New Employee Benefit Enrollment Booklet

2006–07

Health

Dental

Vision

Life

Optional AD&D

Long-Term Disability

Long-Term Care

Flexible Spending Accounts

Welcome!

Welcome to The Texas A&M University System! As an A&M System employee, you have access to a comprehensive package of benefits for you and your family. In addition to several health coverage options, you can select from the following optional coverages:

- Dental
- Vision
- Life
- Long-Term Disability
- Flexible Spending Accounts
- Optional AD&D
- Long-Term Care

For important information about Medicare Part D prescription drug coverage, see page 11.

You may choose to enroll any or all of your eligible dependents in Health, Dental, Vision, Dependent Life and/or Optional 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 Optional 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 on or before 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.

To have maximum flexibility in making your benefit choices, you should review this booklet and your benefit options as soon as possible. For more information, visit System Human Resources online at http://tamus.edu/offices/shro/ where you'll find:

- 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.
- An A&M System newsletter with human resources news and features.
- Holiday schedules for A&M System components.
- Links to information about A&M System retirement programs.

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After you begin employment, you can also log on to The Texas A&M University System HRConnect site (https://sso.tamu.edu). HRConnect provides:

- Employment and payroll information specific to you.
- Information about your benefit coverages.
- 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.
- Links to A&M System online training courses.

Benefit eligibility

You are eligible for A&M System benefits if you work at least 50% time for at least 4½ months. If you are required to be a graduate student for your position, you are eligible for all benefits described in this booklet *except* the Teacher Retirement System (TRS) and Optional Retirement Program (ORP).

Dependents eligible for coverage include your spouse (as defined by Texas law) and unmarried children younger than 25. Older children disabled before age 25 and children in other legal guardian relationships are also eligible. Grandchildren are eligible if they live in your household. Eligible relationships are listed on the online enrollment system and on page 2 of the Dependent Enrollment Form/Certification.

Employer contribution

You will receive the following amounts each month toward your health and Basic Life premiums:

	Full time	Part time
Employee only	$364.04	$182.02
Employee and spouse	$514.40	$257.20
Employee and children	$458.02	$229.01
Employee and family	$589.58	$294.79
Half contribution	$182.02	$91.01

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. The premiums you will pay beginning on your employer contribution eligibility date are listed on page 34. You can receive an employer contribution from only one Texas state agency or institution of higher education.

Employer contribution eligibility date

Unless you are transferring with no break in service from another Texas state agency, you will begin receiving a monthly contribution the first of the month after your 90th day of employment. You can apply this contribution toward your health and Basic Life premiums.

Benefit enrollment period

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 on or before your hire date, your coverages, except Long-Term Care, can take effect either on your hire date or on your employer contribution eligibility date. Long-Term Care coverage will become effective on the first of the month after you enroll.

If you enroll or make changes 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. 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.

You will have to pay the full monthly premium for each coverage (see premiums on page 34) yourself until your employer contribution eligibility date. However, some A&M System universities and agencies provide salary supplements to offset the cost. Your Human Resources office can tell you whether this is available.

About this booklet

This booklet is intended as a convenient summary of the major points of benefit plans. This booklet does not cover all provisions, limitations and exclusions.

The official plan documents, policies and certificates of insurance govern in all cases and are available for your inspection at any time.

If you do not enroll in any coverages or 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 basic package includes the A&M Care 350 health plan and Basic Life coverage of $5,000. This includes $2,000 in Basic Life coverage for each of your eligible dependent children and $5,000 in Accidental Death and Dismemberment (AD&D) coverage on you.

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 half of the employee-only employer contribution ($182.02 for full-time, $91.01 for part-time) 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 $182.02 or $91.01 for dental and vision coverage for you and your spouse.

The contribution, which you will begin receiving on your employer contribution eligibility date, will be applied to Alternate Basic Life, Optional Accidental Death and Dismemberment (AD&D), A&M Dental or DeltaCare USA Dental HMO, Vision and Long-Term Disability (LTD), in that order. You may not use the employer contribution to pay for Optional Life, Dependent Life or Long-Term Care.

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.

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.*

Your dependent children's premiums can also be deducted on a pretax basis if you certify each year that at least one of your covered dependent children meets one of the following criteria:

- The child is 18 or younger on Dec. 31 of that year.
- If the child is older than 18 but younger than 24 on Dec. 31 of that year and is a full-time student, he/she must provide less than half of his/her own financial support. You or someone else provides the rest.
- If the child is older than 18 on Dec. 31 of that year and not a student, or if the child is age 24 and a full-time student, he/she must receive more than half of his/her financial support from you.

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 pay. You will receive the employer contribution for these months unless you terminate employment before Sept. 1. If your monthly out-of-pocket premium cost is $20 or more, you may have the option during the summer to be billed monthly or pay through bank draft. You will receive information about this choice in April, if applicable.

Payroll deductions: Premiums that are deducted from your paycheck are for your insurance coverage during the *previous* pay period. For example, the premiums deducted from your Oct. 1 paycheck (if you are paid monthly) are for your September coverage.

Changing coverage

Your benefit choices generally remain in effect until the beginning of the next plan year (Sept. 1). During the Annual Enrollment period each July, you can make changes for the coming plan year. 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. Likewise, for Life and Optional AD&D coverage, you can add or drop your spouse or a dependent child only within 60 days of a Change in Status.

In most cases, only changes consistent with the Change in Status can be made. For example, if you have a baby, you can add the baby to your health coverage, but you cannot enroll yourself in dental because that decision is not related to the Change in Status. 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 age 25 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 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)

If you have a Change in Status, contact your Human Resources office within 60 days of the change.

Evidence of good health

After your enrollment period, you must provide evidence of good health, wait until the next Annual Enrollment period, and/or experience a Change in Status to enroll in or increase certain coverages. Providing evidence of good health involves completing an application and medical questionnaire. The carrier may ask for more medical information before deciding whether to accept you into the plan.

Protection of personal health information

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

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

About Online Enrollment

If you work for an A&M System member that uses the HRConnect New Employee Enrollment System, you can enroll in most benefits online rather than with paper forms.

Simply log in to Single Sign On (SSO) at https://sso.tamu.edu using your Universal Identification Number (UIN) and your SSO password. You may also access the site from the System Human Resources web site (http://tamus.edu/offices/shro/, click on New Employees). Once you're logged on:

- 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 if you enroll in Life or Accidental Death and Dismemberment coverage.

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, you must be careful not to 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 within SSO.

Before exiting the system, click "submit record for processing" to submit your final choices for processing. Because you can submit changes only once using this system, you should not click "submit record for processing" until you have made all of the elections you wish to make.

While you are making your elections, you can check them on the screen to make sure you pushed the correct buttons for the choices you wish to make. 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.

Once you have submitted your selections, you can make changes to your benefits during the 60-day enrollment period by contacting your Human Resources office.

If your A&M System member is not using the online enrollment system, you can enroll using the New Employee Benefit Enrollment Form, available 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.

