



The Texas A&M University System

Benefits Guide

Insurance and Retirement Programs

for A&M System employees, retirees

and their families

Plan year 2011-2012

WELCOME!

In addition to this guide, the System Benefits Administration website - www.tamus.edu/benefits - has:

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

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

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Every effort has been made to ensure the information presented is accurate and up-to-date. However, this guide provides a summary of the benefits available to you and may not include all the details and provisions associated with each plan. Detailed information is available on-line in the Summary Plan Description Booklets at www.tamus.edu/benefits/offices/benefits/publications/ or from your Human Resources Department.

Benefit Eligibility

Employees: You are eligible to receive benefits as a full-time employee if:

- You work at least 40 hours a week, and
- Your appointment is expected to continue for a term of at least 4 ½ months, and
- You are eligible for retirement benefits as a member of the Teacher Retirement System of Texas.

You are eligible to receive benefits as a part-time employee if:

- You work at least 20 hours a week, and
- Your appointment is expected to continue for a term of at least 4 ½ months, and
- You are eligible for retirement benefits as a member of the Teacher Retirement System of Texas.

If you are a Graduate Student you are eligible for benefits, excluding the Teacher Retirement System (TRS) and Optional Retirement Program (ORP) if:

- You are enrolled in graduate-level classes at an A&M System institution as a condition of employment.
- You work at least 20 hours a week, and
- Your appointment is expected to continue for a term of at least 4 ½ months.

Dependents: In general, eligible dependents are your spouse and children younger than 25. Children can be covered up to age 26, married or unmarried, on any health plan. Unmarried children can be covered up to age 25 on the dental, vision and life insurance plans. Grandchildren are eligible if they live in your household. For more information on eligible dependents, contact your Human Resources office.

You must provide proof of eligibility to enroll any dependents. For more information, see the section on Dependent Documentation (pgs. 6 & 7).

Examples of dependents who are **not eligible** for coverage include:

- A same-sex partner;
- A former spouse.

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

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

For information on “grandfathered” retirement rules for employees working for the A&M System prior to 9-1-2003, contact your HR office.

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

Survivors:

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

Premium rates for survivors are the same as those for active employees, but survivors are not eligible for the employer contribution.

Indefinite coverage for survivor(s) is available if:

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

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

Spouse survivor coverage can continue indefinitely, however, coverage for eligible children or grandchildren covered at the time of the employee's/retiree's death is subject to the age maximum or child's marriage. Dependents who were covered at the time of the employee's/retiree's death can receive coverage for 36 months or until age 25, whichever is *longer*. Dependents not covered at the time of the employee's/retiree's death cannot be added to coverage. Coverage for disabled surviving children may continue indefinitely, subject to coverage rules for disabled children.

Employer Contribution

Included in the employer contribution towards your insurance premiums is an amount provided by the state legislature.

Unless you are transferring with no break in service from another Texas state agency or institution of higher education, you will begin receiving a monthly employer contribution the first of the month after your 90th day of employment.

Your employer contribution amount will depend on whether you are a full-time (40 hours/week) or part-time (20-39 hours/week) employee and whether you enroll dependents. Premiums listed in this guide include the total premium and your cost after you begin receiving the employer contribution.

Benefit Enrollment (for new employees)

- ▶ You can enroll in and make changes to your benefit coverages before your hire date and during your first 60 days of employment. **If you enroll before, on or within seven days after your hire date, your coverages can either take effect on your hire date, on the first of the next month, or on your employer contribution eligibility date.**
- ▶ **If you enroll or make changes after the seventh day after your hire date, but during your 60-day enrollment period,** your coverage or changes can take effect either on the first of the following month or on your employer contribution eligibility date.
- ▶ **If you want coverage to begin before your employer contribution eligibility date,** you will have to pay the total monthly premium until your employer contribution eligibility date.

If you do not enroll in any coverages or do not waive health coverage by the end of your 60-day enrollment period, you will automatically be enrolled in a basic package on your employer contribution eligibility date. **This will cost you money!** This basic package includes the A&M Care health plan for you, Basic Life coverage for you and each of your eligible dependent children and \$5,000 in Accidental Death and Dismemberment (AD&D) coverage on you. You pay the cost that is greater than the employer contribution.

You may enroll any or all of your eligible dependents in health, dental, vision, dependent life and/or AD&D, if you have that coverage on yourself. Only the dependents you list on your enrollment form or on the online system will be covered. However, if you elect family AD&D coverage, all eligible dependents will automatically be covered under that plan.

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

You may also choose to have your coverages begin before your employer contribution eligibility date, but have your dependents' coverages begin on your employer contribution eligibility date.

If you do not want health coverage

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

You can use the half contribution to pay for Alternate Basic Life, Accidental Death and Dismemberment, A&M Dental or DeltaCare USA Dental HMO, Vision and Long-Term Disability, in that order. You may not use the employer contribution to pay for Optional Life or Dependent Life. If you are the policyholder of health coverage from the University of Texas System or the Employees Retirement System, you are not eligible for an additional employer contribution. You can receive an employer contribution from only one Texas state agency or institution of higher education.

If the employer contribution is used for LTD and you receive LTD benefits, part or all of those benefits will be taxable income. If you do not want the employer contribution applied to your LTD coverage, you can waive the contribution at the LTD branch of the online system or by completing the appropriate section on your New Employee Benefit Enrollment Form.

How to Enroll

If your Human Resources office or employing department is using the online HRConnect New Employee Enrollment System, simply log in to Single Sign On (SSO) at <http://sso.tamus.edu> using your Universal Identification Number (UIN) and your SSO password. Once you're logged on, click on ***iBenefits***.

Then:

- Complete the employee information section.
- Enter the names and other required information for any dependents you wish to add to any of your coverages.
- Enroll in any of the coverages listed.
- Designate your beneficiaries for Basic Life, Optional and Accidental Death and Dismemberment coverage if elected.

While you are making your elections, you can check them on the screen to make sure you clicked the correct buttons for the choices you want. You may correct any errors immediately.

The online enrollment system will automatically calculate your total benefit cost. If you don't like what you see, you can make changes immediately and as many times as you like until you find a balance of benefits and cost that meets your needs.

Before exiting the system, click “submit record for processing” to submit your final choices for processing.

If your Human Resources office or employing department is not using the online enrollment system, you can enroll using the New Employee Benefit Enrollment Form, available online or from your Human Resources office. Complete this form and return it to your Human Resources office. You will need to complete a Beneficiary Designation Form and, if you enroll dependents, a Dependent Enrollment Form/Certification.

After you begin employment, you can also log on to our HRConnect site (<https://sso.tamus.edu>). HR Connect provides:

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

Dependent Documentation

Documentation needed to qualify your dependents for coverage

Legal Marriage Documents

If you are legally married OR legally married and physically separated: Your **most recent** Federal Tax Return. Fiscal information can be crossed out. **OR** Marriage Certificate AND Proof of Joint Ownership. A mortgage or bank statement, property tax bill or rental/lease agreement which must be dated within the previous six months and must include both the employee's name and the spouse's name.

Common Law Marriage Documents

Texas Declaration of Informal/Common Law Marriage from the County where the marriage was recognized or recorded, **OR** Your **most recent** Federal Tax Return. Fiscal information can be crossed out AND Proof of Joint Ownership. A mortgage or bank statement, property tax bill or rental/lease agreement which must be dated within the previous six months and must include the employee's name and the spouse's name.

Biological Child Documents

Birth Certificate of Biological Child, **OR** Documentation on hospital letterhead indicating the birth date of the child or children under 6 months old.

StepChild Documents

Child's Birth Certificate showing the child's parent is the employee's spouse, AND Marriage Certificate showing legal marriage between the employee and the child's parent.

Adopted Child Documents

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

Disabled child age 25 or older

A certified Handicapped Child/Disabled Student Attending Physician Statement signed by the employee and the child's attending physician, **OR** Disability Documentation from a State or Federal Agency, such as a Social Security Disability Initial Award Notice/Letter.

Grandchild Documentation

Court papers demonstrating legal guardianship, **OR** An official document showing the child's address is the same as the employee's address, such as: current year school records for grandchildren of driving age, valid driver's license for grandchildren of driving age, currently dated federal or state benefit assistance program record based on residence (such as Medicaid), court record establishing residence, daycare record on the daycare's letterhead, the part of the social security card with the home address of the child, doctor's office records (if not enrolled in Scott & White Health Plan) for children not of school age.

Foster Child Documentation

Official Court or Agency Placement papers.

Legal Guardianship Documentation

Court order establishing guardianship.

Managing Conservatorship Documentation

Court order establishing managing conservatorship.

Premiums

Pretax premiums:

When you enroll in health, dental, vision or accidental death and dismemberment coverage, your share of the premium for you and a covered spouse is deducted from your paycheck before you pay federal income and Social Security taxes, unless you request otherwise. This means that you pay less tax and your take-home pay is higher. If you participate in pretax premiums, you cannot take the earned income health insurance credit on your income tax return.

Once you make your election to participate or not in the pre-tax premium plan, your election is valid for the remainder of the plan year. You may only change this election during annual enrollment.

Summer premiums:

If you work fewer than 12 months (for example, if you are budgeted to work nine or 10½ months) and expect to return in the fall, your summer premiums (June, July and August) will be deducted from your May paycheck. You will receive the employer contribution for these months unless you terminate employment before September 1. You will receive more information about this in April, if applicable.

Payroll deductions:

If you are paid monthly, premiums deducted from your paycheck are for your insurance coverage during the previous month. For example, the premiums deducted from your October 1 paycheck are for your September coverage.

Change in Status

Changes can be made to your A&M System benefits during the Annual Enrollment period each July. Otherwise, you can change your health, dental, vision or Spending Account coverages during the plan year only within 60 days of a Change in Status. The changes you make to your coverage(s) must be consistent with the Change in Status. For example, if you have a new baby, you can add the baby to your health coverage, but not drop your spouse from health coverage.

If you do not make your changes within 60 days, you cannot change coverage until the next Annual Enrollment in July to be effective the following September 1.

Changes in Status include:

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

Evidence of Insurability

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

E of I is required to:

- Add Optional Life of more than three times your annual salary during your initial 60 day enrollment period, or for any amount after your initial 60 day enrollment period.
- Add Spousal-Dependent Life over \$50,000 within your initial 60 day enrollment period.
- Add or increase Spousal-Dependent Life any time after your new-hire period or within 60 days of your marriage.

You can complete the E of I information on Minnesota Life's website, which is accessible through *iBenefits* or, Optional/Dependent Life E of I forms are available from your Human Resources office.

Minnesota Life may ask for more medical information before deciding whether to accept you into the plan. This process normally takes about four weeks but may take longer. You are responsible for expenses incurred. You will be notified of the acceptance or denial of your application. You will not have the coverage unless you receive approval. If you are approved, coverage begins September 1 (if you apply during the annual enrollment period) or the first of the next month if you are approved after September 1.

Annual Enrollment

Annual Enrollment is held each year in the month of July. During this time you may add, change, or remove coverage for yourself and your dependents using the online *iBenefits* system. Elections and/or changes made during this time will be effective September 1, or if evidence of insurability is required and approved, the first of the month following the approval after September 1.

Prior to annual enrollment each year active employees will receive an email notifying them of the upcoming Annual Enrollment period. Retirees and COBRA participants will receive a notification letter via mail.

If no changes are made during Annual Enrollment all benefits will automatically roll over to the next plan year, **with the exception of the Flexible Spending Accounts** and life insurance reductions due to age.

When you both work for the A&M System

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

- You can be covered as an employee on some coverages and as a dependent on others. You cannot be covered as an employee and a dependent on the same coverages, except on AD&D.
- Children can be covered as dependents by either spouse, but not by both, except on AD&D. Both spouses may set up Flexible Spending Accounts and use them to pay dependent expenses. Each spouse may contribute up to \$4,800 to a Health Care Spending Account, but the total both spouses may contribute to Dependent Day Care Spending Accounts is \$5,000.
- You can each enroll separately in health coverage and receive separate employer contributions. Or, one of you can enroll in health and cover the other as a dependent on health. If you do this, the employee covered as a dependent will receive half of the employee-only employer contribution, which can be used to purchase other coverages for the employee, spouse and/or family. To be covered under different health plans, you must each enroll as employees. A spouse who is covered on health as a dependent is not eligible for Basic Life coverage.
- If you elect Alternate Basic Life or Optional Life on yourself, you may not be covered by your spouse on Dependent Life.
- You may elect employee coverage for AD&D and be covered as a dependent on your spouse's family AD&D coverage, but your benefit will not be more than the maximum for which you are eligible under employee coverage. If both you and your spouse elect family AD&D coverage, your children may be covered under both plans. However, you will not receive more than \$25,000 total benefit for each child.

For more information, read "[When You and Your Spouse Both Work for the A&M System.](#)"

COBRA

If you or your covered dependents lose eligibility for benefit coverage due to a COBRA qualifying event, you and/or your dependents will be able to continue coverage, if already enrolled in medical, dental, vision and/or a Health Care Spending Account. COBRA coverage is the same coverage provided to all other participants, but the premiums are 102% of the total premiums. More information about COBRA can be found at [COBRA](#).

Protection of Personal Health Information

Certain information collected by the A&M System will be sent to the insurance carriers of the plans in which you enroll. However, the A&M System and the insurance carriers will treat this information as confidential. The A&M System is committed to protecting your personal health information. The System's Notice of Privacy Practices explains the circumstances under which this type of information can be disclosed, and it explains the rights you have regarding how the information is used.

This document is also available online at [HIPPA](#) or from your Human Resources office.

