



2024-2025 TAMUS Retiree Benefits Guide

Medical
Dental
Vision
Life Insurance
Wellness



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The Texas A&M University System is committed to offering its retirees a comprehensive benefits package at a competitive cost. This package includes medical, dental, vision, life insurance, accidental death & dismemberment, employee assistance 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.

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

Understanding Benefits Language

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

Brand Name Medications

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

Coinsurance or Cost Sharing

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

Copayment (Copay)

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

COBRA

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

Deductible

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

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.

Non-Preferred or Non-Formulary Drugs

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

Out-of-Pocket Maximum

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

Primary Care Physician (PCP)

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

Preferred or Formulary Drugs

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

Reasonable and Customary Fee/Allowed Amount

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

Network Provider/In-network Provider

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

Non-Network Provider/Out-of-Network Provider

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

Benefit Eligibility and Coverage Information

Eligibility

You are eligible for retirement or survivor benefits as an A&M System retiree or survivor.

Dependent Coverage

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

Eligible Dependents include:

- Your dependent children up to age 26 (regardless of marital status); including a natural child, stepchild, a legally adopted child, foster child, or grandchildren you claim on your income tax.
- Managing Conservatorship/Legal Guardian dependents up to age 18 unless accepted court order states otherwise.

Examples of dependents who are not eligible for coverage include:

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

Dependent Documentation

In order for your dependents to have coverage, their **dependent documentation must be submitted and approved within 31 days of the change prior to the effective date of coverage.** All foreign documents should be accompanied by an English translation.

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

Documentation needed to qualify your dependents for coverage:

Legal Marriage Documents

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

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

Common Law Marriage Documents

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

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

Biological Child Documents

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

Step Child Documents

Child's birth certificate showing the child's parent is the employee's spouse, **AND** proof of marriage which includes the marriage certificate showing legal marriage between the employee and the child's parent **AND** proof of joint ownership dated less than a month old. In lieu of the marriage certificate and proof of joint ownership, you can provide your most recent filed Federal Tax Return with signature page or e-file confirmation (financial information can be redacted).

Adopted Child Documents

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

Disabled/Incapacitated Child age 26 or older

A doctor's statement regarding the physical or mental condition of the dependent, whether the dependent is able to maintain self-sustaining employment and whether the condition occurred before the child reached age 26.

In order for the medically incapacitated dependent to be enrolled in coverage when he/she is age 26 or older, the following documentation must be submitted either before the child/grandchild reaches age 26 if currently enrolled or at the time of enrollment:

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

Grandchild Documentation

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

Foster Child Documentation

Official Court or Agency Placement papers.

Legal Guardianship Documentation

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

Managing Conservatorship Documentation

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

Benefits Enrollment

If you are retiring from active employment with the A&M System or another State Agency or Institution, your employer contribution will begin immediately for you and your enrolled dependents.

If you are returning to retire from an outside company, your employer contribution will begin the 1st of the month after 90 days. You will pay the total monthly premium for you and your enrolled dependents if you begin your coverage prior to the employer contribution date.

Current Retiree

Open Enrollment is held each year during the month of July. During this time you may add, change, or drop coverage for yourself and/or your dependents using Workday. Elections and/or changes made during this time will be effective the following September 1. If Optional Life or Spouse Life insurance changes are made during Open Enrollment and 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 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 or is retired from 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, and Vision, in that order. You may not use the employer contribution to pay for Optional Life or Dependent Life.

If you both are retirees from the A&M System

If you and your spouse are both retired from the A&M System:

- You can be covered as an retiree on some coverages and as a dependent on others but you cannot be covered as an retiree 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.
- 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 retiree covered as a dependent will receive half of the employee-only employer contribution, which can be used to purchase other coverages for the retiree, 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 retirees.
- 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 retiree 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 retiree only 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 Retire from 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.

- **During a Life Event:** Select the Benefits app from the Workday Menu and click on the "Benefits" button in the Change column. You will be prompted to select a Change Reason and corresponding date.
- **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:** Create dependent profile in Workday. Click on Menu > Benefits > Dependents button > Add button. Enter the dependent's name and **required information** (date of birth and social security number) Repeat for each dependent.
- **Step 2:** Provide dependent documentation. Once you have created the dependent profile in Workday. Upload dependent documentation to HR Connect 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.