Understanding Benefit Lingo

Here are some terms you'll need to know to better understand your coverages.

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.

Coinsurance or cost sharing: How the cost of a health or dental expense is shared between you and the plan after you pay your deductible. For example, the A&M Care 350 plan's share of most expenses is 80% and your share 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 payable in most cases. After you have paid your deductible, future expenses are covered at the coinsurance or copayment amount. Copayments do not count toward the deductible. You can submit claims for reimbursement of deductible amounts through a Health Care Spending Account.

Formulary: A group of brand-name drugs that the plan can obtain for a lower cost than other brand-name drugs. You pay a lower copayment for a formulary drug than for a nonformulary drug. Each plan has its own formulary.

Out-of-pocket maximum: 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, Mercy and Graduate Student Health plans, a primary care physician (PCP) is a general or family practitioner, an internal medicine doctor, a pediatrician or an obstetrician/gynecologist. Under Humana and FirstCare, the same doctors, except obstetricians/gynecologists, are considered PCPs. However, at FirstCare, you may be able to pay the PCP copayment for a visit to an obstetrician/gynecologist if you call FirstCare for approval before you go. All other doctors under these plans are considered specialists.

Reasonable and customary: 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

You can choose between the two A&M Care plans, and you may have access to an HMO. If you are a graduate student employee, the Graduate Student Health Plan is also an option. 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.

You do not have to enroll in health coverage. Except for the graduate student plan, none of the health plans have pre-existing condition limitations. You cannot change health carriers during the 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 year unless you have certain Changes in Status (see page 4).

A&M Care plans

Under the A&M Care 350 and 1250 plans, 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 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.

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 PharmaCare administering the prescription drug portion.

Differences between the 350 and 1250 plans

The A&M Care 1250 plan has lower premiums than the 350 plan, but a higher deductible and out-of-pocket maximum. The plans also have different coinsurance amounts (the 350 plan pays 80%, while the 1250 plan pays 70%). Deductibles, coinsurance amounts and out-of-pocket maximums for both plans are listed on the charts following this section. Premiums are listed on page 34.

How both A&M Care plans 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 $25 or $45 office visit copayment.

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

- You are not eligible for a $25 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.

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

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. You will not be reimbursed 100% of the charge unless you have met your out-of-pocket maximum. If the primary plan has a copayment for the service, the A&M Care plan will pay no benefits.

Prescription drug program: You will receive a separate ID card from PharmaCare. Both A&M Care plans have a $50-per-person ($150 maximum per family) plan year deductible that applies to retail and mail-order drugs. For a 30-day supply of drugs, after you meet the deductible, you pay $10 for a generic, $25 for a brand-name formulary (preferred) and $50 for a brand-name nonformulary (nonpreferred) drug. For a 90-day supply through the mail-order program, you pay two copayments. You may purchase a 90-day supply at certain retail pharmacies (CVS, Walgreens, K-Mart and Kroger), but you will pay three copayments. Formulary information is available from your Human Resources Office or at http://tamus.edu/offices/shro/pharmacare_formulary.pdf.

–Ask Yourself–

Have I considered each plan's benefits, physician networks, hospitals and costs?

If I take A&M Care 1250, do I have enough money in the bank or a credit card to pay the deductible if I have a hospital stay?

Is my doctor or specialist in the network of the health plan I'm considering? (Keep in mind that your doctor could leave a health plan midyear.)

Do I travel often? How likely is it that I will need nonemergency health care while traveling?

If I have covered children away at school or living in other locations, will they have access to plan providers at those locations?

Are my prescription drugs included in the plan's formulary?

–Enrollment Options–

- *A&M Care 350*
- *A&M Care 1250*
- *HMO (depending on your location)*
- *Graduate Student Health Plan (graduate students only)*

– *Employee only*
– *Employee & Spouse*
– *Employee & Child*
– *Employee & Family*

–For More Information–

- *A&M Care Plan Description Booklet, online at* http://tamus.edu/offices/shro/publications/booklets/hlth_spd.pdf *or from your HR office.*
- *PharmaCare prescription drug formulary (A&M Care participants only), online at* http://tamus.edu/offices/shro/benefits/pharmacare_formulary.pdf *or from your HR office.*
- *Office of Public Insurance Counsel (OPIC), for HMO customer satisfaction/quality-of-care information: http://www.opic.state.tx.us/health.php*
- *Health plan providers (see customer service numbers and web addresses on plan charts)*

Vision benefits: A&M Care participants receive discounts on exams, frames, lenses and laser vision correction 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 (enter 2295 as your client control plan number) or call (800) 501-1459. A brochure is available online at http://tamus.edu/offices/shro/benefits/DavisVisionBrochure.pdf.

HMOs

Four HMOs are available through the A&M System. HMOs require you to select a primary care physician to use as your contact for authorization of all health services. You receive benefits for non-emergency care only if you use HMO providers, unless you are enrolled in FirstCare, which provides lesser benefits if you use providers outside its network.

You must live or work in an HMO's service area to select that HMO. The HRConnect Annual Enrollment system and your Personal Benefits Summary show the HMOs for which you are eligible. This information is also available at the System Human Resources web site, http://tamus.edu/offices/shro.

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. See plan charts for provisions.

The plan has a 12-month pre-existing condition limitation. When you turn in a claim for treatment of a condition, Combined Insurance Plans 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.

Comparing the plans

The charts on the following pages show your share of the cost of a health procedure or service. For example, 20% means you pay 20% (coinsurance) of the cost after any applicable deductibles up to the out-of-pocket limit, then the plan pays 100%; $25/visit means you pay $25 (copayment) for each office visit.

The plan year for all plans is Sept. 1, 2006, through Aug. 31, 2007, but some HMOs have calendar-year limits on some services.

This information is a summary only. If you have questions, call the plan's member services phone number.

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 Nov. 15 to Dec. 31 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, drug coverage will continue to be a part of whichever A&M System health plan you currently have, and your System health premiums will not decrease.

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

For those nearing or over age 65 or others enrolled in Medicare

- *"Medicare & You 2006" handbook (available from Medicare), which contains detailed information about Medicare plans that offer prescription drug coverage.*
- *Medicare web site (http://www.medicare.gov)*
- *Medicare customer service: (800) 633-4227. TTY users should call (877) 486-2048.*
- *State Health Insurance Assistance Program*

