C Premium: ½ your Alternate Basic Life premium

$_____

6. Accidental Death and Dismemberment

Choose your coverage amount and divide by 10,000: _____ × your premium of _____= (Max coverage is the greater of $250,000 or 10 times your annual salary, not to exceed coverage of $800,000.)

$_____

7. Long-Term Disability *

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

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

$_____

8. Spending Accounts

Enter your Health Care Account monthly contribution

$_____

Enter your Dependent Day Care Account monthly contribution

$_____

Your total monthly cost (add 1-8)

$_____

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

Alternate Basic Life: $.700 per $1,000 of coverage

$_____

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

$_____

Subtract the state contribution: full-time: $563.14; part-time: $281.57

$_____

Your total montly cost

$_____

** THE PREMIUMS MAY INCREASE BASED ON YOUR SALARY.*

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

Effective as of February 16, 2026

THE TEXAS A&M UNIVERSITY SYSTEM BENEFITS ADMINISTRATION NOTICE OF PRIVACY PRACTICES

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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOU HAVE THE RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH THE DIRECTOR OF BENEFITS ADMINISTRATION AT (979) 458-6330 OR employeebenefits@tamus.edu **IF YOU HAVE ANY QUESTIONS.**

Commitment to Protecting Health Information About You

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

Your Rights

You have the right to:

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

Your Choices

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

Uses and Disclosures

Benefits Administration may use and share your information to:

- Pay for your health services
- Administer the Plan
- Help manage the health care treatment you receive
- Run its organization
- Help with public health and safety issues
- Provide data for research purposes under certain limited circumstances
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government inquiries
- Respond to lawsuits and legal actions

These are explained further on the following pages.

Your Rights

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

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

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

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

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

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

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

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

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

Your Choices

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

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

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

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

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

Uses and Disclosures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Benefits Administration can share health information about you with organ procurement organizations. It can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Act in response to workers' compensation, law enforcement, and other government requests.

- Benefits Administration can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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

Other Uses or Disclosures That Require Your Authorization

Uses and disclosures of your protected health information not mentioned will be made only with your written authorization, unless otherwise permitted or required by law. You may provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.

Substance Use Disorder Treatment Records: Substance use disorder treatment records received from programs subject to the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR part 2 ("Part 2"), or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, as provided in Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the Plan would use or disclose the record.

If we ask for your authorization, we must provide you with a copy of the authorization after you have signed it. You may revoke an authorization at any time by delivering to us a written notice of revocation, except to the extent that we have already taken action in reliance on the authorization or if we are permitted by law to use the information to contest a claim or coverage under your health plan.

Benefits Administration Responsibilities

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

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

Changes to this Notice

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

Privacy Official

You can contact the Plan's Privacy Official at:

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

Protection of Personal Health Information

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

A Word About Security

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

Medicare Part D Notice of Creditable Coverage

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

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

You should know:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Texas A&M University System has determined that the prescription drug coverage offered by the A&M Care Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

However, if you are enrolled in the A&M Care 65 Plus Medicare Advantage Plan (PPO) you cannot also be enrolled in an outside Part D or Advantage plan as the Express Scripts prescription drug plan included as part of the 65 Plus Medicare Advantage Plan (PPO) is a Medicare Part D plan.

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

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

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

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

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

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

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

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

Contacts and Resources

Human Resources Offices		
Texas A&M University	(979) 862-1718	benefits@tamu.edu
Texas A&M Health Science Center	(979) 862-1718	benefits@tamu.edu
Prairie View A&M University	(936) 261-1730	benefitsteam@pvamu.edu
Tarleton State University	(254) 968-9128	benefits@tarleton.edu
Texas A&M University-Central Texas	(254) 519-8015	hr@tamuct.edu
Texas A&M International University	(956) 326-2365	benefits@tamiu.edu
East Texas A&M University	(903) 886-5049	hr.benefits@tamuc.edu
Texas A&M University-Corpus Christi	(361) 825-2630	benefits@tamucc.edu
Texas A&M University at Galveston	(979) 862-1718	benefits@tamu.edu
Texas A&M University-Kingsville	(361) 593-3398	theresa.perez@tamuk.edu
Texas A&M University-Texarkana	(903) 223-3113	hr@tamut.edu
Texas A&M Transportation Institute	(979) 317-2055	humres@tti.tamu.edu
Texas A&M University-San Antonio	(210) 784-2058	benefits@tamusa.edu
Texas A&M Forest Service	(979) 845-9337	agrilifebenefits@ag.tamu.edu
Texas A&M AgriLife/Extension/TVMDL	(979) 845-2423	agrilifebenefits@ag.tamu.edu
Texas A&M Engineering	(979) 458-7699	engrbenefits@tamu.edu
Texas A&M Engineering Extension Service	(979) 458-6801	Benefits@teex.tamu.edu
Texas Division of Emergency Management	(979) 458-6330	employeebenefits@tamus.edu
West Texas A&M University	(806) 651-2117	benefits@wtamu.edu
Texas A&M University - Victoria	(979) 458-6330	employeebenefits@tamus.edu
System Offices	(979) 458-6330	employeebenefits@tamus.edu

Carrier Phone Numbers and Websites		
Blue Cross and Blue Shield of Texas: A&M Care, J Plan	(866) 295-1212	bcbstx.com/tamus
Delta Dental - A&M Dental PPO	(800) 521-2651	deltadentalins.com/tamus
DeltaCare USA Dental HMO	(800) 422-4234	deltadentalins.com/tamus
Superior Vision by Metlife	(866) 549-2322	metlife.com/info/TAMUS
Express Scripts - A&M Care Drug Program	(866) 544-6970	express-scripts.com
MetLife - Life Insurance and AD&D	(866) 549-2322	metlife.com/info/TAMUS
New York Life Long-Term Disability	(800) 362-4462	mynylgbs.com
Academic Health Plan - GSE Plan	(877) 624-7911	tamus.myahpcare.com
Prime Therapeutics - GSE Plan Prescriptions	(800) 423-1973	primetherapeutics.com
Navia - Flexible Spending Accounts	(800) 669-3539	naviabenefits.com
GuidanceResources	(866) 301-9623	guidanceresources.com
2nd.MD	(866) 841-2575	2nd.md/activate/step1/tamus

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

Understanding Benefits Language

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Network Provider/In-network Provider
A healthcare provider who is part of a plan's network.

Non-Network Provider/Out-of-Network Provider
A healthcare provider who is not part of a plan's network. Costs associated with out-of-network providers may be higher or some costs may not be covered by your plan.

Texas A&M System Benefits

Moore/Connally Building
301 Tarrow St., 5th Floor
College Station, TX 77840
979.458.6330
employeebenefits@tamus.edu