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 retiree 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.

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

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, or AD&D within **31 days of a Qualifying Life Event**. For example, if your spouse gains other medical coverage, you cannot drop your spouse from your dental or vision coverage.

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

Qualifying Life Events include:

- Retiree's marriage or divorce or death of retiree's spouse
- Birth, adoption or death of a dependent child
- Change in retiree'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 retiree's, spouse's or a dependent child's residence that affects eligibility for coverage
- Retiree's receipt of a qualified medical child support order or letter from the Attorney General ordering the retiree 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 retiree, 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 retiree's, spouse's or dependent child's coverage
- The retiree or dependent reaching the lifetime maximum for all benefits from a non-A&M System medical plan (medical plan changes only)
- The retiree 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

Coverage for Survivors

Survivor(s) of deceased employees or retirees may be eligible for coverage beyond the time period allowed through COBRA regulations. Coverage in all cases depends on the survivor having been covered at the time of the 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/retirees, but survivors are not eligible for the employer contribution.

Indefinite Coverage for Survivors

Indefinite coverage for survivor(s) is available if:

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

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

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

Medical Plan Overview

Plan Choices: A&M Care and 65 Plus Medicare Advantage Plan (PPO)

A&M Care Plan - available to all retirees

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

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

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

Enrollment Rules

If you do not enroll during your initial enrollment period, you can only enroll yourself and dependents 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 65 Plus Medicare Advantage Plan (PPO), Express Script's online resource, My Rx Choices, allows members to:

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

A&M Care Plan

Vendor: Blue Cross Blue Shield of Texas (BxBSTX)

Member Services Contact Information:

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

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

Website: bcbstx.com/tamus

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

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

	Network Provider	Brazos Valley Network (BVN) (discounts end April 30, 2025)	Baylor Scott & White Health (BSW)(discounts end April 30, 2025)	Non-Network
Limitations and Restrictions				
Pre-existing condition limitations:	None	None	None	None
Benefit Maximum:	None	None	None	None
Out-of-service area restrictions:	Emergency care - must notify BCBSTX within 48 hours	Emergency care - must notify BCBSTX within 48 hours	Emergency care - must notify BCBSTX within 48 hours	Emergency Care
Maximums and Deductibles				
Deductibles:	\$400 Medical/\$50 Rx	\$400 Medical/\$50 Rx	\$400 Medical/\$50 Rx	\$800 Medical/\$400 Hospital
Out-of-pocket maximum:	\$5,000 + the \$400 medical deductible above \$10,000 + \$1,200 family deductible	\$5,000 + the \$400 medical deductible above \$10,000 + \$1,200 family deductible	\$5,000 + the \$400 medical deductible above \$10,000 + \$1,200 family deductible	\$10,000 + \$800 deductible per person \$20,000 + \$2,400 family deductible
Benefit maximum:	No annual/lifetime maximums, except those listed below			
Hospital Benefits				
In-Hospital care:	20% after deductible	10% after deductible	10% after deductible	\$400/admission + deductible, then 50%
Emergency Room:	\$200 copay (waived if admitted to the hospital) + 20% after deductible	\$200 copay (waived if admitted to the hospital) +10% after deductible	\$200 copay (waived if admitted to the hospital) +10% 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	10% after deductible	10% after deductible	50% after deductible 50% after deductible
Non-Hospital Visits				
*Office visits:	Primary Care: \$20/visit Specialist: \$30/visit Certain surgeries: 20% after deductible	Primary Care: \$5/visit Specialist: \$15/visit	Primary Care: \$20/visit Specialist: \$15/visit	50% after deductible

	Network Provider	Brazos Valley Network (BVN) (discounts end April 30, 2025)	Baylor Scott & White Health (BSW) (discounts end April 30, 2025)	Non-Network
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A&M Care Plan Information (cont)