Provisions	A&M Care 350 Network/Out-of-Network benefits	A&M Care 1250 Network/Out-of-Network benefits
Regions offered	BlueCross BlueShield of Texas (BCBSTX) has networks in all states and all but the following Texas counties: Donley, Hansford, Lipscomb, Ochiltree and Wheeler.	
Pre-existing condition limitations	None	
Out-of-service-area restrictions	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.	
Deductibles	Network: $350/person/plan year Out-of-Network: $700/person/plan year; $350/hospital	Network: $1,250/person/plan year Out-of-Network: $2,500/person/plan year; $500/hospital
Out-of-pocket maximum	Network: $3,000/person/plan year Out-of-Network: $6,000/person/plan year	Network: $3,500/person/plan year Out-of-Network: $7,000/person/plan year
In-hospital care	Network: 20% after deductible Out-of-Network: $350/admission, then 50%	Network: 30% after deductible Out-of-Network: $500/admission, then 50%
Emergency room	Network: 20% after deductible Out-of-Network: 20% after deductible if emergency; otherwise 50%	Network: 30% after deductible Out-of-Network: 30% after deductible if emergency; otherwise 50%
Office visits	Network: $25/visit for Primary Care Physician (PCP) visits; $45 for specialists; certain expensive surgeries—20% after deductible Out-of-Network: 50% after deductible	Network: $25/visit for Primary Care Physician (PCP) visits; $45 for specialists; certain expensive surgeries—30% after deductible Out-of-Network: 50% after deductible
Lab/X-rays	Network: Benefit depends on setting and procedure; see plan description booklet or call BCBSTX for details Out-of-Network: 50% after deductible	Network: Benefit depends on setting and procedure; see plan description booklet or call BCBSTX for details Out-of-Network: 50% after deductible
Surgery	Network: 20% 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	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
Chiropractic care	Network: $45/visit, 30 visits/plan year Out-of-Network: 50% after deductible, 30 visits/plan year	Network: $45/visit, 30 visits/plan year Out-of-Network: 50% after deductible, 30 visits/plan year
Vision/Hearing/Speech	Network and Out-of-Network: Vision—Routine preventive vision exams not covered; Hearing—Illness/accident coverage only	Network and Out-of-Network: Vision—Routine preventive vision exams not covered; Hearing—Illness/accident coverage only
Maternity care	Network: Hospital—20% after deductible; Doctor—$25, initial visit only Out-of-Network: Hospital and doctor—50% after deductible	Network: Hospital—30% after deductible; Doctor—$25, initial visit only Out-of-Network: Hospital and doctor—50% after deductible
Well-baby care	Network: $25/visit; Out-of-Network: Not covered	Network: $25/visit; Out-of-Network: Not covered
Physical therapy	Network: $45/visit Out-of-Network: 50% after deductible	Network: $45/visit Out-of-Network: 50% after deductible
Durable medical equipment	Network: 20% after deductible Out-of-Network: 50% after deductible	Network: 30% after deductible Out-of-Network: 50% after deductible
Home health care	Network: 20% after deductible; $40,000 lifetime maximum; $8,000/person/plan year maximum Out-of-Network: 50% after deductible; $40,000 lifetime maximum; $8,000/person/plan year maximum	Network: 30% after deductible; $40,000 lifetime maximum; $8,000/person/plan year maximum Out-of-Network: 50% after deductible; $40,000 lifetime maximum; $8,000/person/plan year maximum
Skilled nursing facility (not including custodial care)	Network: 20% after deductible; $35,000 lifetime maximum Out-of-Network: 50% after deductible; $35,000 lifetime maximum	Network: 30% after deductible; $35,000 lifetime maximum Out-of-Network: 50% after deductible; $35,000 lifetime maximum
Non-serious mental health — Inpatient / Outpatient*	Network: Inpatient—20% after deductible up to 30 days/plan year; Outpatient–$45/visit, 40 visits/plan year Out-of-Network: Inpatient—50% after deductible up to 30 days/plan year: Outpatient–50% after deductible, 40 visits/plan year	Network: Inpatient—30% after deductible up to 30 days/plan year; Outpatient–$45/visit, 40 visits/plan year Out-of-Network: Inpatient—50% after deductible up to 30 days/plan year: Outpatient–50% after deductible, 40 visits/plan year
Prescription drugs	After you meet the $50/person/plan year prescription drug deductible (three-person maximum): • 30-day supply: $10/generic, $25/brand-name formulary, $50/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 select retail pharmacies PharmaCare—(866) 935-5433; www.pharmacare.com.	
How does this health plan work?	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 pages 8–10 for details.	
Member Services phone number/web site	BlueCross BlueShield of Texas—(866) 295-1212; for information on networks outside Texas—(800) 810-BLUE (2583) www.bcbstx.com	

Provisions	A&M Care 350/1250 Non-Network benefits	Scott & White Health Plan
Regions offered	See previous page	Bryan/College Station, Killeen, limited access in Austin, Prairie View, Stephenville areas
Pre-existing condition limitations	None	None
Out-of-service-area restrictions	None	Emergency care only at hospital, $100/visit (waived if admitted); urgent care, $40/visit at any facility other than College Station S&W facility
Deductibles	350 plan: $350/person/plan year 1250 plan: $1,250/person/plan year	$50/person/plan year prescription drug deductible
Out-of-pocket maximum	350 plan: $3,000/person/plan year 1250 plan: $3,500/person/plan year	$3,000/person/plan year; $6,000 maximum/family/plan year
In-hospital care	20% (350 plan) or 30% (1250 plan) after deductible	$100/day; $500 maximum/admission
Emergency room	20% (350 plan) or 30% (1250 plan) after deductible	$100/visit (waived if admitted); urgent care, $25/visit at College Station S&W facility, $40/visit at any other facility
Office visits	20% (350 plan) or 30% (1250 plan) after deductible	$25/visit
Lab/X-rays	20% (350 plan) or 30% (1250 plan) after deductible	Covered in full
Surgery	Inpatient, outpatient and in physician's office—20% (350 plan) or 30% (1250 plan) after deductible	Inpatient—$100/day, $500 maximum/admission; Outpatient—$25/visit in physician's office, $100/visit at outpatient surgical facility
Chiropractic care	20% (350 plan) or 30% (1250 plan) after deductible, 30 visits/plan year	Discount network available
Vision/Hearing/Speech	Vision—Routine preventive vision exams not covered; Hearing—Illness/accident coverage only	Vision—$25, one exam/plan year; $10/lenses w/frames or $10/bifocals/trifocals w/frames (biennially); $10/box for disposable or daily wear contacts or $10/contact lens for specialty lenses Hearing/Speech (testing and/or therapy)—$25/visit
Maternity care	Hospital and doctor—20% (350 plan) or 30% (1250 plan) after deductible	Hospital—$100/day, $500 maximum Doctor—$25/visit or $300 total fee
Well-baby care	20% (350 plan) or 30% (1250 plan) after deductible	$25/visit
Physical therapy	20% (350 plan) or 30% (1250 plan) after deductible	$25/visit
Durable medical equipment	20% (350 plan) or 30% (1250 plan) after deductible	20%, up to $2,000/person/plan year (includes diabetic supplies and equipment)
Home health care	20% (350 plan) or 30% (1250 plan) after deductible; $40,000 lifetime maximum; $8,000/person/plan year maximum	$25/visit with approval of medical director
Skilled nursing facility (not including custodial care)	20% (350 plan) or 30% (1250 plan) after deductible; $35,000 lifetime maximum	$100/day; $500 maximum/admission (precertification required)
Non-serious mental health* — Inpatient	20% (350 plan) or 30% (1250 plan) after deductible up to 30 days/plan year	$100/day; $500 maximum/admission for days 1–5; days 6–30 covered in full; limited to 30 days/plan year
Non-serious mental health* — Outpatient	20% (350 plan) or 30% (1250 plan) after deductible, 40 visits/plan year	$25/visit up to 30 visits/plan year
Prescription drugs	See previous page	After you meet the $50/person/plan year prescription drug deductible: • 34-day supply: $5/generic (level A), $20/brand-name formulary (level B), $50 or 50% (whichever is less)/nonpreferred formulary (level C), 50% (subject to out-of-pocket maximum)/brand-name nonformulary • 90-day supply: Two copayments required; mail-order purchase available but not required; you must purchase a 34-day supply on new prescriptions for first six months of use
How does this health plan work?	See previous page	Scott & White is a clinic-based HMO. You must receive care through a Scott & White clinic or associated provider to receive benefits, except in an emergency. You must select a Primary Care Physician (PCP). Your PCP can refer you to any specialist in the network.
Member Services phone number/web site	See previous page	(800) 791-8777 or (979) 268-7947 www.swhp.org