A Word About Security

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

Understanding Benefit Lingo

Here are some terms and definitions that will help you understand your coverages.

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

COBRA: The Consolidated Omnibus Budget Reconciliation Act allows you and/or covered dependents to extend health, dental and/or vision coverage beyond the date on which eligibility would normally end. You pay the full premiums plus a 2% administrative fee for this extended coverage. This is not available through the Grad plan, although some extension of coverage is allowed.

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

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

Deductible: The amount of money you must pay toward health, prescription drug or dental expenses for each family member each year before health, drug or dental benefits are reimbursable in most cases. After you have paid your deductible, future expenses are covered at the coinsurance or copayment amount. Copayments, may or may not, count toward the deductible, depending on your chosen health plan. You can submit claims for reimbursement of deductible and copayment amounts through a Health Care Spending Account.

Generic Medications are 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 are brand name medications that are not on the Preferred List because they are less expensive and effective alternatives are available. Non-Preferred medications require a higher copayment.

Out-of-pocket maximum: Generally, the most you will have to spend each plan year for each covered family member for the annual deductible and your coinsurance. Once you've met the out-of-pocket maximum on yourself or a covered dependent, the plan pays 100% of most remaining expenses for you or the dependent for the rest of that plan year. However, in most cases, you must continue to pay copayments even after you reach the maximum.

PCP/Specialist: Under the A&M Care, Scott & White, and Graduate Student Health plans, a primary care physician (PCP) is a general or family practitioner, an internal medicine doctor or a pediatrician.

Preferred or Formulary drugs: A list of drugs that are periodically reviewed and updated by a committee of physicians, pharmacist and other health professionals for effectiveness and cost effectiveness. Each plan has their own Preferred Drug List. Often, brand drugs that have generics available will not be on the formulary list to encourage individuals to purchase the less expensive generic. Some health plans have both preferred and non-preferred drugs on their formulary, the preferred drugs having a lower copayment.

Reasonable and customary fee: The lower of the actual charge for the services or supplies, or the usual charge of most other doctors, dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies.

Health

Plan Choices: You can choose between the two A&M Care plans and you may also have access to a Health Maintenance Organization (HMO). If you are a graduate student employee, the Graduate Student Health Plan is also an option. If you are at the A&M System under a J1 or J2 Visa, you must be enrolled in a plan that meets the requirements of your visa, which includes the A&M Care J plan. If you are age 65, enrolled in Medicare and not working or disabled and enrolled in Medicare, you are also eligible for the 65+ plan. You and your enrolled family members must all be in the same health plan, unless a spouse or dependent child works for the A&M System and chooses separate coverage.

Except for the Graduate Student Plan, none of the health plans have pre-existing condition limitations. In addition, with the exception of the Graduate Student Health plan, none of the plans have a general lifetime maximum benefit; however, there are some limits on specific benefits such as home health care. You cannot change health carriers during the plan year unless you move out of the service area of an HMO, and you cannot add or drop coverage for yourself or any dependents during the plan year unless you have certain Changes in Status.

Enrollment Rules:

- If you do not enroll during your initial enrollment period, you can enroll yourself and dependents only during Annual Enrollment or if you have certain Changes in Status.
- You do not have to provide evidence of insurability to enroll in any of the plans.
- Except for the Graduate Student plan, the plans have no pre-existing condition limitations.

Benefits:

A&M Care plan

Under the A&M Care plan, you may use any doctor, hospital or other provider and receive benefits. However, you receive higher benefits by using a network provider. Both plans cover the same services and have copayments for office visits with network doctors. 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. Both plans also have prescription drug deductibles 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. However, copayments, drug deductibles and out-of-network hospital deductibles do not count toward annual deductibles or out-of-pocket maximums. You continue to pay these costs even after you reach your out-of-pocket maximum. If you use a hospital that is outside the network, you will have to meet a separate out-of-network hospital deductible for each admission.

How A&M Care plan work

You receive network benefits if you live anywhere in the United States except the five counties listed below as “non-network” and use a network provider.

You receive out-of-network benefits if you live anywhere in the United States except the five counties listed below as “non-network” and use a provider not in the network.

You receive non-network benefits if you live in Donley, Hansford, Lipscomb, Ochiltree or Wheeler county. However, if you live in one of these Texas counties and choose to travel to a network doctor, you can take advantage of a \$30 or \$45 office visit copayment.

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

- You are not eligible for a \$30 or \$45 copayment.
- You must file claims for reimbursement.
- You must precertify hospitalizations to avoid a \$500 penalty.
- You are not eligible for preventive care benefits (unless you live in a non-network area). Your deductible and out-of-pocket maximum will be double the network deductible and out-of-pocket maximum.

With dependent coverage, your maximum annual deductible for all family members is three times the individual deductible, and your maximum out-of-pocket expenses for all family members is three times the individual maximum.

The A&M Care plans are administered by **BlueCross BlueShield of Texas (BCBSTX)**, with **Medco** administering the prescription drug portion.

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 American currency at the exchange rate in effect at the time the claim is processed by BCBS. More information, including the international claim form, is available online at www.bcbs.com/bluecard-worldwide/index.html or by calling (800) 810-BLUE.

Emergency admissions:

If you are admitted to a hospital on an emergency basis, you must precertify with BlueCross BlueShield of Texas (BCBSTX) within 48 hours of admission (unless Medicare is your primary coverage). Call (800) 441-9188 to precertify.

Coordination of benefits:

If you or another family member has other health coverage that is primary, the A&M Care plans 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:

A&M Care participants receive discounts on exams, frames, lenses and laser vision services through Davis Vision, Inc. To receive the discount, visit a participating provider and show your A&M Care ID card. For provider information, visit <http://www.davisvision.com>. Click members, then in the Open Enrollment box towards the bottom center of the page, enter 2295 as your client control plan number or call (800) 501-1459. A flyer is available online at <http://tamus.edu/benefits/programs/DavisVisionBrochure.pdf>.

Scott & White Health Plan

The Scott & White Health Plan (SWHP), is available through the A&M System. A PCP designation and/or referral to a specialist is not required by this plan. However, some specialist require a referral or appointment prior to appointment. You receive benefits for non-emergency care only if you use Scott & White network providers.

You must live or work in the SWHP service area to select. The *iBenefits* system will show if you are in the SWHP area. This information is also available [here](#).

If you are enrolled in the SWHP, the following applies:

- If you will be traveling outside the service area for fewer than 90 days, you must remain enrolled in your HMO. *Outside the SWHP's service area, you will have emergency care coverage only.*
- If you will be outside the service area for between 90 and 180 days, you may remain in the HMO (subject to the above conditions) or you may transfer to the A&M Care plan. If you will be outside the service area for 180 days or more, you must change to the A&M Care plan to keep coverage.

You should work with the SWHP before leaving the country to obtain additional maintenance medications. If you need to fill a prescription while in a foreign country, you will have to pay up-front and then submit a claim to your SWHP. **Contact the SWHP within 24 hours if you need emergency care.**

Graduate Student Health Plan

The Graduate Student Health Plan provides graduate students with comprehensive benefits at a lower premium than other plans for employee-only coverage and employee-and-child coverage. It also provides repatriation benefits, which may be useful if you are a foreign national.

The plan has a 12-month pre-existing condition limitation. When you turn in a claim for treatment of a condition, Companion Life will check to see if you have received services for that condition within the 12 months before the treatment date. If you have, you will receive a maximum of \$1,000 in benefits for services related to that condition if you receive those services during your first 12 months of coverage. However, if you can provide proof that you were enrolled in a group health plan for at least 18 months before enrolling in the Graduate Student Health Plan, this waiting period can be waived. For more information on the Graduate Student Plan, visit www.tamuinsurance.com or call 800-452-5772.

A&M Care J Plan

The A&M Care J plan is only available to employees on a J-1 or J-2 visa and their family members. If you fall into this group, your visa requires you to have a plan with a maximum deductible of \$500 and a maximum coinsurance amount of 25%. The benefits are essentially the same as those in the A&M Care plan, including the BlueCross BlueShield in-network and out-of-network benefits, with the following differences:

In-network services	Non-network services
\$500 Deductible per person/plan year	\$1,000 deductible per person/plan year; \$500 hospital deductible for non-emergency services
\$1,500 Maximum family deductible	\$3,000 maximum family deductible
25% Coinsurance percentage for network services	50% coinsurance for non-network services

Graduate student employees on a J1/J2 Visa who reside in the Bryan/College Station area are also eligible to enroll in the Scott & White Health plan, or the Graduate Student plan. Both plans (SWHP and Grad plan) meet the visa requirements.

Since this coverage is a requirement of employment, if you are working for the A&M System on a J1 or J2 visa, the J plan will be your default plan.

REMINDER ABOUT REPATRIATION AND MEDICAL EVACUATION

Repatriation of remains of at least \$7,500 and medical evacuation coverage of at least \$10,000 are also required of those on a J- 1 or J-2 visa.

Both the grad plan and the international student insurance plan provide up to \$25,000 for repatriation of remains and up to \$50,000 for medical evacuation.

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

- Evac/Repat: \$150,000
- Repatriation of Remains: \$15,000
- Visit of Family Member or Friend: \$5,000
- Return of Dependent Children: \$5,000
- Vehicle Return: \$2,500

With a combined single limit of \$150,000 per person.

Health Care While Traveling

All A&M health plans provide benefits in the event of an emergency while traveling. If you know you will be traveling outside your network area or outside the U.S., plan ahead, and know how to use your health plan's emergency benefit features to minimize your out-of-pocket costs.

Emergency care is defined as treatment required because permanent disability or endangerment of life would result if the condition were to go untreated. Examples include unconsciousness, severe bleeding, heart attack, serious burns and serious breathing difficulties. If you have an emergency while traveling, seek help immediately at the nearest emergency facility. *For all plans, if you need nonemergency care:*

- Call your network or primary care doctor and ask him/her for advice or to call in a prescription to a nearby pharmacy.

A&M Care Plans:

You can call (800) 810-BLUE for information on network physicians or facilities outside of Texas. You will receive network benefits if you use a network doctor and out-of-network benefits if you use a non-network doctor.

If you need treatment while traveling outside the United States, call (800) 810-BLUE or visit BCBS online at www.bcbs.com/bluecardworldwide/index.html. Some treatments are considered experimental or investigational and may not be recognized forms of treatment in the U.S. or may not normally be covered by the A&M Care plan. These will not be reimbursed.

Scott & White Health Plan:

For health/prescription drug coverage information specific to your health plan, contact the Scott & White Health Plan (800) 791-8777 or (979) 268-7947

If you will be traveling outside the service area for fewer than 90 days, you must remain enrolled in Scott & White. *Outside the service area, you will have emergency care coverage only.*

If you will be outside the service area for between 90 and 180 days, you may remain in the health plan (subject to the above conditions) or you may transfer to the A&M Care plan. If you will be outside the service area for 180 days or more, you must change to the A&M Care plan to keep coverage.

You should work with Scott & White before leaving your service area to obtain additional maintenance medications. If you need to fill a prescription while in a foreign country, you will have to pay up-front and then submit a claim. **Contact the Health Plan within 24 hours if you need emergency care.**

Prescription Drugs

Each A&M System health plan includes coverage for prescription drugs. You are responsible for:

- The drug deductible, if any, and
- The drug copayment.

Unless otherwise specified, copayments for prescription drugs do not apply towards the out-of-pocket maximum for the health plan in which you are enrolled. In cases where the dispensing pharmacy's charge is less than the copayment, you will be responsible for the lesser amount.

A&M Care Pharmacy Benefit - Medco			
The A&M Care pharmacy benefit is managed by Medco. You will receive a separate ID card from Medco. As described below, both A&M Care plans have a \$50-per-person (\$150 maximum per family) per plan year deductible that applies to retail and mail-order drugs. Your Medco pharmacy benefit allows you to utilize both retail and mail order pharmacy.			
Participating retail pharmacy information and Formulary information is available at http://www.medco.com .			
Annual Drug Deductible (does not apply to medical plan deductible)		\$50/member/plan year (maximum \$150/family/plan year)	
	Generic Drug Copayment	Formulary Drug Copayment	Non-Formulary Drug Copayment
Retail Pharmacy - 30 day supply	\$10	\$35	\$60
Retail Pharmacy – 90 day supply (at participating pharmacies)	\$30	\$105	\$180
Medco by Mail – 90 day supply	\$20	\$70	\$120

Medco's online resource, *My Rx Choices*, allows members to:

- Order prescriptions through Mail Order.
- View your prescription history.
- Personal assessment for possible lower cost alternatives.
- Request assistance from Medco in contacting your provider to request approval for changing to lower cost alternatives/equivalents.
- Compare brand to generic and retail to mail costs.

Medco Preferred Step Therapy Program

Some prescriptions are not covered by the plan unless approval is obtained through coverage review. This program, the Preferred Drug Step Therapy Program, promotes generic and preferred brand medications as first line therapy. If you or someone in our household is using one of the medications below, talk to your doctor and ask about an alternative medication.

Prevacid	Aciphex	Zegerid	Edluar
Pantoprazole	Prilosec Suspension	Actonel	Kapidex
Actonel with Calcium	Lexapro	Ambien CR	Rozerem
Lunesta			

If your doctor believes that you or your family member should use one of the non-covered prescriptions listed above, you or your doctor can request a coverage review. If coverage is approved, you will pay the appropriate copayment for the medication.

Coverage Review 1-800-417-1764

Specialty Medicine

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

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

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

You can contact Accredo at 1-800-922-8279 to:

- Find out if your medication is considered a “Specialty Drug”,
- Start getting your specialty medication through Accredo,
- Talk to a nurse or pharmacist.

