**Benefits FAQs**

**Changes**

**When is the Annual Enrollment period?**

The Annual Enrollment period begins July 1 and runs through July 31 each year. Any changes you make to your benefits during this time will be effective on September 1. Premium changes will be reflected on the first paycheck you receive for services you perform in the new fiscal year. For example, if you are paid monthly, premiums for your September coverage will be reflected on your October 1 paycheck. In late June of each year, System Benefits Administration will distribute information about how and when to make changes to your benefits.

*What are the different types of Changes in Status and how do they impact my benefits?* Federal regulations define situations called Changes in Status that allow employees and retirees to change their Flexible Spending Accounts contributions or health, dental, vision or AD&D coverage during a plan year within 60 days of the Change in Status. Changes in Status are:

- Employee’s marriage, divorce or death of employee’s spouse.
- Birth, adoption or death of a dependent child.
- Child becoming ineligible for coverage due to reaching age 25 or marrying.
- Change in employees, spouse’s or dependent child’s employment status that affects eligibility for coverage.
- Change in employees, spouse’s or 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 a dependent child during his/her employer’s annual enrollment period.
- The employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid.
- Significant employer-initiated or carrier-initiated changes in or cancellation of the employee’s, spouse’s or dependent child’s coverage.
- Change in day care cost due to a change in provider, change in provider’s fees (if the provider is not a relative) or change in number of hours the child needs care (for Dependent Day Care Spending Accounts).

A court order against the spouse of an A&M System employee does not constitute a Change in Status. Also, a change in income, which may affect coverage affordability, does not constitute a Change in Status. If you experience a Change in Status and would like to change your benefit coverages, complete a Benefit Change Form and, if applicable, a Dependent Enrollment Form/Certification within 60 days of the Change in Status. If it has been longer than 60 days since the Change(s) in Status occurred, you must wait until the next Annual Enrollment period to make the change(s).

**I need to change my beneficiaries. What do I do?** Beneficiary information may be updated any time of the year. You can change your beneficiary(ies) for Basic/Alternate Basic Life, Optional Life and/or Accidental Death and Dismemberment (AD&D) in iBenefits. If you participate in the Teacher Retirement System, complete the TRS 11 form or contact TRS at (800) 223-8778 to request this form. If you participate in the Optional Retirement Program (ORP), Tax Deferred Annuity Program or Deferred Compensation Plan, notify your vendor(s) of your new beneficiary.
I will be terminating employment soon. What forms do I need to complete and how can I continue my insurance coverage? COBRA forms to continue health, dental and/or vision coverage will be provided to you at your scheduled Exit/Clearance Interview.

Can I add my grandchild to my insurance coverages? Yes. Your grandchild must be living in your home and you must provide proof of this to your Human Resources office in order for this the grandchild to be added.

I’m a foreign national, and my visa requires that I have medical evacuation and repatriation coverage. Do I meet this requirement under the AD&D or Life Plan? If you have health coverage and Basic Life, then you automatically have medical evacuation coverage. This is provided through Europe Travel Assist under the vendor Minnesota Life.

I will be getting married/divorced soon. What do I need to do to change my name on my records and/or add/drop dependent(s) on my benefits? You will need to apply for and obtain a new Social Security card reflecting your new name and provide a copy of the card to your departmental employment processor. Upon receipt of the appropriate paperwork from your department, your Human Resources office will update your personnel and payroll records. If you want to add or drop dependent(s), complete a Dependent Enrollment Form/Certification.

You may also want to update your beneficiaries through iBenefits under Single Sign On. Beneficiary Designation Form to change beneficiary(ies) for Basic/Alternate Basic Life, Optional Life and/or Accidental Death and Dismemberment (AD&D). If you participate in the Teacher Retirement System and you need to change your beneficiary designation, complete the TRS 11 form or contact TRS at (800) 223-8778 to request this form. If you participate in the Optional Retirement Program (ORP), Tax Deferred Annuity Program, or Deferred Compensation Plan, notify your vendor(s) of your new last name.

Dental Care

The A&M Dental plan has a $1,500 per person maximum benefit each plan year and a $1,500 per person lifetime maximum on orthodontic care. When I have orthodontic care, do the expenses apply to both maximums or only the orthodontic maximum?

Those expenses will apply only to the orthodontic lifetime maximum.

How do I find a Delta Network or Premier dentist in my area? The most up-to-date list of participating dentists is online at http://deltadentalins.com/tamus/. You can also call Delta at (800) 336-8264.