* 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).

Provisions	Humana Health Plans	FirstCare
Regions offered	Corpus Christi/Kingsville, San Antonio	Bryan/College Station, Abilene/Midland/Odessa, Amarillo/ Canyon/Lubbock, Ft. Stockton, Stephenville
Pre-existing condition limitations	None	None
Out-of-service-area restrictions	Urgent or emergency care only, $100/visit (waived if admitted); notify Humana within 48 hrs.	Emergency care only ($100/visit, waived if admitted) or medical support order
Deductibles	None	$50/person/plan year prescription drug deductible
Out-of-pocket maximum	$4,000/person/calendar year; $8,000/family/calendar year	2 × total annual premium; Self-injectable medications—$2,500
In-hospital care	$500/day; $1,500 maximum/admission	$150/day; $750 maximum/admission
Emergency room	$100/visit (waived if admitted); must notify Humana within 48 hrs	$100/visit (waived if admitted); must notify Primary Care Physician (PCP) within 24 hrs.
Office visits	$20/visit; $30/visit for specialty care	$20/visit; $50/visit for specialty care
Lab/X-rays	Inpatient—$500/day; $1,500 maximum/admission Outpatient—$20/visit in Primary Care Physician's (PCP) office or $30/visit in specialist's office; $150/visit at outpatient hospital facility	General lab and X-ray covered in full; $100 for MRI, CT scan, arteriogram, EEG, myelogram and PET scan; $75 for radio-nuclide stress test; $50 for bone mass measurement; 50% for non-pregnancy ultrasound; 50% for infertility diagnosis
Surgery	Inpatient—$500/day, $1,500 maximum/admission Outpatient—$20/visit in PCP's office or $30/visit in specialist's office; $300/visit at outpatient surgical facility	Inpatient—$150/day; $750 maximum/admission Outpatient—$50/visit in physician's office; $250/admission at outpatient surgical facility
Chiropractic care	$30/visit if medically necessary; must be referred by PCP	$50/visit; must be pre-approved
Vision/Hearing/Speech	Vision—$10/visit, one exam/calendar year (optometrist only) Hearing/Speech (testing)—$20/visit in PCP's office or $30/visit in specialist's office; (therapy)—$30/visit	Vision—$20/visit, screening by PCP only; Hearing/Speech (testing and/or therapy)—$20/visit, $50/visit for specialty care
Maternity care	Hospital—$500/day; $1,500 maximum/admission; Doctor—$20 in PCP's office or $30 in specialist's office, initial visit only	Hospital—$150/day; $750 maximum/admission Doctor—Covered in full
Well-baby care	$20/visit in PCP's office or $30/visit in specialist's office	$20/visit
Physical therapy	$30/visit	$50/visit
Durable medical equipment	Covered in full	20%, up to $4,000/person/plan year
Home health care	Covered in full	Covered in full when authorized
Skilled nursing facility (not including custodial care)	Covered in full up to 100 days/calendar year	$150/day; $750 maximum/admission; up to 100 days/plan year
*Non-serious mental health** — *Inpatient*	$100/admission up to 30 days/calendar year	20% up to 30 days/plan year
*Non-serious mental health** — *Outpatient*	$10/visit for first 20 visits/calendar year; $30/visit for next 20 visits/calendar year	$50/visit; limited to 40 visits/plan year
Prescription drugs	• 30-day supply: Level 1 drug: $10; Level 2 drug: $25; Level 3 drug: $50; Level 4 drug: 25% (copayment levels are generally determined by drug costs) • 90-day supply: Three copayments required; must purchase through mail-order program	After you meet the $50/person/plan year drug deductible: • 30-day supply: $10/generic, $25/brand-name formulary, $50/ brand-name nonformulary; 25% self-injectables and high-technology drugs • 90-day supply: $30/generic, $75/brand-name formulary, $150/ brand-name nonformulary; 25% self-injectables and high-technology drugs; must purchase through mail-order program
How does this health plan work?	This plan is an HMO composed of independent practitioners and physician associations. You must select a PCP. If you select a PCP who is an independent practitioner, you can be referred to any specialist in Humana's network. If your PCP is part of a physician association (in San Antonio), you will be referred only to specialists in that association.	This plan is an HMO composed of independent practitioners and physician associations. You must select a PCP. The PCP you select can refer you to any specialist in FirstCare's network, even if the PCP is part of a physician association. The plan includes a point-of-service (POS) benefit. You do not have to use a network provider to receive these benefits. The POS deductible will be $1,500/person/plan year with a $15,000/plan year out-of-pocket maximum. You must meet the deductible, and the plan will then pay 60% of reasonable and customary charges.
Member Services phone number/web site	(800) 448-6262 or (888) 393-6765 (for potential members) www.humana.com	(800) 884-4901 www.firstcare.com