Prior Coverage Authorization

Some medications require authorization prior to coverage under the plan. Medications selected are typically expensive, have off-label (not approved by the FDA) uses or have the potential to be used inappropriately. They require closer review to support their benefit(s) to the patient. Medco clinical personnel determine if the condition falls within the appropriate medical guidelines, which are based on both clinical judgment and current medical literature. A medical diagnosis will need to be obtained from the prescribing doctor and some medications may require additional information. A sample of medications requiring prior authorization are listed below.

Xolair	Provigil	Appetite & weight loss therapy
Botulinum Toxins	Growth Stimulating Agents	Dermatological/Acne (Retin-A/co
Smoking deterrents	Immune Globulins (IVIG)	& Tazorac all dose forms)

Scott & White Health Plan Pharmacy Benefit				
Annual Drug Deductible (does not apply to medical plan deductible)			\$50/member/plan year	
	Generic Drug Copayment***	Brand-Formulary Drug Copayment	Non-Preferred Formulary Copayment	Non-Formulary Drug Copayment
Retail Pharmacy - 30 day supply	\$5	\$25	Lesser of \$50 or 50%	Lesser of \$50 or 50%
90 day Supply - Maintenance	\$10	\$50	Lesser of \$100 or 50%	Two copayments required
Out-Patient Specialty Drugs*	\$50 (level 1*)	\$100 (level 2*)	\$250 (level 3*)	50% after deductible ** (level 4)

If a brand name drug is dispensed when a generic is available, 50% after deductible copay applies.

* Copayments for level 1, 2 and 3 Out-Patient speciality Drugs will apply to the members annual OOP maximum.

** Level 4 Out-patient specialty Drugs are subject to the medical plan deductible of \$350.

*** Deductible does not apply to generic drugs.

Graduate Student Plan Pharmacy Benefit - Medco				
No Annual Deductible				
	Generic Drug Copayment	Brand-Formulary Drug Copayment	Single Source Medication	Maximum Benefit (per plan year)
Student Health Center		\$15		\$1,000
Retail Pharmacy (30 day supply)	\$15	\$25	\$35	\$5,000

*Single Source Medication is a brand name drug without a generic equivalent.

Comparing the plans

The charts on the following pages show your share of the cost of a health procedure or service. For example, **30%** means you pay **30%** (coinsurance) of the cost after any applicable deductibles up to the out-of-pocket limit, then the plan pays **70%**; **\$30/visit** means you pay **\$30** (copayment) for each office visit.

The plan year for all plans is 9-01-11, through 8-31-12. **Scott & White Health Plan** has calendar-year limits on some services.

Provisions	A&M Care	A&M Care
	Network/Out-of-Network benefits	Non-Network benefits
	Your Cost:	Your Cost:
<i>Regions offered</i>	BlueCross BlueShield of Texas (BCBSTX) has networks in all states and all but the following Texas counties: Donley, Hansford, Lipscomb, Ochiltree and Wheeler.	These benefits apply to Medicare primary retirees not enrolled in the A&M Care 65 Plus plan and to employees in the following Texas counties: Donley, Hansford, Lipscomb, Ochiltree and Wheeler.
<i>Pre-existing condition limitations</i>	None	None
<i>Out-of-service-area restrictions</i>	Emergency care—Network benefit; must notify BCBSTX within 48 hours. Nonemergency care—Out-of-network benefit unless you go to a BCBS provider in that area.	None
<i>Deductibles</i>	Network: \$700/person/plan year, \$2,100/family/plan year Out-of-Network: \$1,400/person/plan year; \$700/hospital	\$700/person/plan year, \$2,100/family/plan year
<i>Out-of-pocket maximum</i>	Network: \$5,000/person/plan year; \$10,000/family/plan year Out-of-Network: \$10,000/person/plan year	\$5,000/person/plan year; \$10,000/family/plan year
<i>In-hospital care</i>	Network: 30% after deductible Out-of-Network: \$700/admission, then 50%	30% after deductible
<i>Emergency room</i>	Network: 30% after deductible Out-of-Network: 50% after deductible if emergency; otherwise 50%	30% after deductible
<i>Office visits</i>	Network: \$30/visit for Primary Care Physician (PCP) visits; \$45 for specialists; certain expensive surgeries—30% after deductible Out-of-Network: 50% after deductible	30% after deductible
<i>Lab/X-rays</i>	Network: Benefit depends on setting and procedure; see plan description booklet or call BCBSTX for details Out-of-Network: 50% after deductible	30% after deductible
<i>Surgery</i>	Network: 30% after deductible (inpatient and outpatient) Out-of-Network: 50% after deductible (inpatient and outpatient) Network and out-of-network: In physician's office, see office visit	30% after deductible
<i>Chiropractic care</i>	Network: \$45/visit, 30 visits/plan year Out-of-Network: 50% after deductible, 30 visits/plan year	30% after deductible, 30 visits/plan year
<i>Vision/Hearing/Speech</i>	Network and Out-of-Network: Vision—Routine preventive vision exams not covered; Hearing—Illness/accident coverage only	Vision—Routine preventive vision exams not covered Hearing—Illness/accident coverage only
<i>Maternity care</i>	In Network: Hospital—30% of charges after deductible; Doctor - \$30 initial visit only Out-of-Network: Hospital—50% after deductible; Doctor - 50% after deductible	30% after deductible
<i>Physical therapy</i>	Network: \$45/office-visit setting; Deductible and Coinsurance Outpatient or hospital-related facility setting Out-of-Network: 50% after deductible	30% after deductible 30% after deductible
<i>Durable medical equipment</i>	Network: 30% after deductible; Out-of-Network: 50% after deductible	30% after deductible 60 visits/person/plan year
<i>Home health care</i>	Network: 30% after deductible; 60 visits/person/plan year Out-of-Network: 50% after deductible; 60 visits/person/plan year	30% after deductible 60 visits/person/plan year
<i>Skilled nursing facility (not including custodial care)</i>	Network: 30% after deductible; 60 days/person/plan year Out-of-Network: 50% after deductible; 60 days/person/plan year	Inpatient - 30% after deductible
<i>Mental health</i>	<i>Inpatient</i> Network: Inpatient—30% after deductible; Out-of-Network: Inpatient—50% after deductible <i>Outpatient</i> Network: Outpatient—\$30/visit Out-of-Network: Outpatient —50% after deductible	Outpatient - 30% after deductible
<i>Prescription drugs</i>	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 nonformulary; brand-name copayment + difference between brand-name and generic when generic is available 90-day supply: Two copayments required if purchased by mail-order; three if purchased through certain retail pharmacies. Medco -- (800) 251-7690; http://www.medco.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 nonformulary; brand-name copayment + difference between brand-name and generic when generic is available 90-day supply: Two copayments required if purchased by mail-order; three if purchased through certain retail pharmacies. Medco -- (800) 251-7690; http://www.medco.com
<i>How does this health plan work?</i>	This plan is a preferred provider organization (PPO). If you live in a network area, you may choose any provider in a BlueCross BlueShield network to receive the highest level of coverage. You receive benefits for services provided by an out-of-network provider, but they will be lower. Most employees and retirees live in network areas. However, if you do not live in a network area, you may visit any provider and receive non-network benefits. See page 12 for details.	
<i>Member Services phone number/website</i>	BlueCross BlueShield of Texas—(866) 295-1212; for information on networks outside Texas—(800) 810-BLUE (2583) http://www.bcbstx.com	

Provisions

A&M Care 65 PLUS

Your Cost:

<i>Regions offered</i>	Available everywhere. All enrollees must be retired and enrolled in Medicare Parts A and B.
<i>Pre-existing condition limitations</i>	None
<i>Out-of-service-area restrictions</i>	None
<i>Deductibles</i>	\$500/person/plan year
<i>Out-of-pocket maximum</i>	\$1,400/person/plan year
<i>In-hospital care</i>	20% after deductible
<i>Emergency room</i>	20% after deductible
<i>Office visits</i>	20% after deductible
<i>Lab/X-rays</i>	20% after deductible
<i>High Technology Radiology (MRI, CT & pet scans, stress test, Angiogram & myelography)</i>	20% after deductible
<i>Surgery</i>	Inpatient, Outpatient and in physician's office - 20% after deductible
<i>Chiropractic care</i>	20% after deductible, 30 visits/plan year
<i>Vision/Hearing/Speech</i>	Vision – Routine preventive vision exams not covered; Hearing - Illness/accident coverage only
<i>Physical therapy</i>	20% after deductible
<i>Durable medical equipment</i>	20% after deductible
<i>Home health care</i>	Network: 20% after deductible; 60 visits/person/plan year Out-of-network: 50% after deductible; 60 visits/person/plan year
<i>Skilled nursing facility (not including custodial care)</i>	Network: 20% after deductible; 60 days/person/plan year Out-of-network: 50% after deductible; 60 days/person/plan year
<i>Non-serious mental health*</i>	<i>Inpatient</i> <u>Inpatient</u> - 20% after deductible <i>Outpatient</i> <u>Outpatient</u> - 20% after deductible
<i>Prescription drugs</i>	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 nonformulary; brand-name copayment + difference between brand-name and generic when generic is available 90-day supply: Two copayments required if purchased by mail-order; three if purchased through certain retail pharmacies. Medco -- (800) 251-7690; http://www.medco.com
<i>How does this health plan work?</i>	This plan is a preferred provider organization (PPO). If you live in a network area, you may choose any provider in a BlueCross BlueShield network to receive the highest level of coverage. You receive benefits for services provided by an out-of-network provider, but they will be lower. Most employees and retirees live in network areas. However, if you do not live in a network area, you may visit any provider and receive non-network benefits. See page 12 for details.
<i>Member Services phone number/website</i>	BlueCross BlueShield of Texas—(866) 295-1212; for information on networks outside Texas—(800) 810-BLUE (2583) http://www.bcbstx.com

Scott & White Health Plan

Provisions

Your cost:	
<i>Regions offered</i>	Bryan/College Station, Temple, Killeen, limited access in Austin, Prairie View, Stephenville areas
<i>Pre-existing condition limitations</i>	None
<i>Out-of-service-area restrictions</i>	Emergency care only at hospital, \$150/visit (waived if admitted); urgent care, \$50
<i>Deductibles</i>	\$350/individual; \$1,050/family/plan year
<i>Out-of-pocket maximum</i>	\$3,000/person/plan year; \$6,000 maximum/family/plan year, includes copayments, deductible and co-insurance.
<i>In-hospital care</i>	20% of charges after deductible
<i>Emergency room</i>	\$150/visit (waived if admitted)
<i>Urgent care</i>	\$50/visit; plus 20% co-insurance, if applicable.
<i>Office visits</i>	\$30/visit primary care doctor, \$45/visit with specialist; Today Care (College Station) \$30/visit.
<i>Standard Lab/X-rays</i>	Covered in full
<i>High Technology Radiology (MRI, CT & pet scans, stress test, Angiogram & myelography)</i>	20% of charges after deductible
<i>Surgery</i>	Inpatient and Outpatient— 20% of charges; after deductible
<i>Chiropractic care</i>	Not covered, limited discount network available
<i>Vision/Hearing/Speech</i>	Vision—\$45, one refraction/plan year; \$10/lenses w/frames or \$10/bifocals/trifocals w/frames (biennially); 100% coverage for contact lens up to \$150/plan year. Hearing/Speech (testing and/or therapy)—\$45/visit
<i>Maternity care</i>	Hospital -- 20% of charges; after deductible Doctor -- \$30/\$45 per visit or \$360 or \$540 total flat fee
<i>Well-baby care</i>	No charge
<i>Physical therapy</i>	\$45/visit
<i>Durable medical equipment</i>	20% after deductible, up to \$2,000/person/plan year (includes diabetic supplies and equipment)
<i>Home health care</i>	\$30/visit with approval of medical director
<i>Skilled nursing facility (not including custodial care)</i>	20% of charges, after deductible, with approval of medical director, not including custodial care.
<i>Non-serious mental health*</i>	<i>Inpatient</i> 20% of charges, after deductible <i>Outpatient</i> \$30/visit
<i>Prescription drugs</i>	Deductible - \$50/per person/plan year, does not apply to generic drugs <ul style="list-style-type: none"> • 34-day supply: \$5/generic (level A), \$25/brand-name formulary (level B), \$50 or 50% (whichever is less)/nonpreferred formulary (includes some generics; level C), \$50 or 50% (whichever is greater)/brand-name nonformulary • 90-day supply: two copayments required; mail-order purchase available but not required; you must purchase 34-day supply on new prescriptions for the first six months of use, 90-day supply not available for non-formulary drugs • Outpatient specialty drugs: including, but not limited to, Enbrel, Synvisc, Lupron, Reclast; Level 1 -\$50; Level 2 - \$100, Level 3 - \$250, Level 4 subject to \$350 medical deductible - 50% of charges after deductible with approval of medical director, does not apply to annual out-of-pocket maximum.
<i>How does this health plan work?</i>	The Scott & White Health Plan (SWHP) is an HMO composed of several regional clinics, as well as a network of providers outside the clinics that contract with the health plan. A PCP designation and/or referral to a specialist will <u>no longer</u> be required. However, some specialists will require a referral or diagnosis prior to appointment.
<i>Member Services phone number/website</i>	(800) 791-8777 or (979) 268-7947 http://www.swhp.org