Are there any pre-existing conditions that won’t be covered immediately under the DeltaCare USA Dental HMO? No. All dental services will be covered under the DeltaCare USA Dental HMO as soon as your coverage becomes effective.

If I enroll in DeltaCare USA, will my benefits be reduced if I go to a dentist who is not in the DeltaCare USA network? DeltaCare USA will not pay benefits for treatment from a non-HMO dentist. You will pay the full cost.

Why doesn’t DeltaCare USA have an office visit copayment of $20 or $25 like most of the health plans? The DeltaCare USA plan allows you to pay a set fee (copayment) for each service. The fee varies according to the service, rather than being the same fee for all services, as with some health plans. For preventive care, the plan pays the full cost, and you pay no copayment, so a $20 or $25 copayment plan would actually cost you more. The plan pays the full cost to encourage people to get routine preventive care and perhaps avoid more
serious and costly dental problems. Other copayments are higher. To receive any type of dental service for a $20 or $25 copayment would require higher premiums than most employees would be willing to pay.

What's the maximum benefit DeltaCare USA will pay in a year? Is it different for orthodontia? DeltaCare USA does not have a maximum cost benefit for any type of treatment, including orthodontia. For each service you receive, you pay the copayment listed on the schedule, and DeltaCare USA pays the rest, no matter how many services you receive in a year.

How do I find a DeltaCare USA dentist in my area? To find a DeltaCare USA dentist, go to http://deltadentalins.com/tamus/. You can also call DeltaCare USA at (800) 422-4234. However, because the A&M System is rural-based, network dentists are not available in all areas where we have employees and retirees.

In DeltaCare USA, do I have to get all treatment from a single dentist? You must choose a network general dentist, but you can change to another network general dentist up to four times a year by calling DeltaCare USA. Each covered family member can have a different dentist. You must get treatment from your network general dentist, unless your network general dentist refers you to a network specialist.

Last year, my dentist recommended some treatment, and the A&M Dental plan said it would pay only for a less expensive treatment. Does DeltaCare USA have that same rule? No. You and your network dentist agree on the treatment, and you pay the copayment for that treatment. DeltaCare USA will pay the remaining cost for whichever treatment you choose, even if a less expensive treatment is available.

How is A&M Dental different from DeltaCare USA? The plans have different benefits, provider networks and requirements. With A&M Dental, you can see any dentist you wish and receive benefits, and you can go directly to any dental specialists without a referral. Preventive care is covered at 100% of reasonable and customary fees (as determined by Delta). For other services, you pay an annual $75 deductible and then a percentage of the cost of what the dentist charges for the service. If you use a Delta Network or Premier dentist, you will likely pay less because Delta has contracted with these dentists to provide services at reduced prices. However, you do not have to use a PPO dentist to receive benefits. A&M Dental also has an annual benefit maximum of $1,500 per covered person and an additional $1,500 lifetime limit per covered person for orthodontic care. With DeltaCare USA, you must use DeltaCare USA dentists to receive benefits, you must be referred by your general dentist to dental specialists and the specialist must be in the network. You pay a set fee for each dental service you receive.

I am under the care of a periodontist and have my teeth cleaned twice a year at the periodontist’s office and twice a year at my regular dentist’s office. Will the plan cover all of my cleanings? The A&M Dental plan as well as the DeltaCare USA plan cover the reasonable and customary cost of cleanings, whether the cleanings are done at a regular dentist’s office or a periodontist’s office. If you have your teeth cleaned more often, you must pay the cost of the additional cleanings. The A&M Dental plan pays for three cleanings a year because that is the standard number of cleanings recommended by most dentists for most patients. DeltaCare USA covers one cleaning every six months. To get a periodontal cleaning covered for preventive care, you will need to provide information to Delta that you have previously had other periodontal work done such as scaling and root planning.

How can I find out exactly what my cost will be for my dental care under the A&M Dental plan? One way to be sure you know what your cost will be is to ask your dentist what services he/she is recommending. You can then send your dentist’s suggested treatment plan to Delta, and Delta will tell you what your share of the cost will be.

Life Insurance
Do I need to provide evidence of insurability to enroll in Optional Life coverage? If you enroll in Optional Life after your first 60 days of employment, you will need to provide evidence of insurability (good health), unless you have a Change in Status. If you have a Change in Status, you may enroll in Optional Life coverage of one-half or one times pay without providing evidence of insurability, but you will need to provide evidence of insurability to enroll in higher levels of coverage.