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

Other Healthcare Benefits

*Chiropractic care:	\$30/visit; 30 visits/plan year	\$15/visit; 30 visits/plan year	\$15/visit; 30 visits/plan year	50% after deductible; 30 visits/plan year
Durable medical equipment:	20% after deductible	10% after deductible	10% after deductible	50% after deductible
*Maternity care:	Hospital: 20% after deductible; Doctor: \$20 initial visit only	Hospital: 10% after deductible; Doctor: \$5 initial visit only	Hospital: 10% after deductible; Doctor: \$20 initial visit only	Hospital: 50% after deductible; Doctor: 50% after deductible
*Mental health:	Inpatient: 20% after deductible; Outpatient: \$20/visit	Inpatient: 10% after deductible; Outpatient: \$5/visit	Inpatient: 10% after deductible; Outpatient: \$20/visit	Inpatient: 50% after deductible; Outpatient: 50% after deductible
*Physical therapy:	\$30/visit	\$15/visit	\$15/visit	50% after deductible
*Vision:	\$30/visit	\$15/visit	\$15/visit	Routine preventive eye exams not covered
Hearing:	Illness/accident coverage; 20% coinsurance, one hearing aid per ear, every 36 months	Illness/accident coverage; 20% coinsurance, one hearing aid per ear, every 36 months	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: 1 (866) 544-6970 | [express-scripts.com/](https://www.express-scripts.com/)

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

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

For more information

Medical Summary Plan Description Booklet:

assets.system.tamus.edu/files/benefits/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**. See Retiree Medical Coverage in this guide if your primary carrier is Medicare.

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

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

Brazos Valley Network (discounts end April 30, 2025)

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

The Brazos Valley Network benefits are available to all employees and retirees in the A&M Care Plan, as long as they receive care from covered, in-network physicians in the Brazos Valley area. Use the Blue Cross and Blue Shield Provider Finder to find eligible Brazos Valley Network providers.

Blue Distinction Centers

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

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

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.

If you have an emergency while traveling, seek help immediately at the nearest emergency facility. These providers should then file the claims with the local BCBS group, who will forward payment and claim information to BCBSTX.

For all plans, if you need non-emergency care or a prescription refill, call your 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.

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.

Retirees can use these services for a \$10 charge. You will be asked to pay up front before you speak with the physician.

65 Plus Medicare Advantage Plan (PPO)

Vendor: Blue Cross Blue Shield of Texas (BxBSTX)

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

Member Services Contact Information:

Blue Cross and Blue Shield of Texas: 1 (855) 476-4149

Website: bcbstx.com/tamus-retiree-medicare

[65 Plus MA Plan Summary of Benefits](#)

Express Scripts: 1 (855) 895-4647

Website: express-scripts.com

Limitations and Restrictions	
Pre-existing condition limitations:	None
Benefit Maximum:	None
Out-of-service area restrictions:	None
Maximums and Deductibles	
Deductibles:	\$0
Out-of-pocket maximum: (1/1 through 12/31) Medical	\$750
Benefit maximum:	No annual/lifetime maximums
Hospital Benefits	
In-Hospital care:	5% of total cost
Emergency Room:	5% of total cost; Cost share waived if admitted within 3 days for the same condition.
Surgery:	5% of total cost
Non-Hospital Visits	
Office visits:	0% for Primary Care Provider (PCP) 5% of total cost for specialist
Lab/X-rays:	5% of total cost
High Technology Radiology (MRI, CT & pet scans, stress test, angiogram & myelography):	5% of total cost
Skilled nursing facility (not including custodial care):	\$0 for days 1-20; 5% of total cost for days 21-100
Other Healthcare Benefits	
Routine Chiropractic Care (non-Medicare-covered)	20% of total cost; 30-visits/plan year
Mental health:	Inpatient – 5% of total cost Outpatient - 5% of total cost
Physical therapy:	5% of total cost
Vision:	5% of total cost; eyewear 5% of total cost for 1 pair of eyeglasses (frames and lenses) or contact lenses after cataract surgery
Hearing:	20% of total cost for routine exam; one per year Hearing aid \$2,000 per ear, every 3 years

Prescription Drugs - Express Scripts. This is a Medicare Part D Plan.		
Deductibles: (1-1 through 12-31)	\$0	
Out-of-pocket maximum: (1-1 through 12-31)	\$400	
Retail Prescription Copays:	31 Day	32-90 Day
Generic	\$10	\$30
Formulary	\$35	\$105
Non-Formulary	\$60	\$180
Mail-Order Prescription Copays:	1-90 Day	
Generic	\$20	
Formulary	\$70	
Non-Formulary	\$120	

Plan Administration

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

How the 65 Plus Medicare Advantage Plan (PPO) Works

If you and your eligible dependents are age 65 and older or otherwise eligible for and enrolled in Medicare A&B, you will be placed in the 65 Plus Medicare Advantage Plan (PPO). Under the 65 Plus Medicare Advantage Plan (PPO), Blue Cross Blue Shield provides your Medicare Advantage coverage. The plan allows you to use any doctor, hospital or other provider and receive benefits. You do not need a referral to see a specialist. Medicare Advantage will pay the allowed amount by Medicare after you pay 5% coinsurance. You will receive the maximum benefit under the plan when your provider accepts Medicare assignment for medical services. You may be balance billed by any provider that does not accept Medicare assignment.