Provisions

Graduate Student Health Plan

<i>Regions offered</i>	Available worldwide; outside U.S. benefits paid at 80%
<i>Pre-existing condition limitations</i>	80% up to \$1,000 benefit for an existing condition for 12 months; continuous coverage before enrollment offsets limitation period
<i>Out-of-service-area restrictions</i>	None
<i>Deductibles</i>	\$100/person; \$300/family; in or out-of-network; waived at student health center
<i>Out-of-pocket maximum</i>	\$3,000/person/plan year; \$6,000 maximum/family/plan year
<i>In-hospital care</i>	20% (network)/40% (out-of-network) after deductible
<i>Emergency room</i>	After deductible, \$250 copayment plus 20% (network)/40% (out-of-network)
<i>Office visits</i>	\$25/visit plus 20% (network)/40% (out-of-network); covered in full at student health center
<i>Lab/X-rays</i>	20% (network)/40% (out-of-network) after deductible
<i>Surgery</i>	20% (network)/40% (out-of-network) after deductible
<i>Chiropractic care</i>	\$25/visit plus 20% (network)/40% (out-of-network), when medically necessary due to accident or illness
<i>Vision/Hearing/Speech</i>	\$25/visit plus 20% (network)/40% (out-of-network), when medically necessary due to accident or illness
<i>Physical therapy</i>	\$25/visit plus 20% (network)/40% (out-of-network); must be within 60 days of being released for rehabilitation
<i>Durable medical equipment</i>	20% (network)/40% (out-of-network) after deductible
<i>Home health care</i>	No benefit
<i>Skilled nursing facility (not including custodial care)</i>	No benefit
<i>Mental health*</i>	<u>Inpatient</u> - 20% (network)/40% (out-of-network) after deductible; limited to 30 days/plan year; \$25,000 lifetime maximum <u>Outpatient</u> - \$25/visit plus 20% (network)/40% (out-of-network), (no maximum)
<i>Prescription drugs</i>	\$15 at student health center up to \$1,000; Plus drug card \$15/generic, \$25/brand name; \$35/single source drug, up to \$5,000 annual maximum benefit (no per illness maximum) Generic Drug - a medication duplicated by another company once the patent expires Brand Name Drug - A medication developed by a pharmaceutical company Single Source drug - A brand name drug without a generic equivalent
<i>How does this health plan work?</i>	This plan is for graduate student employees only. Students must be taking at least six credit hours or otherwise be working toward a degree. It is a preferred provider organization (PPO). You may choose any provider in the network to receive the highest level of coverage. You receive benefits for services provided by an out-of-network provider, but they will be lower. You will be reimbursed 100% for services you receive at a student health center.
<i>Member Services phone number/website</i>	(800) 452-5772 or www.tamuinsurance.com http://www.TAMUGSIPLAN.com

* The benefits above apply to most mental health conditions. However, for certain serious conditions, the state sets minimum coverage requirements. They are 60 days/plan year for inpatient care (subject to plan's in-hospital care copayment) and 45 days/plan year for outpatient care (subject to the plan's office visit copayment).

Wellness Programs

A&M Care Plans

Personal Health Manager

The Personal Health Manager (PHM) is a resource consisting of online tools and information to help you make informed health care decisions.

From the Personal Health Manager home page, you can:

- Take a Health Assessment
- Ask a Nurse Trainer, Dietitian or Life Coach: Members can interact online with a Blue Care Advisor on non-emergency, health-related questions or send questions about fitness, nutrition, or managing stress.
- Use the Interactive Symptom Checker
- Explore topics in the Health Information and Care Center
- Access Member Care Profile
- Read the latest health news, search for specific health topics or explore the prescription drug index

Blue Points

Members and their qualifying dependents can earn Blue Points when they complete designated wellness activities and report them in the Personal Health Manager. This rewards members and their dependents who make an effort to build and maintain healthy habits.

The online program generates points for completing designated tasks such as:

- Daily physical activity
- Read and rate health-related articles
- Downloading healthy recipes

Blue Points are redeemable for a variety of items at the online Blue Points Redemption Center.

Nurseline

- 24/7 NurseLine provides around the clock member advice for health conditions such as high fevers, earaches, cuts and bruises by phone.
- 24-7 NurseLine also provides an Audio Health Library that contains over 1200 pre-recorded health messages including:
 - Kicking the smoking habit
 - Ways to get a good night's rest
 - Managing high blood pressure
 - Getting a grip on stress
 - Asthma and self-management

Maternity Program: A Healthy Start for Mothers and Babies

The Blue Cross and Blue Shield of Texas (BCBSTX) Special Beginnings® maternity program offers support and education, pregnancy risk factor identification and ongoing communication/ monitoring from early pregnancy to six weeks after delivery. Members should call (888) 421-7781, 8 a.m. – 6:30 p.m., CT, to enroll in the program as soon as they find out they are pregnant.

Program staff in the Health Care Management Division will schedule follow up calls with you before and after delivery to:

- Identify any risk factors that might adversely affect the pregnancy
- Determine progress in self-management techniques
- Provide education on prenatal, postpartum and newborn care
- Reinforce the physician's treatment plan
- Help manage high-risk conditions such as gestational diabetes and preeclampsia
- Offer assistance on how to access other pregnancy-related resources

Scott & White Health Plan

Vital Care

Vital Care is the heading under which the Scott & White Health Plan offers a variety of programs, tools and resources to help you learn more about your health and to make positive changes. You do not have to be a health plan member to use these on-line resources.

Programs include:

- Health Risk Assessment
- Stress Management
- Depression Management
- Smoking Cessation
- Weight Management
- Exercise Program
- Overcoming Insomnia

VitalCare Nurse Advice Line

Available 24 hours a day, every day of the year, these nurses can help determine if you can take care of an illness at home, need an appointment, an urgent care or emergency room visit.

Disease and Condition Care Management Programs

These programs provide you with the resources for 21 chronic diseases/illnesses. Members are assigned a health coach for one-on-one guidance.

Asthma	Chronic Back Pain	Chronic Kidney Disease
Chronic Obstructive Pulmonary Disease	Cognitive Impairment	Congestive Heart Failure
Coronary Artery Disease	Crohn's Disease	Depression
Diabetes	Epilepsy/Seizures	HIV/AIDS
Hypertension	Migraines	Multiple Sclerosis
Obesity	Osteoarthritis	Parkinson's Disease
Post Traumatic Stress	Rheumatoid Arthritis	Ulcerative Colitis

Retiree Health Coverage

Age 65 and Still Working

Although many factors dictate whether your A&M System health plan or Medicare will be primary or secondary, in general, **coverage is determined by the status of the A&M health plan policy holder**. If the policy holder is working at the A&M System, regardless of age, the A&M System health plan will be primary to Medicare.

For example, if you are the covered employee and return to A&M as a working retiree, your A&M System health plan will be your and your spouse's primary coverage (if your spouse is covered under your plan) during the months in which you actually work. If you are the policyholder and you're retired, if you are both *eligible* for Medicare, Medicare will be primary for both you and your spouse, even if your spouse is working but does not have his/her own insurance, because the policyholder is retired.

If you, and your spouse are covered under Medicare and an A&M Care plan, let your health providers know who is primary and secondary, *especially* if you're still working.

If you are younger than 65 and not on Medicare

You are eligible for network benefits if you use a network provider. If your spouse is 65 or older, he/she is considered non-network. However, if you return to work for the A&M System, you and your spouse, regardless of age, will both be eligible for network benefits while you are working. Under the A&M Care plan, you pay only the copayment for office visits at network providers.

You receive non-network benefits if you live in Donley, Hansford, Lipscomb, Ochiltree or Wheeler county. However, if you live in these Texas counties and choose to travel to a network doctor, you can take advantage of the office visit copayment. See page 13 for differences between network and non-network payments.

Your A&M Care ID card has a toll-free telephone number you can call to locate BlueCross BlueShield (BCBS) network providers outside Texas. These providers should then file the claims with the local BCBS group, who will forward payment information to BlueCross BlueShield of Texas (BCBSTX).

If you are 65 or older or on Medicare

If you are 65 or older and eligible for Medicare Parts A and B or if you are disabled and enrolled in Medicare Parts A and B, you are considered non-network. You may use any doctor and receive the benefits described in the A&M Care Non-Network or 65 PLUS plan charts. If your spouse is younger than 65, he/she is eligible for network benefits, such as a \$30 or \$45 copayment for office visits.

Enrolling in Medicare Parts A and B

If you are 65 or older and not working for the A&M System, all A&M Care plans pay benefits as if you are enrolled in Medicare Parts A and B. This means you must enroll in both Medicare Parts A and B to receive the maximum benefits available. Most HMOs also pay maximum benefits only if you are enrolled in both Parts A and B. You will be penalized by Medicare with higher premiums if you do not enroll in Part B when you are first eligible, and you will be able to enroll only during certain times.

A&M Care plans and Medicare coordination

If you are enrolled in Medicare and not currently working for the A&M System, your charges must first be submitted to Medicare. Generally, if you live in Texas, Medicare will then forward your claims directly to BCBSTX for payment. If you live outside Texas, you must submit your claims to BCBSTX after Medicare has paid its share, along with the Explanation of Benefits from Medicare.

Your A&M Care plan benefits are calculated based on the entire bill from your health care provider.

After Medicare pays its benefit, your A&M Care plan pays either its full benefit or the difference between the total bill and the amount Medicare paid. This means that you receive full reimbursement in many cases.

Example:

Let's say you have a \$200 office visit. First, you must meet your \$155 Medicare Part B deductible, then Medicare will pay 80% of the remainder (\$36 in this case.) The difference between the total bill (\$200) and the Medicare benefit (\$36) is \$164.

If you have not yet met your A&M Care deductible for the plan year, the full \$200 charge will be applied toward your deductible under whichever A&M Care plan you have, and the plan will pay nothing.

If you've already met your A&M Care deductible, all A&M Care plans will pay the \$148 remainder left from Medicare, since that is less than the amount that would have been paid if you had not had Medicare.

Medicare has a calendar-year deductible (January through December), while the A&M Care plans have plan-year deductibles (September through August).

Age 65 and still working.

If you are enrolled in the 65 PLUS plan and you return to work for more than six months in a plan year, you must switch to another health plan. Any time worked in a month counts as having worked the full month. This is because premiums for the 65 PLUS plan are based on that plan being secondary to Medicare, and when you return to work, your A&M System health coverage becomes primary.

Notice of Creditable Coverage for Medicare Part D

All A&M System health plan prescription drug benefits have been certified to be comparable to or better than those provided by the new Medicare Part D prescription drug plan. This means that if you have A&M System health coverage and become eligible for Medicare Part D but decide to enroll at a later date, you will not have to pay a higher premium than you would have paid if you'd enrolled when you first became eligible. You may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium.

Medicare Part D is available if you qualify for Medicare Part A and/or Part B. Enrolling or not enrolling in Medicare Part D will not change your enrollment in Parts A and/or B and will not impact the non-prescription drug part of your A&M System health coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare or from Oct. 15 to Dec. 7 of any later year. If you drop or lose your A&M System health coverage and don't enroll in Medicare Part D within 63 days after your coverage ends, you may be required to pay more to enroll in Medicare Part D later. In this case, you may enroll as soon as you drop or lose A&M System coverage and don't have to wait until the normal Part D enrollment period.

Because System health plans usually provide better drug benefits at a lower cost, Medicare Part D enrollment is not necessary for most System employees and retirees enrolled in System health plans. However, if you qualify for financial assistance, you will save on Part D premiums, copayments and coinsurance, which could mean you would benefit from Part D. Financial assistance is available to Medicare beneficiaries with incomes up to 150% of the Federal Poverty Level and limited resources.

To determine if you qualify for financial assistance with Medicare Part D, you can contact the Social Security Administration (SSA) at (800) 772-1213 (TTY 800-325-0778) or visit SSA online at <http://www.socialsecurity.gov>.

Medicare Part D is offered through private, Medicare-approved prescription drug plans. All Medicare drug plans will offer a standard level of coverage set by Medicare. If you decide to enroll in a Medicare prescription drug plan, you will pay a premium of about \$32.50 per month, although some providers may charge less. This fee will likely change over time. You will also have to pay a \$250-a-year deductible.

If you are eligible for Medicare, you can be enrolled in both your System health plan and Medicare Part D, **but you cannot receive prescription drug benefits from both plans**. Your options include keeping your A&M System health coverage and not enrolling in Part D, or keeping your A&M System health coverage and also enrolling in Part D. If you enroll in Part D, you will not receive a drug benefit from your system health plan, but your System health premiums will not decrease.

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

For more information about Medicare

- “Medicare & You 2012” handbook (available from Medicare), which contains detailed information about Medicare plans that offer prescription drug coverage.
- Medicare website <http://www.medicare.gov>
- Medicare customer service: (800) 633-4227. TTY users should call (877) 486-2048.
- State Health Insurance Assistance Program (SHIP)

Dental

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

Enrollment Rules:

- Everyone is eligible for the PPO plan. Eligibility for the HMO depends on where you live and whether there are HMO dentists in the area.
- If you do not enroll during your initial enrollment period, you can enroll yourself and dependents only during annual Enrollment or if you have a certain Change in Status.
- 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 Care Dental PPO**

The plan has two levels of network providers. Each time you need services, you can choose a PPO dentist, a Premier dentist or a non-network dentist. PPO providers reduce their fees by about 30%, and Premier providers reduce their fees by about 15%. Both groups of providers have agreed to specific fee schedules, and you are not liable for any costs over Delta's allowable amount. You can also use a non-network provider and receive the regular plan benefits shown in this chart based on the provider's full fees, but your out-of-pocket costs may be higher. To find a network dentist in your area, go to <http://www.deltadentalins.com/tamus>, or refer to the plan's provider directory, available from your Human Resources office.