How does the automatic Dependent Basic Life coverage work? Employees and retirees who have Basic Life or Alternate Basic Life coverage automatically have $5,000 of life insurance coverage on all eligible dependent children. This benefit does not include spouses. You do not have to specifically enroll your children. They are automatically covered. The coverage cannot be waived.

What is the difference between Basic Life/Basic AD&D, Alternate Basic Life and Optional Life? Basic Life/Basic AD&D is automatically provided to those who enroll in an A&M System health plan, and the employer contribution pays the premium. Those who do not take System health coverage and do not certify that they have other health coverage may buy Basic Life/Basic AD&D, but must pay for it themselves. Alternate Basic Life is available to employees and retirees who do not enroll in an A&M System health plan, but certify that they have other health coverage. Because they certify that they have other health coverage, they can use half of the employer contribution to buy other coverage’s, including Alternate Basic Life, which has a maximum coverage level of $50,000. Optional Life is available to all employees except those in Alternate Basic Life, but the employer contribution may not be used to pay the premiums. Those eligible for Alternate Basic Life may choose to buy either Optional Life or Alternate Basic Life, but not both.

If I increase my Optional Life coverage during Annual Enrollment, when is the increase effective? After completing and submitting your evidence of good health application, the increase becomes effective on the first of the month following approval of your application or September 1, whichever is later.

Why set up an Alternate Basic Life plan if anyone can buy Optional Life? To keep from increasing many employees’ tax bills, we must prohibit using the employer contribution to buy life insurance through the Optional Life plan. However, we want employees eligible for half the employer contribution to be able to buy up to $50,000 of life insurance with that money. That’s why we set up a separate plan just for them. To avoid any extra taxes for that group, we limited the amount of life insurance that could be purchased through Alternate Basic Life to $50,000.

How does the Living Access benefit work? The Living Access benefit is designed to give you access to part of your Basic, Optional or Alternate Basic Life benefit if you have a terminal condition. Often those who are terminally ill need the extra money that can be provided by this benefit. To qualify for a Living Access benefit, you must be covered under Basic Life, Optional Life or Alternate Basic Life and a doctor must certify that you have less than 24 months to live. You can receive up to 50% of your total coverage amount. If your spouse and/or covered children have Dependent Life coverage, they are also eligible for the Living Access benefit.

If I sign up for Dependent Life, are all of my eligible dependents automatically covered? No. You must list each dependent you wish to cover when you enroll. You must provide evidence of insurability (good health) to add a spouse, unless you enrolled him/her within 60 days of when you first became eligible for coverage or within 60 days of a Change in Status.

What is the portability provision in the life insurance program? Under the portability provision, you may continue the same amount of Life coverage without providing evidence of good health. The premiums will be higher than those paid by active employees, but much lower than those for the conversion policy. Some provisions, such as the Living Access Benefit, that are available to active employees are not included in the portability program.
How do I change my beneficiaries? You may change your beneficiaries at any time through iBenefits or by completing a Beneficiary Designation Form and submitting it to your Human Resources office. The form is available on the System Benefits Administration web site or from your Human Resources office. When you change your beneficiary in HRConnect or when your Human Resources office receives your completed form, your new beneficiary designations will supersede all previous designations.

Long-Term Disability

Do I need to provide evidence of insurability to enroll in Long-Term Disability (LTD)? You do not have to provide evidence of insurability (good health) to enroll, but you must be actively at work on the day your coverage is scheduled to go into effect or coverage will be delayed. If you are not actively at work, coverage will become effective on the first subsequent day you report to work. When you enroll, you must indicate whether you are, or are not, a tobacco user. You will have the opportunity to enroll without evidence of insurability during each Annual Enrollment period. However, pre-existing condition limitations will apply.

What are the pre-existing condition limitations for LTD coverage? A pre-existing condition is one for which you had symptoms, received medical treatment, consultation, care or services, or took prescribed drugs or medicines during the three months before your LTD coverage began. You cannot receive LTD benefits for a pre-existing condition if your period of disability begins during your first 12 months of plan coverage.

If I become disabled, will my LTD benefit be taxed? If you are paying the full premium, your benefit will not be taxed. However, if you have waived health coverage and are using part of the employer contribution to pay your LTD premiums, your LTD benefits will be taxed. That’s because the premiums are paid with after-tax dollars if you pay them and non-taxed dollars if the state pays them. The IRS looks at coverage paid for by the state as deferred income that is subject to taxation when received.