For health care services, including stress tests, outpatient surgeries, emergency room visits and hospitalizations, you pay 5% coinsurance until you meet your \$750 out-of-pocket maximum for the plan year. Once the out-of-pocket maximum is met, the plan may pay up to 100% of the remaining eligible expenses when utilizing a provider who accepts Medicare assignment.

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

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

International Claims

If you require medical treatment while out of the country, you are only covered in an emergency per [Medicare rules](#). The Blue Cross and Blue Shield Global Core program gives members traveling outside of the United States and its territories access to urgent and emergency medical assistance services and doctors and hospitals in more than 200 countries around the world. The plan covers you overseas even though Medicare does not. Charges incurred will be converted into U.S. currency at the exchange rate in effect at the time the claim is processed by BCBSTX. More information, including the international claim form, is available online at [bcbsglobalcore.com](https://www.bcbsglobalcore.com) or by calling 1 (800) 810-BLUE (2583). If you have questions about what medical care is covered when you travel, please call 65 Plus Medicare Advantage (PPO) customer service at 1-855-476-4149 or access information at www.bcbsglobalcore.com.

Vision Benefits

The 65 Plus Medicare Advantage Plan (PPO) provides coverage for one preventive eye exam per person, per year.

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.

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.

Retirees can use these services for a \$10 copay for urgent care and \$0 copay for behavioral health. You will be asked to pay up front before you speak with the physician.

Pharmacy Coverage



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

A&M Care and 65 Plus Medicare Advantage Plan Pharmacy Benefit

The A&M Care and 65 Plus Medicare Advantage Plans have three coverage management programs:

- Prior Authorization
- Step Therapy
- Drug Quantity Management

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

Prior authorization

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

Step Therapy

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

Drug Quantity management

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

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

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

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

Specialty Medicines

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

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

<ul style="list-style-type: none">• Cancer• Growth Hormone Deficiency• HIV• Hepatitis C• Parkinson’s Disease	<ul style="list-style-type: none">• Crohn’s Disease• Multiple Sclerosis• Pulmonary Arterial Hypertension• Hemophilia• Rheumatoid Arthritis
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For more information on specialty medicines, contact Express Scripts at 1 (866) 544-6970 or visit [express-scripts.com](https://www.express-scripts.com).

Retiree Medical Coverage



Medicare Coordination of Benefits

Medicare-Eligible Retirees in the A&M Care Plan

If you are a Medicare-eligible retiree enrolled in the A&M Care Plan, you are considered Medicare Primary if you are:

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

If you are Medicare-Primary, the A&M Care plan pays benefits as if you are enrolled in Medicare Parts A and B. In addition, you will not be eligible for copayments.

Plan benefits are calculated based on the total billed amount from your health provider. After Medicare pays, your A&M Care plan pays either the full benefit or the difference between the Blue Cross and Blue Shield allowed amount and the amount Medicare paid. This means that you receive full reimbursement in some cases. The chart below shows an example of the coordination of benefits with Medicare and the A&M Care Plan if you have a \$243 doctor's office visit.

	Medicare Primary (A&M Care Plan) Plan year: January-December	A&M Care Primary (Medicare Secondary) Plan year: September-August
Primary Payer	Cost: \$243 Medicare Deductible: \$226 Remainder: \$17 Medicare pays 80%: \$14	\$20 or \$30 copayment, depending on the provider. If using a network provider, claim is paid at in-network levels. If a non-network provider is used, deductible and co-insurance apply.
Secondary Payer	\$243 is applied toward your \$400 A&M Care deductible. If the A&M Care deductible has already been met, A&M Care will pay the \$226. Retiree pays 20%: \$3 Cost for retiree (deductible + 20%): \$229	\$226 is applied to the Medicare deductible.