Provisions	Mercy Health Plan	Graduate Student Health Plan
Regions offered	Laredo	Available worldwide; outside continental U.S. and Alaska, out-of-network benefits apply
Pre-existing condition limitations	None	$1,000 benefit for an existing condition for 12 months; continuous coverage before enrollment offsets limitation period
Out-of-service-area restrictions	No coverage except for urgent care ($25/visit) or emergency care $50/visit (waived if admitted)	None
Deductibles	None	$100/person/plan year (network); $250/illness (out-of-network); waived at student health center
Out-of-pocket maximum	$1,000/person/plan year; $2,000/family/plan year	$3,000/person/plan year; $6,000 maximum/family/plan year
In-hospital care	$200/day; $600 maximum/admission	20% (network)/40% (out-of-network) after deductible
Emergency room	$50/visit (waived if admitted)	After deductible, $75 copayment plus 20% (network)/40% (out-of-network)
Office visits	$25/visit	$25/visit plus 20% (network)/40% (out-of-network); covered in full at student health center
Lab/X-rays	Covered in full	20% (network)/40% (out-of-network) after deductible
Surgery	Inpatient—$200/day; $600 maximum/admission Outpatient—$25/visit in physician's office; $100 at outpatient facility (including procedures such as endoscopies and colonoscopies)	20% (network)/40% (out-of-network) after deductible
Chiropractic care	$25/visit; must be referred by Primary Care Physician (PCP)	$25/visit plus 20% (network)/40% (out-of-network), when medically necessary due to accident or illness
Vision/Hearing/Speech	Vision—$25/visit; one exam/plan year; eye refraction only Hearing/Speech (testing and/or therapy)—$25/visit	$25/visit plus 20% (network)/40% (out-of-network), when medically necessary due to accident or illness
Maternity care	Hospital—$200/day, $600 maximum/admission; Doctor—$25/visit, initial visit only	20% (network)/40% (out-of-network) after deductible
Well-baby care	$25/visit	20% (network)/40% (out-of-network) after deductible
Physical therapy	$25/visit; must be referred by PCP	$25/visit plus 20% (network)/40% (out-of-network); must be within 60 days of being released for rehabilitation
Durable medical equipment	20%	20% (network)/40% (out-of-network) after deductible
Home health care	Covered in full	No benefit
Skilled nursing facility *(not including custodial care)*	Covered in full up to 100 days/calendar year	No benefit
*Non-serious mental health** *Inpatient*	$200/day; $600 maximum/admission; limited to 30 days/plan year	20% (network)/40% (out-of-network) after deductible; limited to 30 days/plan year; $25,000 lifetime maximum
*Non-serious mental health** *Outpatient*	Group or individual: $25/visit; combined limit of 40 visits/plan year	$25/visit plus 20% (network)/40% (out-of-network); maximum benefit of $50/day (individual) or $25/day (group)
Prescription drugs	• 30-day supply: $10/generic, $20/brand-name formulary, $40/brand-name nonformulary • 90-day supply: $10/generic, $20/brand-name formulary, $40/brand-name nonformulary; must purchase through mail-order program	After deductible, $15 plus 20% of drug cost; $15 at student health center; $1,500 benefit maximum/accident or illness; $3,000 annual maximum benefit
How does this health plan work?	This plan is an HMO composed entirely of independent practitioners. You must select a PCP. The PCP you select can refer you to any specialist in the Mercy network.	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.
Member Services phone number/web site	(800) 617-3433 or (956) 723-7667 www.mercyhealthplans.com	(800) 452-5772 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).

Dental

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

- You can enroll in either plan regardless of your health coverage choice.
- 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 (see page 4).
- You do not have to provide evidence of good health to enroll in either plan.
- The plans have no pre-existing condition limitations.

DeltaCare USA dentists are not available in all parts of Texas. The plan will be an option within the New Employee Benefit Enrollment system only if you 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 completing a New Employee Benefit Enrollment form (http://tamus.edu/offices/shro/publications/Forms/100.pdf) and submitting it to your Human Resources office.

–Ask Yourself–

How much do I spend on dental care in a year? Is it more or less than the DeltaCare USA Dental HMO premiums and copayments or the A&M Dental premiums, deductible and coinsurance?

If I'm thinking about enrolling in DeltaCare USA, do I live near a network general dentist?

Would I pay less using DeltaCare USA or the A&M Dental plan, considering the out-of-pocket cost of services, deductible and premiums?

Should I use the Health Care Spending Account for my dental expenses instead of purchasing dental insurance (see page 24)?

If I have other dental coverage, do I need coverage from more than one plan?

–Enrollment Options

- *A&M Dental (PPO)*
- *DeltaCare USA (Dental HMO)*

and

- *Employee only*
- *Employee & Spouse*
- *Employee & Child*
- *Employee & Family*

–For More Information–

- *A&M Dental Plan Description Booklet, from your Human Resources office or online at http://tamus.edu/offices/shro/publications/booklets/dental_spd.pdf.*
- *Delta Dental web site (http://www.wekeepyousmiling.org/group_sites/tamus/)*
- *Customer service:*
  (800) 336-8264 (A&M Dental) (PPO)
  (800) 422-4234 (DeltaCare USA) (HMO)

	A&M Dental (PPO)	DeltaCare USA (HMO)
Access to care	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 reasonable and customary fees. 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 www.wekeepyousmiling.org/group_sites/tamus/, or refer to the plan's provider directory, available from your Human Resources office.	The plan has networks in Texas, Tennessee, Florida, Colorado, New York and Utah. You must use a network general dentist or be referred to a specialist by a network general dentist. 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 www.wekeepyousmiling.org/group_sites/tamus/. Specialists are not listed in the directory.
Deductible	$75/person/plan year; $225 family maximum	None
Maximum benefit	Regular: $1,500/person/plan year Orthodontia: $1,500/person/lifetime	Regular: None Orthodontia: None
Your cost for preventive care	$0 (if you use a network provider). The plan covers two regular or periodontal cleanings per plan year at 100% up to reasonable and customary fees. Deductible does not apply.	Comprehensive oral exam: $0 Cleaning (once each six months): $0 Panoramic X-rays (once every three years): $0
Your cost for basic care	You pay the deductible plus 20% of the reasonable and customary fee for fillings, root canals, extractions and periodontics. Once you reach your maximum annual benefit, you pay 100%.	You pay a pre-set fee, for example: Amalgam fillings: $0 Resin-based composite filling; two surfaces, posterior; permanent: $65 Anterior root canal, excluding final restoration: $110 Periodontic scaling and root planing; per quadrant, limited to 4 quadrants per 12 consecutive months: $55
Your cost for major restorative care	After you meet your deductible, you pay 50% of the reasonable and customary fee for crowns, dentures and bridges. Once you reach your maximum annual benefit, you pay 100%.	You pay a pre-set fee, for example: Crown; porcelain/ceramic: $380 Complete denture; maxillary: $335
Your cost for orthodontics	After you meet your deductible, you pay 50% until you reach your maximum lifetime benefit, then you pay 100%.	You pay a pre-set fee, for example: Orthodontic evaluation: $25 Orthodontic treatment plan and records: $200 Fixed appliance insertion (banding) for comprehensive treatment: $100 Comprehensive treatment, permanent teeth: children up to age 19, $1,900; adults: $2,100
Filing claims	PPO/Premier dentists file claims for you.	Not applicable.
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.	None; you choose the procedure you want from the covered services and pay the applicable copayment.

Vision

The A&M System's vision plan, which is administered by Spectera, provides coverage for eye exams, eyeglass frames and lenses, and contact lenses as well as discounts on some eye surgeries. If you receive an exam through your health plan, you can submit a claim for your copayment or coinsurance amount to Spectera, and Spectera will reimburse you up to $45.