Why is our LTD benefit offset by other retirement or disability benefits we receive? The purpose of LTD coverage is to ensure you have a source of income in case you are unable to work due to a disability. However, the plan also wants to encourage you to return to productive employment as soon as possible. By guaranteeing a percentage of your pay, the plan ensures you will have a certain level of income, although it may come from various sources. While 65% of pay may not sound like enough to live on, keep in mind that you do not pay Social Security or federal income tax (in most cases) on your LTD benefits and on some other potential disability benefits. Also, you will not have many work-related expenses, such as commuting costs, while you are not working, so you may not need as much income. If the plan were to always pay 65% regardless of other benefits, the premiums would be much higher. Also, some disabled employees might receive more than 100% of their pay from various sources, providing little incentive for them to return to work. This would further increase plan costs and premiums.

What kinds of other benefits offset my LTD benefit? The benefits that offset the LTD benefit include those under individual and family Social Security, any group LTD plan (including those through professional associations), A&M System leave programs, Railroad Retirement Act, Jones Act, workers’ compensation, occupational disease law, compulsory benefit act or law, and similar plans or laws. Your LTD benefit will not be offset by any disability or retirement benefits from an employer-sponsored retirement plan, including TRS and ORP, unless you actually receive those benefits.

Why is the Long-Term Disability benefit period for mental-health-related disabilities limited to 24 months? The 24-month limit applies only to non-organic mental-health-related disabilities. Benefits for organic mental illnesses, such as schizophrenia, bipolar disorder and Alzheimer’s, are paid the same as for physical disabilities. The potential length of non-organic mental-health-related disability claims is difficult to determine, so large reserves must be kept to cover these disabilities. This causes LTD plan costs, and therefore premiums, to increase. For that reason, payment periods for non-organic mental-health-related disabilities are
limited by most employers. The 24-month limit is in line with the industry standard for LTD coverage and should help reduce our claims costs and keep premiums low for everyone.

**Health Care**

**If Medicare is primary, do I have to use network doctors and hospitals?** No. In the A&M Care plans, you will be considered non-network and will receive the same benefits no matter which doctors and hospitals you use.

**If I have Medicare as my primary carrier, do I have to pre-certify with BlueCross BlueShield?** No.

**If my doctor submits evidence that I must have a drug not on the formulary list for medical reasons, can I get the no formulary drug by paying the formulary copayment?** If your doctor provides documentation to Medco before the prescription is filled stating that you have tried the formulary drug and you must have the no formulary drug for medical reasons, and if Medco approves the substitution, you will pay only the formulary copayment. Formulary information is available at www.medco.com or from your Human Resources office.

**Under the A&M Care plans, how long will it take to get prescriptions filled through the mail-order program?** Once Medco by Mail receives a prescription and order form with all of the required information, your prescription is filled and mailed, on average, within three days for orders that do not require intervention. Orders sent by regular mail usually take an additional two to five days to arrive. If you want to ensure faster delivery, you may pay more for overnight delivery.

**What is a formulary list?** The formulary is a list of preferred brand-name drugs that have been compared and evaluated with other brands and provide maximum quality and value. Many therapeutic categories (for example, ulcer medications) have two or more brand-name drugs that are used for the same purpose. To maximize your savings, you should present the list to your physician each time you are to receive a prescription and, when possible, ask your physician to consider the use of generically equivalent alternatives. You are not required to use the drugs on this list, and they are not the only drugs covered by the plan. If a drug you are using is not on the list, you may still have your physician prescribe that drug for your use, but you will pay a higher copayment.

**How will I know if my prescription will be filled with a brand-name or a generic medication?** Generic alternatives will be dispensed by the pharmacist whenever available and legally permitted, unless your physician specifically indicates on the prescription “dispense as written.” The generic version of a drug has the same chemical compound as its brand-name counterpart. The use of generic drugs offers a simple and safe alternative to help reduce your prescription drug costs. If a generic drug is available and you have your prescription filled with a brand-name drug, the plan will pay only the cost of the generic. You will be responsible for paying the difference, plus the brand-name copayment. You pay only the brand-name copayment when no generic is available.