Determining Primary and Secondary Coverage

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

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

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

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

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

For more information about Medicare please refer to these resources:

Medicare website <https://www.medicare.gov>

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

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

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

For More Information

A&M Care Plan Summary Plan Description Booklet:

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

Dental Coverage



Plan Choices

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

Enrollment Rules

- Eligibility for the HMO depends on where you live 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, Colorado, New York and Utah.**

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

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

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

Delta Dental PPO

Vendor: Delta Dental

Member Services Contact Information:

Delta Dental: 1 (800) 422-4234

Website: deltadentalins.com/tamus

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

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

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

For More Information

Dental Summary Plan Description Booklet:

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

Delta Dental HMO

Vendor: Delta Dental

Member Services Contact Information:

Delta Dental: 1 (800) 422-4234

Website: deltadentalins.com/tamus

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

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

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

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

For More Information

Delta Dental HMO Benefits Highlights

assets.system.tamus.edu/files/benefits/website/DeltaFeeSchedule.pdf

Vision Coverage



Plan

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

Enrollment Rules

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

Benefits

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

	Network Benefit	Non-Network Benefit
Eye exam (one per plan year)	100% after \$10 copayment.	Up to \$50. Copayment doesn't apply
Materials	100% after \$15 copayment for: <ul style="list-style-type: none"> • Frames - every plan year, up to \$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. <ul style="list-style-type: none"> • 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

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

Superior Vision website: microsite.superiorvision.com/tamus

Customer service: (800) 507-3800

Life Coverage

Plan Choices

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

Enrollment Rules

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.

- If you and your spouse are both retired from the A&M System, or if one of you is retired and the other is still working for the A&M System, and you enroll in 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 retirement, you may:
 - » Enroll in coverage at any time by providing Evidence of Insurability (EOI)

Benefits

Age Reductions

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

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

*Dependent Spouse Life cannot exceed the Retiree Optional Life.

Evidence of Insurability

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

EOI is required to:

- If you enroll in coverage for the first time, or increase your coverage
- Enroll new dependents within 31 days of acquiring them.
- Enroll a spouse for the first time or if increasing spouse coverage

You can complete the EOI information on The Hartford'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. The Hartford may ask for more medical information before deciding whether to grant your request. This process normally takes about four weeks but may take longer.

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

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 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.

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 the pre-defined limits.

Premiums

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

Accelerated Death Benefit

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

Additional Benefits

Employee Assistance Plan (EAP)

The Hartford's EAP services include:

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

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

Empathy for Employees

As part of your policy with The Hartford, you have complementary access to Empathy, a service that can assist you with pre-planning – such as will preparation and funeral arrangements – to ease your family's burden in the future. These services offer support and guidance to help you prepare for difficult moments of grief and loss. Some of the services available to you include:

Online Will Preparation – Step-by-step guidance and support for preparing a will.

On-Demand Assistance – Get around the clock professional advice and support from the Empathy Care Team.

Funeral Planning – Detailed instructions and on-demand assistance available to help plan a funeral, burial and/or cremation.

End-of-life Wishes – Make informed decisions now so that your final preferences can be honored.

Step-by-Step Checklist – Find clear guidance and expert knowledge for your every need.

Estate planning – Settle administrative, legal, and tax details to ease the burden of your family.

To access these services, register online at join.empathy.com/hartfordcare. Once you register, you can access these services online or by calling 1 (229) 544-2332.

Empathy for Beneficiaries

As part of your policy with The Hartford, you and your beneficiary have complimentary access to Empathy, a service that helps families through all the emotional and practical challenges that follow a loss. You and your beneficiary have access to resources, and trained professionals who are there to listen and offer support and guidance during this difficult time. Some of the services available include:

Easy-to-use App – Access resources and services in one place to help you navigate the challenges of loss.

Dedicated Care Team – Chat one-on-one with a dedicated Care Manager for expert advice and on-demand support.

Grief Counseling – Licensed social workers are available to listen and give support.

Funeral Planning - Assistance is available to manage the logistics of funeral planning, burial, cremation and other related services.

Obituary Writing – Online obituary writing wizard tool offers step-by-step guidance.

Estate Administration – Guidance is available for navigating estate and probate processes.

Account Deactivation – Get help closing unneeded financial accounts, memberships and subscriptions.