	Network benefit	Non-network benefit
Eye exam (one exam per plan year)	100% after $10 copayment.	Up to $45. Copayment doesn't apply.
Materials	100% after $25 copayment for: • Eyeglasses (frames and lenses), every other plan year. • Eyeglass lenses, one standard pair every plan year. Scratch coating, polycarbonate lenses, basic progressive lenses, tints and UV coating are covered in full. For higher dollar frames, you will have to pay the copayment plus the difference between Spectera's maximum frames allowance and the cost of the frames.	Lenses: $50 to $80, depending on type of lenses. Frames: Up to $50. Copayment doesn't apply.
Contact lenses (once every plan year in place of eyeglass benefit)	100% after $25 copayment 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 2 follow-up visits. Spectera will provide a $150 allowance for lenses that are not covered in full (such as toric, gas permeable and bifocal contacts). When electing these types of contacts, the materials copay does not apply. Medically necessary contacts are covered in full.	Up to $150 for elective contacts; up to $210 for medically necessary contacts. Copayment doesn't apply.
Refractive eye surgery	15% off reasonable and customary cost, or 5% off promotional price.	Not applicable.

Benefits

The plan covers exams for a $10 copayment and most materials for a $25 copayment if you use a network provider. If you use a provider not in the network, the plan will pay limited benefits. The chart on the previous page describes plan benefits for the most common products and services.

Using your benefits

When you use a network provider, you simply pay your copayment (and any expenses not covered) and the plan pays the rest. If you use a non-network provider, you pay the full cost to the provider and submit a claim, including the original bill, to Spectera 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.

Enrollment

You may enroll yourself only or yourself and one or more family members. If you do not enroll during your initial enrollment period, you may not enroll yourself and dependents until the next Annual Enrollment period. You cannot add or drop coverage until the next Annual Enrollment period. You can, however, add or drop newly eligible or noneligible family members if you have certain Changes in Status (see page 4). The plan has no pre-existing condition limitations.

–Ask Yourself–

How much do I spend on vision care in a year? Is it more or less than the premiums and copayments?

If I have vision exam coverage through my health plan, do I need coverage for other vision services and supplies through the vision plan?

Should I use the Health Care Spending Account for my vision expenses instead of purchasing vision insurance (see page 24)?

–Enrollment Options–

- *Employee only*
- *Employee & Child*
- *Employee & Spouse*
- *Employee & Family*

–For More Information–

- *Vision Plan Description Booklet, online at http://tamus.edu/offices/shro/publications/booklets/vision_spd.pdf or from your HR office.*
- *Spectera web site (http://www.spectera.com) Click on "Members and Future Members."*
- *Spectera customer service: (800) 638-3120*

Life

The A&M System offers Basic Life, Alternate Basic Life, Optional Life and Dependent Life insurance. Your eligibility for Basic, Alternate Basic and Optional Life depends on whether you have health coverage and whether that coverage is employee coverage through the A&M System. The plan you select determines which Dependent Life plans you are eligible for. For more information, see the chart below.

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

When you retire, your Optional Life coverage maximum is reduced to $100,000 if you are younger than age 70. When you reach age 70, it will be reduced to $60,000. If you leave A&M System employment but do not retire, you may elect to keep your life insurance coverage until age 70. Some plan provisions will be different, and premiums will be higher.

How much coverage does it provide for...

	Myself?	My spouse?	My children?
Basic Life/ Basic AD&D*	$5,000 in life insurance and $5,000 in AD&D coverage.	None.	$2,000 in life insurance on each eligible dependent child.
Alternate Basic Life/ Basic AD&D*	$50,000 or seven times your salary, whichever is less, as well as $5,000 in Basic AD&D coverage.	None.	$2,000 in life insurance on each eligible dependent child.
Optional Life	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.	None.	None.
Dependent Life Plan A	None.	50% of your Optional Life coverage amount, if spouse is enrolled.	10% of your Optional Life coverage amount on each enrolled eligible child.
Dependent Life Plan B	None.	$5,000 in life and $5,000 in AD&D coverage, if spouse is enrolled.	$5,000 in life and $5,000 in AD&D coverage on each enrolled eligible child.
Dependent Life Plan C	None.	50% of your Alternate Basic Life coverage amount, if spouse is enrolled.	10% of your Alternate Basic Life coverage amount on each enrolled eligible child.

* *Basic AD&D provides only death and dismemberment benefits, and does not provide medical evacuation, repatriation and other benefits offered by Optional AD&D (see page 19).*

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 on the online system or on your Dependent Enrollment Form/Certification are covered under Dependent Life.*

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 25%–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.

Which plans can I enroll in?

You are automatically covered if you enroll in an A&M System health plan. The System covers the cost. If you do not enroll in System health coverage but certify that you have other health coverage, you can have Alternate Basic Life instead (see below). If you have no health coverage, you can purchase Basic Life.

You can enroll if you do not enroll as an employee 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.

You can enroll regardless of whether you enroll 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 can enroll if you have Optional Life coverage. You pay for the coverage yourself.

You can enroll if you have Basic Life, Alternate Basic Life or Optional Life coverage. You pay for the coverage yourself.

You can enroll if you have Alternate Basic Life coverage. You pay for the coverage yourself.

–Ask Yourself–

If I were to die, would my family need money just for funeral expenses and some lifestyle adjustments, or would they need enough to live on for several years?

Does my family have other sources of income or benefits?

Will my children need money for college?

Do I have debts that my survivors would have to assume?

What expenses would I have if a dependent died?

–Enrollment Options–

- *Basic Life/Basic AD&D*
- *Alternate Basic Life/Basic AD&D*
- *Optional Life*
- *Dependent Life Plan A, B or C*

After your initial enrollment period, you may:

- *Enroll in coverage at any time by providing evidence of good health,*
- *Enroll in Optional Life coverage of ½ or one times salary within 60 days of a Change in Status (see page 4) without providing evidence of good health,*
- *Increase Optional Life coverage by one increment up to four times salary during Annual Enrollment or within 60 days of a Change in Status without providing evidence of good health, or*
- *Enroll new dependents within 60 days of acquiring them without providing evidence of good health.*

–For More Information–

- *Life Plan Description Booklet, online at http://tamus.edu/offices/shro/publications/booklets/life_spd.pdf or from your HR office.*
- *Ft. Dearborn customer service: (800) 778-2281*

Optional AD&D

Optional 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 Optional AD&D.

Plan choices

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.

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

You can enroll during your initial enrollment period or during future Annual Enrollment periods. Evidence of good health is not required because the policy pays only for accidents.

–Enrollment Options–

- *Employee only*
- *Employee & Family*

–For More Information–

- *Optional AD&D Plan Description Booklet, online at http://tamus.edu/offices/shro/publications/booklets/add_spd.pdf or from your HR office.*
- *Fort Dearborn customer service: (800) 778-2281*
- *Worldwide Assistance Services customer service: (877) 715-2593*

Benefits and Services

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%
Arm or leg	70%
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%

Other benefits

- Additional benefit for an accident in which the driver was using a seatbelt and airbag.
- A benefit after 12 months of paralysis from an accidental spinal cord injury.
- Grief counseling and financial counseling if a covered person dies.
- Education and child care benefits for your family if you die.