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

DeltaCare USA Dental HMO

The DeltaCare USA is not available in all parts of Texas. You must live or work within the same first-three-digit zip code area as an HMO dentist. If you do not, but are willing to travel to a network dentist, you can enroll by submitting a Benefit Enrollment form to your HR office.

To receive benefits under the DeltaCare USA plan, you must use the general dentist listed on your ID card.

The plan has networks in Texas, Tennessee, Florida, Georgia, California, Washington, D.C., Maryland, Colorado, New York and Utah. You must use a network general dentist or be referred to a specialist by a network general dentist. When you enroll, Delta Dental will assign you a dentist. If you wish to change dentists, contact Delta Dental at (800) 422-4234. To find a network dentist, go to <http://www.deltadentalins.com/tamus>. Contact Delta Dental directly for information on specialists.

A&M Dental PPO

Deductible	\$75/person/plan year; \$225 family/plan year
Maximum benefit	Regular: \$1,500/person/plan year; Orthodontia: \$1,500/person/lifetime
Your cost for preventive care	\$0 (if you use a network provider). The plan covers three regular or periodontal cleanings per plan year at 100% up to maximum allowable charges . Deductible does not apply.
Your cost for basic care	You pay the deductible plus 20% of the maximum allowable charges for fillings, root canals, extractions and periodontics. Once you reach your maximum annual benefit of \$1,500, you pay 100%.
Your cost for major restorative care	After you meet your deductible, you pay 50% of the maximum allowable charges for crowns, dentures and bridges. Once you reach your maximum annual benefit of \$1,500, you pay 100%.
Your cost for orthodontics	After you meet your deductible, you pay 50% until you reach your maximum lifetime benefit of \$1,500, then you pay 100%.
Filing claims	PPO and Premier dentists file claims for you.
Alternate benefit provision	When more than one procedure could provide suitable treatment, the plan will pay for the least expensive procedure. You may apply this benefit to whichever procedure you wish to have.

PROCEDURE: CROWN	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	NON-DELTA DENTAL DENTIST
Dentist bills	\$800.00	\$800.00	\$800.00
Dentist accepts as payment in full	\$548.00 (Delta Dental's allowed amount)	\$688.00 (Delta Dental's allowed amount)	\$800 (No fee agreement with Delta Dental)
Delta Dental's payment Major benefit paid at 50%	\$274.00	\$344.00	\$344.00
Patient share	\$274.00	\$344.00	\$456.00
Patient savings	\$252.00	\$112.00	\$0.00

*Patient's share is the coinsurance, any remaining deductible, any amount over the annual maximum and any services your plan does not cover. However, when visiting a non-Delta Dental dentist, the patient share also includes the difference between the allowed amount and the dentist's submitted charge.

For More Information

- Dental Summary Plan Description Booklet online at: <http://www.tamus.edu/assets/files/benefits/pdf/spddental.pdf>.
- Delta Dental Online at <http://www.deltadentalins.com/tamus>
- Customer Service: 1-800-521-2651

DeltaCare USA Dental HMO

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

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
Filing claims	Not applicable.
Alternate benefit provision	None; you choose the procedure you want from the covered services and pay the applicable copayment.

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

Dental Service	Copayment
Deductible	\$0
Oral Exam - X-rays, Cleaning	\$5
Flouride Treatment - child (age <19)	\$0
Filling - Amalgam	\$8
Crown	\$185-\$395
Root Canal - molar	\$365
Extraction - erupted tooth or exposed root	\$14
Orthodontia (child to age 19)	\$1,150
For a complete listing of copayments, go to http://www.tamus.edu/assets/files/benefits/pdf/programs/DHMO15B.pdf/	

Vision

Plan Choices: The A&M System’s vision plan provides coverage for eye exams, eyeglass frames and lenses, and contact lenses as well as discounts on some eye surgeries. If you have vision exam coverage through your health plan, you may use either that benefit or the vision plan’s exam benefit. You must enroll and pay a monthly premium for vision coverage. This plan is administered by **EyeMed Vision Care**.

- Enrollment Rules:**
- You can enroll yourself or existing, noncovered dependents during your initial enrollment, Annual Enrollment or if you have certain Changes in Status.
 - 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 most materials for a \$15 copayment if you use a network provider. If you use a provider not in the network, the plan will pay limited benefits. The chart below describes plan benefits for the most common products and services.

When you use a network provider, you pay your copayment (and any non-covered expenses) and the plan pays the rest. If you use a network provider and are filing your vision claim under your medical plan, you will have to submit a claim to **EyeMed Vision Care** with your Explanation of Benefits or statement from your provider. If you use a non-network provider, you pay the full cost to the provider and submit a claim, including the original bill, to **EyeMed Vision Care** 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
<i>Eye exam (one exam per plan year)</i>	100% after \$10 copayment. This typically includes patient case history, exam for eye pathology abnormalities, dilation, refraction, visual skill testing and diagnosis and prescription for contacts or glasses.	Up to \$50 . Copayment doesn’t apply.
<i>Materials</i>	100% after \$15 copayment for: <ul style="list-style-type: none"> • Frames - every other plan year, up to \$130. • Eyeglass lenses, one standard pair every plan year. Standard single vision; standard lined trifocal, standard lined bifocal, standard lenticular and standard progressive . For higher dollar frames, you will have to pay the copayment plus the difference between EyeMed's maximum frames allowance, \$130, and the cost of the frames.	Lenses: \$50 to \$100 , depending on type of lenses. Frames: Up to \$90 . Copayment doesn’t apply.
<i>Contact lenses (once every plan year in place of eyeglass benefit)</i>	100% up to \$150 allowance for normal lenses. This covers the full cost of the contacts (one pair of standard contact lenses or up to six boxes of disposables), fitting and/or evaluation fees, and up to two follow-up visits. EyeMed Vision Care will provide a \$150 allowance for lenses that are not covered in full (such as toxic, gas permeable and bifocal contacts) and up to 100% for medically necessary contacts.	Up to \$150 for elective contacts; up to \$210 for medically necessary contacts. Copayment doesn’t apply.
<i>Refractive eye surgery</i>	15% off reasonable and customary cost, or 5% off promotional price.	Not applicable.

Vision Materials Discount Program

EyeMed Vision Care has an additional Materials Discount Program. At participating providers, you will receive a **40%** discount on an additional pair of eyeglasses or contact lens, once you have exhausted your vision benefit for the year. The discount will apply to the retail price and can be purchased any time during the plan year after you have used the plan. Call **1-855-862-4300** to find a participating provider in your area. Not all providers participate in this program. Retailers such as Sam's and Wal-Mart do NOT because of the large discounts they already offer.

Laser Vision Correction

EyeMed Vision Care has partnered with the **U.S.Laser Network** of America (LVNA) to provide our members with access to discounted laser correction providers, 1-877-28-SIGHT.

For additional information or to locate a network provider, visit: www.eyemedlasik.com or call 1-877-5LASER6.

For More Information

- Vision Summary Plan Description Booklet online at: <http://www.tamus.edu/assets/files/benefits/pdf/spdvision.pdf>
- EyeMed Vision Care online at <http://www.eyemedvisioncare.com/>
- Customer service: 1-855-862-4300

Life

Plan Choices: The A&M System offers Basic Life, Alternate Basic Life, Optional Life and Dependent Life insurance. Eligibility for various life insurance plans depends on whether you have health coverage through the A&M System. The plan you select for yourself can affect eligibility for the dependent life plans.

Enrollment Rules: Coverage for Life insurance is effective on the date specified, (see Benefit Enrollment Period, page 4) or the first of the month following approval if evidence of insurability (EOI) is required.

- You must be actively at work on the day your coverage, or increase in coverage, is to begin.
- If you and your spouse both work for the A&M System and you take Optional or Alternate Basic Life, your spouse may not cover you through his/her Dependent Life.
- Children may not be covered on Dependent Life by both parents. Only dependents you list are covered under Dependent Life.

After your initial enrollment period, you may:

- Enroll in coverage at any time by providing EOI.
- Enroll in Optional Life coverage of ½ or one times salary within 60 days of a Change in Status without providing EOI.
- Increase Optional Life coverage by one increment up to three times salary within 60 days of a change in Status without providing EOI, or
- Enroll new dependents within 60 days of acquiring them without providing EOI. Spouses must always provide EOI for coverage over \$50,000.

Benefits: Life Insurance pays benefits to your beneficiaries if you die or to you if a covered family member dies, if you covered that dependent. Basic Accidental Death and Dismemberment (AD&D) pays an additional benefit in the event of the accidental death or dismemberment of a covered employee.

If you have a salary increase or decrease, your dependent coverage amount will **not** change. During annual enrollment, or as a result of a life status event, you may make a change to your dependent life coverage, but it must be to one of the amounts available. To increase coverage, your spouse must provide EOI.

Premiums:

Lower Optional Life premiums are available if you have not used any tobacco products in the last 12 months. You can change your tobacco status at any time.

Living Access 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 up to 50% of your plan benefit. Your beneficiary will receive the remaining benefit after your death. This benefit is also available to dependents who are covered under Dependent Life.

- **Travel Assistance** - provided by Global Rescue - covers employees and dependents traveling 100 miles or more when traveling for business or pleasure. Features include a repatriation benefit, access to emergency medical assistance, emergency travel arrangements and pre-trip resources.
- **Legal Services**, provided by Ceridian Life Works - offers employees, retirees and their families a free 30 minute initial consultation with an attorney, drafting of wills and other legal documents.
- **Beneficiary Financial Counseling Services**, through PricewaterhouseCoopers provides assistance with estate planning, budgeting, taxes, etc., for beneficiaries receiving a benefit of \$25,000 or more.

Age Reductions

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

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

Coverage Options

Basic Life/ Basic AD&D <i>Coverage for you:</i> <i>Child coverage:</i>	<i>You are automatically covered if you are enrolled in an A&M System Health plan. The System covers the cost. If you have no health coverage, you can purchase Basic Life.</i> \$7,500 in life insurance coverage and \$5,000 in AD&D coverage. \$5,000 in life insurance on each eligible dependent child.
Alternate Basic Life/ Basic AD&D <i>Coverage for you:</i>	<i>You can enroll if you are not enrolled as an employee or retiree in System health coverage but certify that you have other health coverage. You can pay for Alternate Basic Life using the employer contribution. If you select this coverage, you cannot enroll in Optional Life.</i> Employee: \$50,000 or up to seven times your salary, whichever is less, as well as \$5,000 in Basic AD&D coverage. Retiree: \$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	<i>You can enroll regardless of whether you are enrolled in a System health plan or whether you certify that you have other health coverage, but you pay for the coverage yourself. If you select this coverage, you cannot enroll in Alternate Basic Life. You must provide evidence of insurability to enroll after your initial enrollment or to increase Optional Life coverage at a later time.</i> Employee: ½, 1, 2, 3, 4, 5 or 6 times your annualized salary (salary divided by the number of months you work, multiplied by 12) to a maximum coverage of \$1 million. Retiree: Maximum of \$100,000 if younger than 70, \$60,000 if older than 70. Coverage will automatically be reduced to \$60,000 or \$30,000, respectively on the first month following your 70th or 80th birthday. See chart above for age reduction.
Dependent Life Plan A <i>Spouse coverage:</i>	You can enroll if you have Optional Life coverage. You pay for the coverage yourself. Employee: Coverage amounts of \$25,000, \$50,000, \$75,000, \$100,000, \$150,000 or \$200,000, not to exceed your coverage amount.* Retiree: Coverage amounts of \$25,000, \$50,000 depending on your age and coverage (see top of page). Child coverage: \$10,000 per child.*
Dependent Life Plan B	You can enroll if you have Basic Life, Alternate Basic Life or Optional Life coverage. You pay for the coverage yourself. 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 dependent child.
Dependent Life Plan C	You can enroll 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: 10% of your Alternate Basic Life coverage amount on each enrolled child.

* If you had coverage prior to September 1, 2009, your dependent coverage amount(s) may be “grandfathered”, meaning the amounts did not change when the coverage amounts were changed on September 1, 2009.

For More Information

- Life Summary Plan Description Booklet, online at: <http://www.tamus.edu/assets/files/benefits/pdf/spdlife.pdf> or from your HR office.
- Minnesota Life customer service: (877) 443-5854
- Global Rescue: (855) 516-5433

AD&D

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

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

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

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

Enrollment Rules:

- You can enroll during your initial enrollment period or during future Annual Enrollment periods.
- Evidence of Insurability (EOI) is not required because the policy pays only for accidents.
- Once you enroll in the AD&D plan, you can reduce or drop your coverage at any time. You can enroll in or increase coverage only during Annual Enrollment. You can change from individual to family coverage or family coverage to individual coverage only during Annual Enrollment or within 60 days of a Change in Status.

Benefits:

For loss of: Your benefit is the following percentage of the full coverage amount:

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 in both ears	50%
Thumb and index finger of the same hand	25%

Coma Benefit

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

Felonious Assault Benefit

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

Child Care Benefit

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

COBRA Benefit (Medical Continuation)

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

Education Benefit

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

Naming a Beneficiary

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

Changing Your Coverage

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

For More Information

- AD&D Plan Description Booklet, online at <http://www.tamus.edu/assets/files/benefits/pdf/spdadd.pdf> or from your HR office.
- Minnesota Life customer service: (877) 443-5854

Long-Term Disability

Plan Choices: Long-Term Disability (LTD) provides income if you cannot work due to a disability. Cancer, a back problem, an injury from a car accident, or any other condition that keeps you from being able to perform your job is considered a disability. You do not have to be permanently disabled or unable to work at all to qualify for benefits. LTD is an optional coverage for which you pay the full cost.