Identity Theft Protection – Step-by-step instructions to freeze credit and protect the identity of your loved one.

Family Collaboration – Support for the process by sharing with up to 10 others on an account.

Secure Vault – A safe place to upload, organize, and share crucial documents.

To access these services, register online at empathy.com/partner/Hartford or download the Empathy app, use access code: **EMP-HART**. Empathy's dedicated Care Managers are available via chat, email, text and phone. Once registered, you or your beneficiary can access these services online or by calling (270) 681-1364.

OG Benefits Dedicated Customer Support

The Hartford partners with OG Benefits to provide additional guidance on the life insurance plans. This service also provides:

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

You can contact them at (833) 867-5300, Monday-Friday 8 AM to 5 PM, for a consultation about Life and Dependent Life Insurance coverage.

Travel Assistance and ID Theft Protection Services

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

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

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

Call toll-free at 1 (800) 243-6108 to use this service or view the [Travel Assistance and ID Theft Protection flier](#).

Life Coverage

Basic Life/Basic AD&D	You are automatically covered if you are enrolled in an A&M System medical plan.
Coverage for you:	\$7,500 in life insurance and \$5,000 in AD&D coverage
Child Coverage:	\$5,000 in life insurance on each eligible dependent child.
Alternate Basic Life/Basic AD&D	If you are not enrolled in A&M System medical coverage, but certify that you have other medical coverage, you can pay for Alternate Basic Life using the employer contribution. If you select this coverage, you cannot enroll in Optional Life.
Coverage for you:	\$50,000 or the amount of Optional Life you had immediately before enrolling in this plan, whichever is less, as well as \$5,000 in Basic AD&D coverage
Child Coverage:	\$5,000 in life insurance on each eligible dependent child.
Optional Life	Retiree: Maximum of \$100,000 if younger than 70. Coverage will automatically be reduced to \$60,000 at age 70 and \$30,000 at age 80.
Dependent Life Plan A	You can enroll your dependents if you have Optional Life coverage. You pay for the coverage yourself.
Spouse Coverage:	Retiree: Maximum spouse coverage is \$50,000 for retirees younger than age 70; \$30,000 for retirees ages 70–79; \$15,000 if retiree is age 80 or older. The retiree spouse coverage amount may not be greater than the retiree coverage amount.
Child Coverage:	\$10,000 per child.
Dependent Life Plan B	
Spouse coverage:	\$5,000 in life and \$5,000 in AD&D coverage; if spouse is enrolled.
Child Coverage:	\$5,000 in life insurance on each eligible enrolled dependent child.
Dependent Life Plan C	You can enroll your dependents if you have Alternate Basic Life coverage. You pay for the coverage yourself.
Spouse coverage:	50% of your Alternate Basic Life coverage amount, if spouse is enrolled.
Child Coverage:	\$5,000 on each enrolled child.
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

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

The Hartford website: thehartford.com/learn/tamus

Accidental Death and Dismemberment

Plan Choices

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

Retirees can choose up to \$200,000 if younger than age 70, and up to \$60,000 if age 70 or older.

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

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

Enrollment Rules

- You can enroll at retirement, 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 you 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.tamu.edu.

For more information

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

Health and Wellness Programs

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.

Work/Life Solutions by GuidanceResources by ComPysch

Work/life solutions includes telephonic counseling services, training, and resources to help retirees deal with stressful issues like parenting, coping with the death of a loved one, and more. These services are completely confidential, and can be easily accessed by visiting guidanceresources.com or the retiree dedicated number (833) 306-0105.

Hinge Health

Hinge Health takes non-surgical care guidelines and turns them into a digital 12-week program for chronic musculoskeletal 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 65 Plus Medicare Advantage Plan (PPO). 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, 65 Plus Medicare Advantage (PPO) or J Plan. For more information and eligibility information, visit wonderhealth.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.

Hello Heart is available to all retirees 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.

For more information or to register, visit join.helloheart.com/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 retirees, spouses, and dependents (age 18+) enrolled in the A&M Care Plan. Retirees enrolled in the 65 Plus Medicare Advantage Plan (PPO) are not eligible. For more information visit, go.cylinderhealth.com/tamus.