Travel assistance services

While you are traveling, the plan provides help and referrals in many areas, including:

- Replacement of medication and eyeglasses.
- Local medical referrals.
- Emergency travel arrangements.
- Interpretation/translation.
- Repatriation benefits to cover the cost of transporting your body back to your home country if you die.
- Medical evacuation benefits to cover the cost of moving you to the nearest medical facility to receive appropriate treatment if you become seriously ill or injured and cannot receive treatment where you are.

Travel benefits meet the visa requirements for foreign nationals, even if you buy only $10,000 in Optional AD&D coverage. These benefits and services are provided by Worldwide Assistance Services.

–Ask Yourself–

Is my life insurance adequate in case of an accidental death, or do I need more coverage? How much more coverage?

Would I need additional money if I were to lose a limb, eyesight, speech or hearing in an accident?

Would I need additional money if one of my dependents was killed or injured in an accident?

Long-Term Disability

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.

Benefits

If you become disabled, the LTD plan pays you 65% of your base pay *minus* other disability benefits you are eligible to receive. This means your total disability income from *all* sources will be at least 65% of your base pay.

The *maximum* monthly benefit is $8,000. The *minimum* monthly benefit is $100 or 10% of your monthly benefit before deductions for other income benefits, whichever is greater. Benefits become payable after 90 days of disability.

Monthly payments (except for nonorganic mental impairments) continue until your disability (as defined under Eligibility for benefits at right) ends, you reach age 65 or you die, whichever occurs first. If you become disabled after age 60, benefits may be paid for a limited time after age 65.

If you are unable to perform all of the duties of your job because of nonorganic mental impairments, you will receive benefits for a maximum of 24 months.

Your monthly LTD benefit is reduced by any sick leave or vacation pay you receive and most disability benefits you are *eligible* to receive from other group plans, workers' compensation or any government plan, including Social Security.

Your LTD benefit is reduced by benefits from TRS or ORP if you receive payments while receiving LTD benefits.

If you pay the full LTD premium yourself, 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.

Eligibility for benefits

You are eligible for LTD benefits when you have met the definition of disability for 90 days. Disability means you cannot perform the duties of your job because of a physical or mental impairment. You will continue to receive disability benefits after 60 months of disability only if, due to a physical or organic mental impairment, you cannot do any job for which you are or could become qualified by training, education or experience.

Benefits for partial disability are available. If you are able to perform some but not all of the duties of your job due to a disability and, as a result, are earning less than 80% of your regular pay, you may be considered partially disabled and eligible for plan benefits.

Pre-existing condition

If you have a pre-existing condition, the Long-Term Disability plan will not pay benefits until you have been covered by the plan for 12 months or until you have gone 90 days after LTD coverage begins without receiving care or taking medication for the condition. A pre-existing condition is a sickness or injury for which you receive medical treatment, consultation, care or services (including diagnostic measures) or take prescribed drugs or medicines during the 90 days before LTD coverage begins.

Enrollment

You do not have to provide evidence of good health to enroll in LTD. If you do not elect coverage during your initial enrollment period, you may enroll during a subsequent Annual Enrollment period.

Lower premiums are available for nontobacco users. You are considered a nontobacco user if you have not used any tobacco products for more than 12 months. You can change this designation at any time.

–Ask Yourself–

Is my income necessary to my family's financial security?

Do I have enough vacation or sick leave to continue my pay if I cannot work or if I have to work a reduced schedule for longer than 90 days?

Do I have many years of state service and am I near retirement age?

–Enrollment Options–

- *Employee only*

–For More Information–

- *Long-Term Disability Plan Description Booklet, online at* *http://tamus.edu/offices/shro/publications/booklets/ltd_spd.pdf* *or from your HR office.*
- *About Disability brochure.*
- *MetLife customer service: (800) 243-8786*

Long-Term Care

Long-Term Care provides benefits if you require nursing and custodial care, which means that you need help with daily activities such as dressing and eating. These services are not usually covered by your health plan.

Enrollment

If you enroll during your initial 90 days of eligibiity, you do not have to provide evidence of good health. If you enroll after your initial 90 days of eligiblity, you must provide evidence of good health. Your spouse may also enroll; however, he/she must provide evidence of good health. You may also have enrollment information sent to your children age 18 and older, parents, parents-in-law, grandparents or siblings, but they must make their own enrollment decisions and arrange to pay premiums directly to the carrier, John Hancock. Packets containing complete information, premiums and enrollment forms are available from your Human

Benefits

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
- respite care
- caregiver training
- emergency alert
- assisted living
- 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 (6 years) times your daily benefit.

The plan has a 90-day qualification period for most types of care.

The plan offers two optional enhancements 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 do 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.

Resources office or by visiting the John Hancock web site or calling John Hancock customer service.

Premiums

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

Premiums are listed in the Long-Term Care enrollment kit, available from your Human Resources office. You also may request a kit or get premium information by visiting the John Hancock web site or calling John Hancock customer service.

–Ask Yourself–

Could I pay the bills if my spouse or I needed long-term care?

What would the effect be on living expenses, college plans for the children and other long-range plans if I had to spend my savings on long-term care?

–Enrollment Options–

- *Employee*
- *Spouse*

–For More Information–

- *John Hancock web site* (http://tamus.jhancock.com). *Enter TAMUS as the user name and mybenefit as the password.*
- *John Hancock customer service:* (800) 498-9100.

Spending Accounts

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.

Health Care Spending 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 expenses through this account, the child must meet certain criteria set by the IRS (criteria are listed on page 4 under "Premiums").

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.

–Ask Yourself–

Will I spend more than the minimum contribution amount ($20/month) this year on planned health care expenses not paid by insurance? Will I or any of my dependents need braces, new glasses or contact lenses? Will our medical and prescription drug copayments, deductibles and coinsurance total more than my minimum contribution amount?

Do I spend at least $40/month on day care? Does the chart on page 27 show I can save more money using the Dependent Day Care Spending Account or tax credit?

Dependent Day Care Spending Account

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 27 or visit the PayFlex web site, http://www.payflex.com, to determine which works best for you.

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). A monthly administrative fee of $3.75 will also be deducted tax-free from your first paycheck each month.

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, the plan administrator, to receive reimbursement from your account. When you incur an *eligible health care expense*, you must send PayFlex a copy of the bill or explanation of benefits from your health plan.

You may take money out only to reimburse yourself for an eligible expense incurred between the date your participation began and Dec. 31, 2007. This means you must receive the product or service during that period, regardless of when you pay for it. If services are provided over a multiyear period (braces, for example), reimbursement is based on the cost of the portion of services received during the current plan year.

Reimbursements

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.

You will receive your first reimbursement check after you mail in your first claim *and* after you have received your first paycheck reflecting your benefit elections.