Enrollment Rules:

- You do not have to provide evidence of insurability (EOI) to enroll in LTD.
- If you do not elect coverage during your initial enrollment period, you may enroll during another Annual Enrollment period, also without EOI. Lower premiums are available for non-tobacco users. You are considered a non-tobacco user if you have not used any tobacco products for more than 12 months. You can change this designation at any time.

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

Definition of Disability

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

Maximum/Minimum Monthly Benefit

Maximum \$8,000, minimum \$100 or 10% of your monthly benefit before deductions of other income, whichever is greater.

Your benefit amount will be reduced by earnings you receive from: sick leave pay, workers' compensation, Social Security or any other government plan, or TRS or ORP payments.

Elimination Period

90 days from onset of continuous disability

Pre-Existing Condition

The plan will not cover a disability resulting from a pre-existing condition until you have been covered under the plan for 12 months or until you have gone 90 days (after coverage begins) without receiving medical treatment, consultation, care or services, including taking prescribed medications for the condition.

If you pay the full LTD premium yourself, your deduction is taken after-tax and your LTD benefits will not be taxable when you receive them. If you apply part or all of the employer contribution to your premium, part or all of your benefit will be taxable. The taxable portion will be proportional to the amount of premium paid by your employer.

Nonorganic Mental Impairments

Maximum Benefit period of 24 months

Catastrophic Disability

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

Reducing Benefit Duration

Benefit is provided monthly until the greater of the “Reducing Benefit Duration” or Social Security Normal Retirement Age.

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

For More Information

- LTD Plan Description Booklet, online at <http://www.tamus.edu/assets/files/benefits/pdf/spdltd> or from your HR office.
- LTD claim office: **Cigna (800) 732-1603** or www.cigna.com.

Long-Term Care

Long Term Care (LTC) provides benefits for necessary services such as nursing and custodial care when a person becomes incapable of caring for him or herself. Covered services depend on the individual's condition and can include help in the person's home with daily activities such as eating and dressing or assistance in a nursing home. Services covered under LTC are not covered under disability or Medicare and most health plans have limitations on what they will pay.

Available only to those enrolled prior to January 1, 2012.

Benefits:

A person becomes eligible for LTC benefits when a licensed health care practitioner certifies that you require substantial assistance from another person to perform two or more activities of daily living due to loss of functional impairment which is expected to last at least 90 days. The six activities of daily living are:

- Bathing
- Eating
- Toileting
- Dressing
- Transferring
- Maintaining continence

The plan pays benefits for:

- adult day care
- nursing and custodial care received from a state-licensed nursing home, alternate-care facility or home health care agency
- caregiver training
- emergency alert
- assisted living
- respite care
- hospice
- adult foster care

You select from five benefit levels:

- \$100/day
- \$150/day
- \$200/day
- \$250/day
- \$300/day

You will receive up to your full benefit amount for each day you spend in a nursing or assisted-living home or alternate-care facility, regardless of other coverage. You will receive 75% of that benefit for each day you need home health care, adult day care, hospice or adult foster care services. Your maximum lifetime benefit is 2,190 (six years) times your daily benefit.

The plan offers two options for an additional premium:

- The automatic benefit increase option increases your daily maximum benefit by 5% each year, with no increase in your premium. If you did not elect this option, you will have the opportunity every three years to increase your daily maximum benefit with an increase in premiums.
- The nonforfeiture option ensures that if you stop paying premiums after at least three years you will still be able to receive benefits equal to the sum of the premiums you paid or 30 times your daily benefit, whichever is greater. If you stop paying premiums after at least 10 years, you will be able to receive your premiums or 90 times your daily benefit.

Waiver of Premiums:

Your premium payments will be waived once you complete the Qualification Period, provided you meet the benefit eligibility requirements under the policy on that date. The waiver will continue as long as you remain eligible for benefits.

Premiums:

Premiums are based on your age when you enrolled in coverage and change only if there is a general change in your rate category. Your spouse's premium was also based on his/her age at the time of enrollment.

Portability:

If you retire or leave The Texas A&M University System, your coverage may be continued at group rates. You will pay premiums directly to John Hancock.

For More Information

- John Hancock website at <http://tamus.jhancock.com> (username=TAMUS, password=mybenefit in all lowercase)
- John Hancock customer service (800) 498-9100.

Flexible Spending Accounts

Plan Choices: Flexible Spending Accounts allow you to set money aside to use to reimburse yourself for health care and dependent day care expenses incurred during the plan year. You never pay federal income or Social Security taxes on this money. When you have such expenses, you can pay yourself back from your accounts with before-tax dollars. Flexible Spending Account elections must be renewed each year. Unused balances in your accounts do not carry over to the next year.

- *Health Care Spending Account:* Minimum contribution: \$20/month; Maximum contribution: \$4,800/year
- *Dependent Day Care Spending Account:* Minimum contribution: \$40/month
Maximum contribution: \$5,000/year (\$2,500 if married and filing a separate income tax return)

**Enrollment
Rules:**

- You can enroll in the Health Care Flexible Spending Account, Dependent Care Spending Account, or both, within 60 days of employment, within 60 days of certain Changes in Status and during annual enrollment.
- Elections for subsequent plan years takes place during annual enrollment. If you are currently enrolled you must enroll again for the next plan year during annual enrollment. Your election for the current year will not automatically carry forward to the next plan year.

Changing your elections - After enrolling, your elections remain in effect through August 31, 2012. You may change your elections only at the beginning of each plan year, unless you have certain Changes in Status. If this happens, you may change your elections within 60 days of the change. The change you make must be consistent with the type of Change in Status you have. If you have questions regarding the changes you can make to your Flexible Spending Accounts, call PayFlex at (800) 284-4885 or your Human Resources office. If you increase your contributions to the plan because of a Change in Status, the increased benefit is available only for services incurred after the first of the month following the receipt of your change.

If you leave A&M System employment during the plan year, you can choose to continue contributing to the health care spending account on an after-tax basis through COBRA. If you do so, you may continue to submit claims incurred between September 1, 2011, and August 31, 2012. If you do not elect to continue contributing, you may not submit any claims incurred after your employment ends. Your contributions to your Dependent Day Care Account must end when your employment ends. However, you may continue to submit claims incurred between September 1, 2011, and August 31, 2012, as long as you have an account balance.

Benefits:

Health Care Account

The Health Care Spending Account allows you to use before-tax dollars to pay medical, dental, vision and hearing care expenses not paid by your A&M System benefit plans for you and your dependents. You do not have to be covered through an A&M System health plan to enroll. If you wish to pay a dependent child's health care expenses through this account, the child must meet certain criteria set by the IRS (criteria are listed on page 7 under "Premiums"). The plan year for Flexible Spending Accounts runs from September 1 to August 31.

You can use the Spending Account for the same medical expenses that are eligible for an income tax deduction, but you cannot use both the account and the deduction for the same expense.

Dependent Day Care

The Dependent Day Care Spending Account allows you to use before-tax dollars to pay for dependent day care expenses that are necessary to allow you and your spouse to work. You may enroll only if your spouse works or is a full-time student or disabled. The dependent receiving the care must live in your home at least eight hours a day, be claimed as a dependent on your tax return or be in your legal custody, and be 12 or younger or an older dependent who requires care due to a physical or mental disability.

You can use the Spending Account for the same day care expenses that are eligible for a tax credit. However, you cannot use both the account and the tax credit for the same expense. Since the tax credit limit is \$6,000 and the Spending Account limit is \$5,000, you can pay some expenses through the Spending Account and take the tax credit on the rest. See the chart on page 43 or visit the PayFlex website, <http://www.healthhub.com>, to determine which works best for you.

Restrictions

Both types of accounts carry certain restrictions. These include:

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

Using the Spending Accounts

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

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

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

Dependent Day Care Spending Account	
<p><i>Covered expenses include:</i></p> <ul style="list-style-type: none"> • Day care fees for children 12 or younger or older disabled dependents • Babysitting fees (work-related only) 	<p><i>Expenses not covered include:</i></p> <ul style="list-style-type: none"> • Tuition and fees for private school, grades kindergarten through 12th • Overnight camps and extracurricular lessons • Supply fees • Club or organization membership fees
<p>For a complete listing of allowable health care and/or day care expenses, contact PayFlex at (800) 284-4885 or http://www.healthhub.com, or see IRS Publications 502 and 503 (keep in mind that these publications contain some information not pertaining to the A&M System Spending Account Program), available online at http://irs.ustreas.gov or by calling (800) 829-3676.</p>	

Debit Card

If you elect the debit card, you can pay for your eligible healthcare expense(s) at the point of service: the doctor’s office, a pharmacy, or other health care service provider. When you have a copay, the money will be taken directly from your account, so you don’t have to pay for the service and file for reimbursement. Dependent Day Care expenses cannot be paid using the debit card.

Debit cards can only be used at non-healthcare related merchants (grocery stores, discount stores) locations that have implemented an Inventory Information Approval System (IIAS). The IIAS recognizes whether an expense is eligible or ineligible for reimbursement by a healthcare FSA.

If you elect the debit card option:

- An annual fee of \$9 will be deducted from your annual election.
- Your card will be mailed to your home address in a plain envelope from Omaha, NE.
- The card is good for FIVE years. Don’t throw it away after you deplete the current year funds.
- If you need additional cards for your dependents, contact PayFlex at (800) 284-4885 or order online www.healthhub.com.
- In most cases, you will not be required to submit a claim or receipt. However, be sure to always save your itemized receipts, in the event you receive a “Request for Receipt” letter or email from PayFlex. If you receive a request for documentation from PayFlex, you must return the requested documentation within 21 days of the date of the letter to ensure your PayFlex debit card remains active.

Grace Period

The grace period is a provision under federal law that allows the A&M System to extend the time flexible spending account participants have for withdrawing funds from their Health Care and/or Dependent Day Care Spending Accounts. Under this provision, participants who have funds remaining in their accounts at the end of the plan year, August 31, can use those funds to pay eligible expenses incurred for the next 75 days, through November 15.

Paper Claims

If you do not elect the debit card option, or do not use your debit card for a particular purchase, you can still submit claims using the on-line Express claim function, uploading, faxing, or mailing your claim to PayFlex.

When you file a claim, you may receive a reimbursement check, or you may choose to have your reimbursement directly deposited in the account in which your paycheck is deposited. If you want to have your reimbursement deposited into a different account, you can complete a Direct Deposit Authorization Form and submit it directly to PayFlex. The form is available at www.tamus.edu/as-sets/files/benefits/pdf/programs/DirectDepositAuthForm.pdf or on the PayFlex website, www.healthhub.com.

Filing Deadline - Claims against your 2011-2012 account must be filed by December 31, 2012.

Tax Credit vs. Dependent Day Care Account

To find out whether the Spending Account or tax credit may be best for you, login to www.myhealthhub.com, click on My HealthHub Resources and then, Planning Tools.

Health Expenses Flexible Spending Account Worksheet

This worksheet will help you calculate your election for a healthcare flexible spending account while keeping you from contributing more than you will be able to withdraw. Remember, money you set aside for your 2010-2011 FSA account does not roll over to the next plan year and amounts not reimbursed by the deadline are forfeited. You can contribute any amount from a minimum of \$20 a month to a maximum of \$4,800 a year. If you and your spouse both work for the A&M System, one or both of you can have Health Care Accounts. If you both have accounts, you can each contribute up to \$4,800 a year.

Annual Expenses	Expenses for 2010-2011	Projected Expenses for 2011-2012
<i>Medical expenses such as:</i>		
Health Insurance Deductible	\$ _____	\$ _____
Copayments for Dr. visits	\$ _____	\$ _____
Co-insurance	\$ _____	\$ _____
Prescription Deductible	\$ _____	\$ _____
Prescription Copayments	\$ _____	\$ _____
<i>Dental expenses such as:</i>		
Dental Deductible	\$ _____	\$ _____
Dental Co-Insurance or Copayments	\$ _____	\$ _____
Orthodontic Expenses	\$ _____	\$ _____
<i>Vision expenses such as:</i>		
Vision Exam - Copayments	\$ _____	\$ _____
Eyeglasses & contacts	\$ _____	\$ _____
Lasik Surgery	\$ _____	\$ _____
<i>Other health-related expenses:</i>		
Other	\$ _____	\$ _____
Other	\$ _____	\$ _____
Other	\$ _____	\$ _____
Total out-of-pocket expenses projected for next year		\$ _____ *

Be conservative in your estimate! It is important to put no more money into an FSA than you are sure you will use during the year.

* For your monthly contribution, you will need to divide this amount by the number of pay periods in your plan year, or the number of pay periods remaining in the Plan Year if you are enrolling mid-year.

Dependent Care Expenses Flexible Spending Account Worksheet

This worksheet will help you determine your election for the dependent care flexible spending account. The dependent care flexible spending account is designed to reimburse expenses related to the care of children or adults* so that you can work. Generally, eligible expenses include nursery, pre-school, afterschool care or dependent day care facilities.

Type of Expense	Projected Expenses for 2011-2012
Licensed day care, nursery or preschool	
Cost per week/month	\$ _____
Number of weeks/months	_____
	\$ _____
Before or after school care programs	
Cost per week/month	\$ _____
Number of weeks/months	_____
	\$ _____
Childcare during summer months (for school age children)	
Cost per week/month	\$ _____
Number of weeks/months	_____
	\$ _____
Total expenses projected for next year:	\$ _____ **
	=====

Be conservative in your estimate! It is important to put no more money into an FSA than you are sure you will use during the year.