Teladoc Health for Diabetes and Hypertension

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. Teladoc Health for Diabetes program is available to those enrolled in the A&M Care or J Plan. Teladoc Health for Hypertension program is available to those enrolled in 65 Plus Medicare Advantage Plan (PPO), but not those enrolled in the A&M Care 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 and Hypertension or to register, visit teladochealth.com/register/tamus. For more information on Teladoc Health for Diabetes or to register, visit teladochealth.com/now/TAMUS.

You may also register by phone at 800-835-2362. The registration code is **TAMUS**.

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 retirees, spouses and dependents with type 2 diabetes between the ages of 18 and 79 who are enrolled in the A&M Care plan. There are some medical conditions that would exclude patients from the Virta treatment. Retirees 65 and older and retirees enrolled in the 65 Plus Medicare Advantage Plan are not eligible. To check for eligibility and learn more, visit virtahealth.com/join/tamus.

Blue Rewards

Blue Rewards Program gives 65 Plus Medicare Advantage Plan (PPO) members a healthy and easy way to earn up to a \$100 gift card from major national retailers. You receive a gift card of your choice (one per year) for completing Health Actions throughout the year. Earn rewards by completing a Healthy Action such as: your annual wellness visit, flu vaccine, colorectal cancer screening, diabetic screening, and more. To learn more or to sign up, go to www.BlueRewardsTX.com or call the number on the back of your member ID card.

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 65 Plus Medicare Advantage Plan (PPO) and you have to proactively sign up with Experian to take advantage of the identity protection services. ID protection services include: credit monitoring, up to \$1 million in identity theft insurance, and identity repair.

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

Blue Points

Well onTarget understands how hard it can be to maintain a healthy lifestyle. With the Blue Points program, you will be able to earn points for regularly participating in many different healthy activities. You can redeem these points in the online shopping mall, which provides a wide variety of merchandise for you to choose from. You must be enrolled in the A&M Care 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.

Open to Retirees in the A&M Care Plan only. Retirees in the 65 Plus Medicare Advantage Plan (PPO) are not eligible.

Inside Rx Pets

The program is available to all retirees enrolled in the A&M Care Plan or the 65 Plus Medicare Advantage Plan (PPO) with Express Scripts 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 the A&M Care and 65 Plus Medicare Advantage Plan (PPO).

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 non-Medicare eligible retirees and their dependents. To enroll, log in to Blue Access for Members at bcbstx.com/tamus and search for the Fitness Program under Wellness.

Silver Sneakers Fitness Program

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

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

Monthly Premiums – Retirees

September 1, 2024

Health	Retiree Only		Retiree & Spouse		Retiree & Child(ren)		Retiree & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	\$965.90	\$ 0.00	\$1,527.98	\$281.04	\$1,356.42	\$195.26	\$1,756.90	\$395.50
65 Plus MA (PPO)	\$864.48	\$ 0.00	\$1,365.86	\$118.92	\$1,212.74	\$51.58	\$1,570.21	\$208.81

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

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

Vision	Retiree Only		Retiree & Spouse		Retiree & Child(ren)		Retiree & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
	\$8.36		\$17.72		\$13.70		\$24.44	

Basic Life	The premium for this plan is usually paid by the employer contribution.							
	Basic Life \$4.70				Alternate Basic Life \$.626 per \$1,000 of coverage.			

Optional Life	Your age on September 1 will be the age used to calculate your premiums for the rest of the fiscal year.					
	Age	Non-tobacco rate	Tobacco rate	Age	Non-tobacco rate	Tobacco rate
Monthly Rate per \$1,000:	Under 25	\$.05	\$.10	50-54	\$.20	\$.40
	25-29	.05	.10	55-59	.36	.72
	30-34	.05	.10	60-64	.56	1.12
	35-39	.06	.12	65-69	.76	1.52
	40-44	.07	.14	70-74	1.43	2.86
	45-49	.12	.24	75+	2.00	4.00

Dependent Life	Plan A: Child \$.06 per \$1,000 of coverage Plan B: Spouse: \$1.05 (flat rate) for \$5,000 in DL & AD&D Child: \$0.32 (flat rate) for \$5,000 in DL & AD&D Plan C; ½ Alternate Basic Life premium; 1/10 if no spouse is covered					
	Age	Non-tobacco rate	Tobacco Rate	Age	Non-tobacco rate	Tobacco Rate
	Under 25	\$.05	\$.060	50-54	\$.23	\$.276
	25-29	.06	.072	55-59	.43	.516
	30-34	.08	.096	60-64	.66	.792
	35-39	.09	.108	65-69	1.27	1.524
	40-44	.10	.120	70-74	2.06	2.472
	45-49	.15	.180	75+	2.06	2.472