Examples of Covered Expenses

Health Care Spending Account

Covered expenses include:

- Copayments and deductibles
- Many over-the-counter medications*
- Orthodontia
- Glasses, contact lenses and supplies (such as saline solution and enzyme cleaner)
- LASIK surgery
- Smoking cessation programs and prescribed drugs
- Dental care
- Hearing aids

* *Guidance on covered and noncovered medications can be found online at http://tamus.edu/offices/shro/otc.pdf.*

Expenses not covered include:

- Health insurance premiums
- Nicotine patches or diet pills*
- Exercise programs and equipment*
- Medical or dental cosmetic surgery or drugs*

* *Unless prescribed for treatment of an illness or injury*

Dependent Day Care Spending Account

Covered expenses include:

- Day care fees for children 12 or younger or older disabled dependents
- Babysitting fees (work-related only)

Expenses not covered include:

- Tuition and fees for private school, grades kindergarten through 12th
- Overnight camps and extracurricular lessons
- Supply fees
- Club or organization membership fees

For a complete listing of allowable health care and/or day care expenses, contact PayFlex at (800) 284-4885 or http://www.mypayflex.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://www.irs.ustreas.gov or by calling (800) 829-3676.

Restrictions

Both types of Flexible Spending Accounts carry certain restrictions. However, you can benefit from the plans and avoid losing money by carefully determining how much you will need to pay in health care and/or day care expenses during the plan year. Restrictions are:

- If you set up both types of Flexible Spending Accounts, you cannot transfer money between accounts.
- Federal law requires that you forfeit (lose) money in your accounts that you have not used by Nov. 15, 2007. This money is returned to the System and cannot, by law, be refunded to you. Forfeitures are used to offset administrative expenses such as printing Spending Account plan description booklets.

–Enrollment Options–

- *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)

–For More Information–

- *Spending Account Plan Description Booklet, online at http://tamus.edu/offices/shro/publications/booklets/fsa_spd.pdf or from your HR office.*
- *PayFlex web site (http://www.mypayflex.com)*
- *PayFlex customer service: (800) 284-4885*
- *IRS web site* (http://www.irs.ustreas.gov)

Changing your elections

After enrolling, your elections remain in effect through Aug. 31, 2007. You may change your elections only at the beginning of each plan year, unless you have certain Changes in Status (see page 4). 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 in which your contribution amount increased.

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 Sept. 1, 2006, and Nov. 15, 2007. 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 Sept. 1, 2006, and Aug. 31, 2007, as long as you have an account balance.

Tax Credit vs. Dependent Day Care Account

The chart below shows how the tax savings using the child care tax credit on your income tax return compares to the savings using the Dependent Day Care Account. Calculations assume standard deductions and that married couples file jointly. Your personal tax situation may be different. Remember, this chart shows the difference in tax savings between the two methods—total tax savings is much greater.

To find out whether the Spending Account or tax credit may be best for you, follow these steps:

1. Find your approximate gross family income per year in the left column.
2. Look across to the marital status and number of children that best fits you.
3. If a number appears in the Tax Credit column, the federal tax credit saves that much more per year than the Spending Account.
4. If a number appears in the Spending Account column, the Dependent Day Care Account saves that much more per year than the tax credit.

Note: The examples with two dependents assume the maximum, $5,000, is contributed to a Spending Account and that the remaining $1,000 is applied to the tax credit. The tax credit column assumes that the entire $6,000 is applied to the tax credit.

Gross Family Income	Status: Single 1 dependent, Expenses: $3,000		Status: Single 2 dependents, Expenses: $6,000		Status: Married 1 dependent, Expenses: $3,000		Status: Married 2 dependents, Expenses: $6,000	
Method:	Tax Credit	Spending Account	Tax Credit	Spending Account	Tax Credit	Spending Account	Tax Credit	Spending Account
$14,000		230		383		230		383
$16,000		230		383		230		383
$18,000		100		383		100		383
$20,000	101			383	101			383
$22,000	301			383	301			383
$24,000	371			173	371			173
$26,000	263		38		341		38	
$28,000	161		248		311		248	
$30,000	131		198		221		388	
$32,000	101		147		101		237	
$34,000	71		97		71		97	
$38,000	41			3	11			3
$40,000	11			53		20		53
$42,000		20		103		50		103
$44,000		50		153		80		153
$45–75K		80		153–633		80		153–133
$77,000		380		633		280		333
$78,000		380		633		380		433
$80–90K		380		633		380		633
$95–155K		330		583–473		330–284		583–473
$160,000		284		473		284		473
$170–200K		284		473–723		284		473

Retirement Programs

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 $210,000 federal limit. *The employer/employee contribution amounts are set by state legislation and are subject to change.*

All System employees are also eligible to participate in the Tax-Deferred Account (TDA) program and the Deferred Compensation Plan (DCP) from their first day of employment. You may enroll in these plans at any time. Your contributions will begin the month after you enroll.

Contributions to TRS, ORP, TDA and DCP 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.

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.

If you are in TRS, you must also provide documentation that you are receiving or have applied to receive your TRS annuity payments.

Teacher Retirement System of Texas (TRS)

You contribute 6.4% of your pay to TRS on a before-tax basis. The A&M System currently contributes an amount equaling 6% 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 Sept. 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. 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. The criteria for receiving an unreduced TRS annuity will change for those who begin participating in TRS on or after Sept. 1, 2007.

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 rolled 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% 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://tamus.edu/offices/shro/retirement/orptda.html. 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 28). Your choice of benefit payment options after you retire depends on the payment options offered by the vendor(s) you chose. *You should consult your tax advisor before withdrawing any funds.*

No loans or hardship withdrawals are permitted under ORP while you are a participant.

Tax-Deferred Account and Deferred Compensation Plans

You may enroll in the Tax-Deferred Account (TDA) Program and/or the Texa$aver Deferred Compensation Plan (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 either of these programs, 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/shro/retirement/orptda.html. DCP vendors 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 Human Resources web site,
http://tamus.edu/offices/shro/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 each vendor. 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.

For more information on these programs, contact your Human Resources office or visit the System Human Resources web site at
http://tamus.edu/offices/shro/retirement.

Other Plans

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

Discount Hearing Program

To locate the nearest AHAA provider, call (800) 984-3272 or visit AHAA's web site at http://www.AHAAnet.com. You can also click on the AHAA link from the System Human Resources web site at http://tamus.edu/offices/shro/benefits.

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 AHAA member card or an ID card that shows you to be an A&M System employee. The discount is given at the time of purchase. A Health Care Spending Account (see page 24) may be used for out-of-pocket expenses after the discounts.

Answer Financial

Visit Answer Financial Online at http://www.answerfinancial.com (the link on the System Human Resources web site will take you directly to information for A&M System employees). If you don't have Internet access, you can call Answer Financial toll-free at (866) 493-8888 to speak to a licensed agent.

Answer Financial® Inc. offers insurance services through its subsidiaries, Insurance Answer Center, ® Inc.

Answer Financial offers access to hundreds of top-rated insurance companies by phone or through the company's award-winning web site. Comparison shop quickly and easily and save on the following insurance products and financial services:

- Auto insurance
- Homeowners'/renters' insurance
- Home warranty
- Prepaid legal services
- Life insurance
- Pet insurance
- Travel protection
- Vision care
- Prescription drug savings plan
- Online banking
- Dental insurance
- Health insurance
- Long-term care insurance