* If your dependent is over age 13, he/she must be physically or mentally incapable of caring for themselves.

** For your monthly contribution, you will need to divide this amount by the number of pay periods in your plan year, or the number of pay periods remaining in the Plan Year if you are enrolling mid-year.

In order to be reimbursed for dependent care FSA you will need to provide, the social security number for individual dependent care providers or the taxpayer identification number for care centers and schools.

Eligible Expenses include, but are not limited to:

- Summer Day camp
- Before and after school care
- Extended day programs
- Custodial childcare
- Eldercare

Ineligible expenses include, but are not limited to:

- Overnight camp
- Education and tuition expenses (kindergarten and above)
- Field trip expenses

Retirement Programs - Mandatory Plans

Plan Choices: If you are a benefits-eligible employee, you are automatically enrolled in the Teacher Retirement System of Texas (TRS) on your first day of work unless you are required to be a graduate student for your position. If you are employed in an ORP-eligible position, you may make a one-time, irrevocable election within 90 days of eligibility to enroll in the Optional Retirement Program (ORP) instead of TRS. If you are eligible for ORP, you will receive additional information. You will be given only one 90-day period to elect ORP during your career in Texas public higher education. If you have participated in ORP through previous employment with a Texas state institution of higher education, you must continue participating in ORP. Under both plans, you and the A&M System contribute toward your retirement benefit on your eligible salary up to the \$245,000 federal limit. The employer/employee contribution amounts are set by state legislation and are subject to change.

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

Teacher Retirement System of Texas (TRS)

You contribute 6.4% of your pay to TRS on a before-tax basis. For 2011-12, the A&M System contributes an amount equaling 6.0% of your pay.

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

You can receive an unreduced standard annuity when the sum of your age and years of TRS service equals at least 80 or at age 65 with at least 5 years of service. If you begin TRS participation on or after September 1, 2007, you can receive an unreduced standard annuity at age 60 when the sum of your age and years of TRS service equals at least 80 or at age 65 with at least 5 years of service. Reduced benefits are available for early age retirement if you are age 55 with 5 or more years of service or you are younger than 50 but you have 30 or more years of service.

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

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

Optional Retirement Program (ORP)

You contribute 6.65% of your pay to ORP on a before-tax basis. The A&M System currently contributes an amount equaling 6.4% of your pay. These contributions go into an individual account. If you enroll in ORP, you will forfeit all TRS benefits previously earned (except your contributions, which will be refunded to you or rolled into an individual retirement account).

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

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

You are eligible to receive your account balance upon termination of employment in all Texas institutions of higher education, reaching age 70½, retirement or death. If you leave A&M System employment and withdraw your funds before age 55, your withdrawal may be subject to income tax, plus penalties, and you may not be eligible for A&M System retiree insurance benefits (see “Retiree insurance benefits” on page 30). Your choice of benefit payment options after you retire depends on the payment options offered by the vendor(s) you chose. Consult your tax advisor before withdrawing any funds.

No loans or hardship withdrawals are permitted under ORP.

Retiree insurance benefits

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

- you are at least age 65 and have at least 10 years of service credit, or your age plus years of service equal at least 80 and you have 10 years of service credit,
 - you have 10 years of service with the A&M System, and
 - the A&M System is your last state employer.
- * You must also provide documentation that you are receiving or have applied to receive your TRS annuity payments or have an intact ORP account (an IRA **rollover** is not an intact account.).

Retirement Programs - Voluntary Plans

Plan Choices: Tax-Deferred Account and Deferred Compensation Plans

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

These programs are often referred to as tax-deferred retirement savings plans because you contribute part of your monthly salary before you pay federal income tax. By contributing before tax, you reduce your current income tax. Your contributions and their investment earnings are tax-deferred until you withdraw them at retirement. Because taxes on your earnings are deferred, your account grows faster than an account in which earnings are taxed each year. You pay income taxes when you withdraw your tax-deferred dollars (including their investment gains), but your overall income and tax bracket may be lower at that time. You can also enroll in a Roth TDA, which allows you to contribute after taxes and pay no taxes on your earnings when you begin receiving your retirement funds. Enrollment in these programs enables you to take advantage of the tax laws to increase your retirement savings.

When you enroll in the TDA program, you select an investment vendor. A list of TDA vendors is available from your Human Resources or Payroll office and online at <http://tamus.edu/offices/benefits/retirement/activevendors/>. The DCP vendor is Great West. More information on the TexaSaver DCP can be found at <http://www.texasaver.com> (click on “457 Plan Information”).

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

You may contribute as little as \$25 per month to a TDA and \$20 per month to a DCP. The maximum contribution is determined by the IRS. These limits are available at the System Benefits Administration website, <http://www.tamus.edu/assets/files/benefits/pdf/retirement/DeferralLimitsChart.pdf>. The amount and frequency of benefit payments you receive during retirement will depend on your age at the time payment begins, how much you have in your account and the type of payment plan you choose. Payment options are determined by the product you choose. For example, some allow you to take all of your money out in a single payment when you retire, while others require you to receive payment over time, such as in monthly payments.

Enrollment Rules:

Tax Deferred Accounts

To enroll, you must complete a TDA Salary Reduction Agreement ([HR 17](#)), and a TDA Vendor New Account Application and turn it in to your Human Resources or Payroll Office. Your investment vendor may be able to help you complete these forms. You may also use the HR17 form to change your vendor at any time.

TexasSaver DCP

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

For more information on these programs, [click here](#).

Other Plans

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

Discount Hearing Program:

American Hearing Aid Associates (AHAA) allows you to buy hearing aids for 30% off the manufacturer's suggested retail price or receive a \$250 discount off the provider's price, whichever is the greater savings, if you use an AHAA provider. Purchase of a hearing aid includes testing, fitting, orientation and routine maintenance of the instrument for the length of its service warranty and:

- Quarterly cleanings and adjustments.
- Yearly audiometric screenings.
- Yearly hearing aid evaluations.
- First-year warranty and loss/damage insurance.
- Repair and/or loss and damage replacement renewal options.
- Batteries for the life of your hearing aids.

AHAA is available to you, your covered dependents, parents and grandparents. You don't need to enroll in the plan or pay premiums. Simply visit a participating provider and present your ID card that shows you to be an A&M System employee or retiree. The discount is given at the time of purchase. A health care spending account may be used for out-of-pocket expenses after the discounts.

To locate the nearest AHAA provider, call (800) 984-3272 or visit AHAA's website at <http://www.AHAAnet.com>. You can also click here: <http://tamus.edu/benefits/programs/#ahaa>.

GMS Global Mobility Solutions:

If you are planning a move, Global Mobility Solutions can help make all necessary arrangements. You pay nothing for GMS services, which include planning the move, helping you sell your home, selecting movers, helping you find housing that meets your needs and is within your budget, and prequalifying you for a mortgage. In addition, the GMS website (<http://gmsmobility.com>) provides many tools that can assist you with your move, including:

- A calculator that compares the cost of living in hundreds of major U.S. cities.
- City Report, which shows how different cities compare in terms of population, climate, crime, cost of living and educational facilities.
- Community Calculator, which provides information about different cities.
- Crime Lab, which reports the crime rate for hundreds of U.S. cities.
- A Moving Calculator, which estimates how much your move will cost.
- A Relocation Wizard, which develops a timeline for your move.
- A mortgage payment calculator.

Contact GMS Global Mobility Solutions by telephone at (800) 617-1904, Ext. 8850 or visit GMS online at <http://www.gmsmobility.com> or by clicking here <http://www.tamus.edu/assets/files/benefits/pdf/Relocate.pdf>.

Vision Discount Program:

The Vision Discount Plan is a discount program available for employees, retirees and their families who are not enrolled in the EyeMed Vision Plan. This program is offered through EyeMed.

Select Plan D: Exam and Materials Discount

Vision Care Services	Member Cost
Exam with dilation as Necessary:	\$5 off routine exam \$10 off contact lens exam
Complete pair of Glasses Purchase*: frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
Standard Plastic Lenses:	
Single Vision	\$50
Bifocal	\$70
Trifocal	\$105
Frames:	
Any frame available at provider location	40% off retail price
Lens Options:	
UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch-Resistance	\$15
Standard Polycarbonate	\$40
Standard (progressive) Add-on to Bifocal	\$65
Standard Anti-Reflective Coating	\$45
Other Add-Ons and Services	20% discount
Contact Lens Materials:	
(Discount applied to materials only)	
Disposable	0% off retail price
Conventional	15% off retail price
Laser Vision Correction:	
Lasik or PRK	15% off retail price - or - 5% off promotional price
Frequency:	
Examination	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact Lenses	Unlimited
*Items purchased separately will be discounted 20% off the retail price.	

THIS IS NOT INSURANCE

**Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6.

Member will receive a 20% discount on those items purchased at participating Providers that are not specifically covered by this Discount design. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location.

This Discount design is offered **with the EyeMed Select panel of providers**. There are no out-of-network benefits.

For more information contact EyeMed at 1-855-862-4300 and ask about the Texas A&M System Select Plan D.

Marsh PersonalPlans

Beside the core benefits available to you, Marsh's PersonalPlans offers additional services that may be of interest. You may enroll in these programs at any time.

Group Auto and Home Insurance

This product offers voluntary auto, home, renters and other personal property insurance. Take advantage of special group rates.

Identity Theft

If you become a victim of identity theft, the restoration process can be confusing to handle on your own. ID TheftSmart™ will help you achieve a comprehensive restoration of your name and credit due to fraudulent activity. Plus, they offer continuous monitoring of your credit files.

Health Insurance Mart

One of the biggest advantages of this plan is the ability to compare multiple plans, premiums and benefits all from solid insurance companies rated "Excellent" by A.M. Best Company.

Real Estate Services

A nationwide service program that offers cash rebate incentives to members who buy or sell Real Estate.

Pet Insurance

This insurance covers a multitude of medical problems and conditions for dogs, cats, birds, rabbits, reptiles and other exotic pets. Vaccination and routine care coverage is also available.

Home Mortgage Program

A dedicated team of experts is ready to help you buy, build or refinance a primary residence, vacation home, or investment property. This product offers access to home financing that advances your immediate long-term financial goals.

With Marsh Voluntary benefits, you have immediate internet access to a wide range of voluntary benefits and medical/financial tips - 24 hours a day, 7 days a week. Visit www.tamuspersonalplans.com for:

- Immediate access to information on eligibility and plan benefits
- Simplified management of personal benefits and finances
- Life event planning
- Free quotes
- Plan summaries - for selected and available plan benefits
- Frequently asked questions and their answers

These services are provided to you at no cost, and you are never under any obligation to purchase a product or service. You will be responsible for any costs associated with the products/services you do decide to purchase. These products and services are available to any of your family members, including those who do not qualify for other A&M System benefit coverages.

For More Information

Customer Service 1-866-814-7516 or visit www.tamuspersonalplans.com, (8 a.m. - 5 p.m. CST, M-F.)

Monthly Premiums

Effective Sept. 1, 2011

Basic Life

The premium for this plan is usually paid by the employer contribution.
Basic Life \$3.97 Alternate Basic Life \$.529 per \$1,000

Health

The following chart applies to you if you are a **full-time employee** (work at least 40 hours per week) **or retiree**:

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	\$462.21	\$ 99.47	\$831.99	\$284.36	\$693.33	\$215.03	\$1016.87	\$376.80
Scott & White Health Plan	\$497.60	\$134.86	\$923.64	\$376.01	\$733.01	\$254.71	\$1086.31	\$446.24
A&M Care 65+	\$406.44	\$ 43.70	\$731.59	\$183.96	\$609.66	\$131.36	\$894.17	\$254.10

The following chart applies to you if you are a **part-time employee** (work 20 to 39 hours per week):

	Employee Only		Employee & Spouse		Employee & Child(ren)		Employee & Family	
	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost	Total Cost	Your Cost
A&M Care	\$462.21	\$282.82	\$831.99	\$560.16	\$693.33	\$456.16	\$1016.87	\$698.82
Scott & White Health Plan	\$497.60	\$318.21	\$923.64	\$651.81	\$733.01	\$495.84	\$1,086.31	\$768.26
Graduate Student Health Plan	\$194.00	\$ 14.61	\$735.00	\$463.17	\$406.00	\$168.83	\$ 920.00	\$601.95

Dental

	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
A&M Dental PPO	\$29.41	\$58.82	\$61.76	\$94.11
DeltaCare USA Dental HMO	\$20.71	\$36.84	\$37.12	\$57.68

Vision

Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
\$6.32	\$13.44	\$10.38	\$18.50

Optional Life

If your birthday falls between 9-1-11 and 2-28-12 and you will move to a higher cost category, you must pay the higher premium for the entire year. *Monthly rate per \$1,000:*

Age	No-tobacco rate	Tobacco rate	Age	No-tobacco rate	Tobacco rate
under 20	\$.05	\$.06	45-49	\$.12	\$.15
20-24	.05	.06	50-54	.19	.24
25-29	.05	.07	55-59	.35	.45
30-34	.05	.08	60-64	.54	.69
35-39	.06	.09	65-69	.72	1.31
40-44	.07	.10	70-74	1.37	2.12
			75 and older	1.91	2.17

Dependent Life

Plan A: Spouse: Employee age-based rate per \$1,000 of coverage; Child: \$.06 per 1,000 of coverage
Plan B: \$1.37/month (flat rate)
Plan C: ½ Alternate Basic Life premium; (1/10 if no spouse is covered)

AD&D

Monthly rate per \$10,000:	Employee Only	Employee & Family	
	\$.14	\$.24	
Retiree Only	\$.28	Retiree & Family	\$.46

Long-Term Disability

Monthly rate per \$100/monthly pay:	Non-tobacco rate	Tobacco rate
	\$.192	\$.249

Flexible Spending Account Debit Card (Health Care Account only)

\$9.00/year

Leave Without Pay

The premiums shown below are your monthly health and Basic Life premiums because you are not eligible for the employer contribution. If you are on a Family and Medical Leave Act leave without pay, you are eligible to receive the employer contribution and pay the premiums shown on page 50.