AD&D	Retiree Only		Retiree & Family	
	Monthly rate per \$10,000			
	\$.28		\$.46	

Survivor Rates

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

	Participant Only	Participant & Spouse	Participant & Child(ren)	Participant & Family
A&M Care	\$965.90	\$1,527.98	\$1,356.42	\$1,756.90
65 Plus MA (PPO)	\$864.48	\$1,365.86	\$1,212.74	\$1,570.21
A&M Dental PPO	\$30.00	\$60.00	\$63.00	\$96.00
DeltaCare USA Dental	\$21.08	\$37.48	\$37.76	\$58.66
Vision	\$8.36	\$17.72	\$13.72	\$24.44

Premium Worksheet

1. Medical

Enter your cost. Add \$30 if you or your spouse use tobacco products.

\$ _____

2. Dental

Enter premium amount.

\$ _____

3. Vision

Enter premium amount.

\$ _____

4. Optional Life

Choose your coverage amount _____ and divide by 1,000: _____ × your age-based premium of _____ =

\$ _____

5. Dependent Life

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

\$ _____

Plan B Premium: \$1.05 spouse/\$.32 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 _____ =

\$ _____

Your total monthly cost (add 1-6)

\$ _____

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

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

\$ _____

Enter the total of your premiums shown above for Dental (line 2), Vision (line 3), and AD&D (line 6).

\$ _____

Subtract the state contribution: full-time: \$447.38

\$ _____

Your total montly cost

\$ _____

Effective as of September 1, 2021

THE TEXAS A&M UNIVERSITY SYSTEM BENEFITS ADMINISTRATION

NOTICE OF PRIVACY PRACTICES

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

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

Commitment to Protecting Health Information About You

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

Your Rights

You have the right to:

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

Your Choices

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

Uses and Disclosures

Benefits Administration may use and share your information to:

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

These are explained further on the following pages.

Your Rights

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

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

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

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

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

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

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

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

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

Your Choices

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

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

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

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

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

Uses and Disclosures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Benefits Administration Responsibilities

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

For more information, visit <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>.

Changes to this Notice

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

Privacy Official

You can contact the Plan's Privacy Official at:

Director of System 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. Visit the A&M System [Privacy webpage](#) for more information.

A Word About Security

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

Medicare Part D Notice of Creditable Coverage

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

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

You should know:

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

Human Resources Offices

Texas A&M University	(979) 862-1718	benefits@tamu.edu
Texas A&M Health Science Center	(979) 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	hr@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	(979) 845-2423	agrilifebenefits@ag.tamu.edu
Texas A&M Engineering	(979) 458-7699	engrbenefits@tamu.edu
Texas A&M Engineering Extension Service	(979) 458-6801	HR@teex.tamu.edu
Texas Division of Emergency Management	(979) 458-6330	employeebenefits@tamus.edu
West Texas A&M University	(806) 651-2117	benefits@wtamu.edu
System Offices	(979) 458-6330	employeebenefits@tamus.edu

Carrier Phone Numbers and Websites

Blue Cross and Blue Shield of Texas: A&M Care Plan	(979) 295-1212	bcbstx.com/tamus
65 Plus Medicare Advantage Plan (PPO)	(855) 476-4149	bcbstx.com/tamus-retiree-medicare
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	(844) 549-2603	metlife.com/info/texas-am-university-system/
Express Scripts - A&M Care Drug Program	(866) 544-6970	express-scripts.com
Express Scripts: A&M Care 65 Plus Medicare Part D Program	(855) 895-4647	express-scripts.com
The Hartford	(833) 867-5300	thehartford.com/learn/tamus
GuidanceResources by ComPsych GuidanceResources by ComPsych for Retirees	(866) 301-9623 (833) 306-0105	guidanceresources.com
2nd.MD	(866) 841-2575	2nd.md/activate/step1/tamus

Information on benefits can be found on the Benefit Administration website at tamus.edu/benefits.

Texas A&M System Benefits

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