	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
A&M Care	\$482.14	\$864.68	\$721.23	\$1,055.94
Scott & White Health Plan	410.32	1,019.87	613.51	897.94
Graduate Student Health Plan	502.85	928.89	738.35	1,092.93

Survivor

Survivors are eligible only for Health, Dental and Vision coverage. Premiums are as follows:

	Participant Only	Participant & Spouse	Participant & Child(ren)	Participant & Family
A&M Care	\$462.21	\$831.99	693.33	1,016.87
Scott & White Health Plan	\$497.60	\$923.64	733.01	1,086.31
A&M Dental Dental PPO	\$ 29.41	\$ 58.82	61.76	94.11
DeltaCare USA Dental HMO	\$ 20.71	\$ 36.84	37.12	57.68
Vision	\$ 6.32	\$ 13.44	10.38	18.50

Premium Worksheet

1. Health: Enter premium amount. The employer contribution has already been deducted. \$ _____
 2. Dental: Enter premium amount. \$ _____
 3. Vision: Enter premium amount. \$ _____
 4. Optional Life: Take your annualized salary, multiply by your coverage amount (½, 1, 2, 3, 4, 5 or 6), and round down to the nearest thousand (to a maximum of \$1,000,000). Divide by 1,000:
 _____ × your age-based premium of _____ = \$ _____ *
 5. Alternate Basic Life: Divide your coverage amount by 1,000: _____ × .529 = \$ _____
 6. Dependent Life:
 Plan A Premium: Your Optional Life premium (see #4) _____ × (spouse coverage amt/1000)
 + (child coverage amt/1000 X.06) = _____ \$ _____ *
 Plan B Premium: \$1.37/month (flat rate) \$ _____
 Plan C Premium: Your Alternate Basic Life premium (see #5) _____ × .5 (.1 if covering
 children only) = \$ _____
 7. Accidental Death and Dismemberment: Choose your coverage amount and divide by
 10,000: _____ × your premium of _____ = \$ _____
*(Maximum coverage is the greater of \$250,000 or 10 times your annual salary, not to
 exceed coverage of \$800,000.)*
 8. Long-Term Disability: Divide your annual salary by 12. Divide that number
 (or \$12,307, if less) by 100: _____ × your premium of _____ = \$ _____ *
 9. Long-Term Care: If you are enrolled, use the premium shown in HRConnect. If not, you will
 need to contact John Hancock for more information.
 Employee coverage \$ _____ + Spouse coverage \$ _____ = \$ _____
 10. Spending Accounts: Enter Health Care Account monthly contribution \$ _____ +
 Dependent Day Care Account monthly contribution _____ = \$ _____
 11. YOUR TOTAL MONTHLY COST (Add 1 through 10) = \$ _____
- Complete items 12 and 13 if you do not have A&M System health coverage but certify that you have other health coverage:
12. Employer Contribution: Enter the total of your premiums shown above for Dental (line 2),
 Vision (line 3), Alternate Basic Life (line 5), AD&D (line 7) and Long-Term Disability (line 8)†
 or \$183.36 (\$91.68 if part-time), whichever is less. - \$ _____
 13. YOUR TOTAL MONTHLY OUT-OF-POCKET COST (Subtract line 12 from line 11)= \$ _____

* The premiums may increase based on your salary.

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

Appendix

THE TEXAS A&M UNIVERSITY SYSTEM NOTICE OF PRIVACY PRACTICES

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.

A federal regulation, known as the “HIPAA Privacy Rule” requires that we provide detailed notice in writing of our privacy practices.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this notice, we describe the ways that we may use and disclose health information about you. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies an individual or where there is a reasonable basis to believe the information can be used to identify an individual. This information is called “Protected Health Information” (PHI). This notice describes your rights and our obligations regarding the use and disclosure of PHI. We are required by law to:

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

We reserve the right to make changes to this notice and to make such changes effective for all PHI we may already have about you. If and when this notice is changed, we will post this information on our website and provide you with a copy of the revised notice upon your request.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

A. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The following categories describe the different ways we may use and disclose PHI for treatment, payment, or health care operations. The examples included with each category do not list every type of use or disclosure that may fall within that category.

Treatment: No disclosures are anticipated in this category since medical care and treatment is provided only by licensed physicians and medical providers and not the A&M System benefit programs, per se.

Payment: We may use and disclose PHI so that we can bill, collect and remit premiums and eligibility information to your designated health benefit carrier with the A&M System. For example, we must provide your health carrier with periodic reports showing that you are eligible for benefits and have paid your premiums for their coverage. We may use and disclose PHI when you apply for any insurance coverage that requires you to provide a medical history. We may use and disclose PHI when you apply for disability retirement or disability benefits that require you to provide your detailed medical records. We may use and disclose your PHI to verify your health benefit enrollment to a health benefit carrier or health care provider when you seek medical treatment or care. We may use and disclose your PHI to an insurance carrier that provides you with, or has previously provided you with, additional health coverage. We may use and disclose your PHI to the members of a health plan grievance review panel convened at your request to consider the denial of a medical claim by our third-party administrator.

Health Care Operations: We may use and disclose your PHI in performing business operations that are called health care operations. We may use and disclose your PHI to our consulting actuary when we evaluate the cost of our health plans and determine premiums. For example, we periodically review large medical claims in detail to determine cost patterns and their impact on our health plan costs. We may use and disclose your PHI to a third-party claims reviewer who has contracted with the A&M System to audit claim payments. We may use and disclose your PHI as part of the demographic information that is included when we solicit bids on our health plans. We may use and disclose your PHI as requested by federal or state legislative bodies as they review health costs. We may use and disclose your PHI to provide training to new employees who work with PHI within the scope of their employment in the A&M System.

Communications From Our Office: We may contact you to provide you with information about changes to your health benefit plans or other health-related benefits and services that may be of interest to you. For example, if the A&M System offered a new dental benefit option, we would contact you.

B. OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION

Uses and Disclosures for Which You Have the Opportunity to Agree or Object: We may use and disclose PHI about you in some situations where you have the opportunity to agree or object to certain uses and disclosures of PHI about you. If you do not object, then we may use and disclose these types of PHI.

Individuals Involved in Your Care or Payment for Your Care: We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care. If you are present and able to consent or object (or if you are available in advance), then we may use or disclose PHI only if you do not object after you have been informed of your opportunity to object. If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether the use or disclosure of PHI is in your best interests. For example, if you are unable to communicate normally with us for some reason, we may find it is in your best interest to give your benefit eligibility and premium payment information to the friend or relative who is with you. We may also use and disclose PHI to notify such persons of your location, general condition or death. We also may coordinate with disaster relief agencies to make this type of notification. We may also use professional judgment and our experience with common practice to make reasonable decisions about your best interest in allowing a person to act on your behalf to pay premiums or communicate information about your benefits that contains PHI about you.

C. OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT

We may use and disclose PHI about you in the following circumstances without your authorization or opportunity to agree or object, provided that we comply with certain conditions that may apply.

Required By Law: We may use and disclose PHI as required by federal, state or local law. Any disclosure must comply with the law and is limited to the requirements of the law.

Public Health Activities: We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following:

- To prevent or control disease, injury or disability;
- To report disease, injury, birth or death;
- To report child abuse or neglect;
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA regulated products or activities;
- To locate and notify persons of recalls of products they may be using;
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease; or
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to a health oversight agency for oversight activities including, for example, claims audits, investigations, inspections, licensure and disciplinary activities, and other activities conducted by health oversight agencies to monitor the health care system, government health care programs, and compliance with certain laws.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests, or other required legal processes when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Law Enforcement: Under certain conditions, we may disclose PHI to law enforcement officials for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency;
- To alert law enforcement of a death that we suspect was the result of criminal conduct;

- Required by law;
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About a crime or suspected crime committed at the workplace; or
- In response to a medical emergency not occurring at the workplace, if necessary to report a crime, including the nature of the crime, the locations of the crime or the victim, and the identity of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors: We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may do their jobs.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation and transplantation.

Research: We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.

To Avert a Serious Threat to Health or Safety: We may use or disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can be made only to a person who is able to help prevent the threat.

Specialized Government Functions: Under certain circumstances, we may disclose PHI:

- For certain military and veteran activities, including determination of eligibility for veterans benefits and where deemed necessary by military command authorities;
- For national security and intelligence activities;
- To help provide protective services for the president and others;
- For the health or safety of inmates and others at correctional institutions or other law enforcement custodial situations for the general safety and health related to the facility.

Disclosures Required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you as described in Section III of this notice.

Workers' Compensation: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

D. OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRE YOUR AUTHORIZATION

All other uses and disclosures of PHI about you will be made only with your written authorization. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent we have taken action based on the authorization.

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use for treatment, payment, and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care or benefit coverage that otherwise are permitted by the Privacy Rule. We are not required to agree to your request. If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you or verify coverage in the case of an emergency. To request restrictions, you must make your request in writing to our Privacy Official. In your request, please include (1) the information that you want to restrict, (2) how you want to restrict the information (for example, restricting use to this office, restricting disclosure only to persons outside this office, or restricting both), and (3) to whom you want those restrictions to apply.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. You must make your request in writing to our Privacy Official. You must specify how you would like to be contacted (for example, by regular mail to your post office box and not your home). We are required to accommodate reasonable requests.

Right to Inspect and Copy: You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. This includes your insurance and billing records but does not include information gathered or prepared for a civil, criminal, or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. To inspect and copy PHI contact our Privacy Official. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor, and supplies used to meet your request.

Right to Amend: You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request, you must submit your request in writing to our Privacy Official. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request.

Right to Receive an Accounting of Disclosures: You have the right to request an accounting of certain disclosures that we made of PHI about you. This is a list of disclosures made by us during a specified period of up to six years *except for disclosures made:*

- For treatment, payment, and health care operations;
- For use in or related to a facility directory;
- To family members or friends involved in your care;
- To you directly;
- Pursuant to an authorization of you and your personal representative;
- For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes);
or
- Before April 14, 2003.

If you wish to make such a request, please contact our Privacy Official, who is identified below. The first list that you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may cancel your request at any time before costs are incurred.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this notice at any time, even if you have previously agreed to receive this notice electronically. To obtain a paper copy of this notice, contact the Privacy Official.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or the Office for Civil Rights, United States Dept. of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. To file a complaint with us, please contact our Privacy Official at the address and number listed below. We will not retaliate or take action against you for filing a complaint.

V. QUESTIONS

If you have any questions about this notice, please contact our Privacy Official at the address and telephone number listed below.

VI. PRIVACY OFFICIAL CONTACT INFORMATION

You may contact our Privacy Official at the following address and telephone number:

Mr. Kevin P. McGinnis
Director of Risk Management and Benefits Administration
The Texas A&M University System
John B. Connally Building, 5th Floor
301 Tarrow
College Station, TX 77840
Phone: (979) 458-6160

For More Benefit Information

Campus	Website Link and Phone Numbers	Email Address
Texas A&M University	employees.tamu.edu 979-862-1718	benefits@tamu.edu
Texas A&M Health Science Center	www.tamhsc.edu 979-436-9207	benefits@tamhsc.edu
Prairie View A&M University	www.pvamu.edu/hr 936-261-1730	benefitsteam@pvamu.edu
Tarleton State University	www.tarleton.edu/hr 254-968-9128	employment@tarleton.edu
Texas A&M University - Central Texas	www.ct.tamus.edu/departments/hr/index.html 254-519-5457	t.flores@ct.tamus.edu
Texas A&M International University	inside.tamui.edu/ohr 956-326-2365	hr@tamui.edu
Texas A&M University-Commerce	tamu-commerce.edu/hreeo/ 903-886-5049	Cynthia.Todhunter@tamu-commerce.edu
Texas A&M University-Corpus Christi	hr.tamucc.edu 361-825-2630	human.resources@tamucc.edu
Texas A&M University at Galveston	www.tamug.edu/hrd/ 409-740-4534	penningt@tamug.edu
Texas A&M University-Kingsville	www.tamuk.edu/hr 361-593-4998	kuhp2008@tamuk.edu
Texas A&M University-Texarkana	www.tamut.edu 903-223-3113	jennifer.baird@tamut.edu
Texas Transportation Institute	tti.tamu.edu 979-845-9668	ttih@ttimail.tamu.edu
Texas A&M University at San Antonio	www.tamusa.edu/tamus.edu/hr/index.html 210-932-7115	tesquerra@tamusa.tamus.edu
Texas Forest Service	texasforestservicetamu.edu 979-458-6695	SNoack@tfs.tamu.edu
Texas A&M AgriLife	aghr.tamu.edu 979-845-2423	jkyles@ag.tamu.edu
Texas Engineering Experiment Station (TEES, College of Engineering)	tees.tamu.edu/personnel 979-458-7693	teeshr@tamu.edu
Texas Engineering Extension Service	teex.org 979-458-6801	martha.alexander@teexmail.tamu.edu
West Texas A&M University	wtamu.edu/administration/personnel-benefits.aspx 806-651-2117	personnel@mail.wtamu.edu
System Offices	www.tamus.edu/offices/hr 979-458-6161	SystemsOfficesBenefits@tamus.edu

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