**Under the A&M Care plans, I understand some medications may be limited or require prior authorization. Which drugs are these?** Generally, the A&M Care plans will cover drugs that are prescribed for the medically necessary treatment of an injury, illness or disease. The plans do not cover drugs prescribed for fertility treatment or cosmetic purposes, including hair growth agents. To obtain some drugs, you must first have your physician fax or mail documentation of the medical necessity of the drug using the preauthorization form available on the Medco web site, www.medco.com. Medco will then determine whether to authorize coverage for the drug. If Medco does not authorize coverage, you may still obtain the drug, but you will pay the full cost. Some drugs are restricted to certain ages, dosages or diagnoses and may require prior authorization. Call Medco at (866) 544-6970 (toll free), or visit the web site at www.medco.com, if you have a question about whether a medication is covered, requires prior authorization or is restricted.
Why don’t retirees eligible for Medicare have to use network providers? Medicare has already set the amount a doctor who accepts assignment may charge for services for those on Medicare. These rates are greatly reduced from what the doctor normally charges. In addition, since the A&M Care plans generally pay after Medicare, the balance due is relatively small. Consequently, making Medicare-eligible retirees use network doctors would generate little or no savings for the A&M Care plans.

If I choose not to enroll in Medicare, will my benefits be paid the same way as an active employee’s are paid? The answer is whether you are actively employed or retired. If you are actively employed with the A&M System, you may postpone enrolling in Medicare until you retire. In this case, your benefits will be paid the same as other active employees. If you are retired and eligible for Medicare, the A&M Care plan will pay benefits as if you are enrolled in Parts A and B of Medicare, even if you are not actually enrolled. To get full health benefits, you must enroll in both parts of Medicare as soon as you become eligible.

I am a retiree and will turn 65 this year. Does that mean I should enroll in 65 PLUS? If you fall into this category, you must enroll in both Medicare Parts A and B to receive the maximum benefits available. You will be penalized by Medicare with higher premiums if you don’t enroll in Part B when you’re first eligible, and you’ll be able to enroll only during certain times except in certain circumstances. Those with Medicare as their primary payer are not eligible for office visit copays.

If I buy a brand-name drug, do I just pay the formulary or non-formulary copayment? If no generic equivalent is available, you pay the formulary copayment if you buy a brand-name drug on the formulary and the non-formulary copayment if you buy a brand-name drug not on the formulary. Many plans have mandatory generic substitution. If a generic is available, many plans require that you pay more if you do not want to take the available generic. If you are covered by one of the A&M Care plans, your doctor can submit medical evidence that you need the brand-name drug because you can’t take the generic drug, and Medco, the A&M Care drug plan administrator, may approve payment of the brand-name formulary or non-formulary copayment.

Can I add or drop dependents from my health plan during the plan year? If you have a Change in Status, you may add or drop the dependent affected by the change to or from your health, dental or vision plan within 60 days of the change. Otherwise, you may not add or drop dependents except during Annual Enrollment (effective Sept. 1). Changes in Status are:

- Employee’s marriage, divorce or death of employee’s spouse.
- Birth, adoption or death of a dependent child.
- Child becoming ineligible for coverage due to reaching age 25 or marrying.
- Change in employees, spouse’s or dependent child’s employment status that affects eligibility for coverage.
- Change in employees, spouse’s or 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 a dependent child during his/her employer’s annual enrollment period.
- The employee, spouse or dependent child becoming eligible or ineligible for Medicare or Medicaid.
- The employee/retiree or dependent child loses coverage under the State Medicaid or Child Health Plan or becomes eligible for premium assistance under the Medicaid or Child Health Plan.
• Significant employer-initiated or carrier-initiated changes in or cancellation of the employee’s, spouse’s or dependent child’s coverage.
• Change in day care cost due to a change in provider, change in provider’s fees (if the provider is not a relative) or change in number of hours the child needs care (for Dependent Day Care Spending Accounts).

A court order against the spouse of an A&M System employee does not constitute a Change in Status. Also, a change in income, which may affect coverage affordability, does not constitute a Change in Status.

If, after a few months, I don’t like the health plan I selected, can I change to a different plan? No. You must remain in whichever plan you choose for the rest of the plan year (through Aug. 31). You may change plans only during the next Annual Enrollment period.

Are the A&M Care plans the same as the BlueCross BlueShield (BCBSTX) plans? Yes. BCBSTX administers the A&M Care plans for the A&M System.

What are the key phone numbers for BlueCross BlueShield of Texas?

• Member services: (866) 295-1212
• Precertification: (800) 441-9188
• Mental health precertification: (800) 528-7264
• BlueCard (for network physician information outside Texas): (800) 810-BLUE

Both precertification numbers can be dialed directly or accessed by calling member services. Member services representatives will be available from 8 a.m. until 8 p.m., Monday through Friday.

How do I know if I live in a BlueCross/BlueShield network area? Only five Texas counties (Donley, Hansford, Lipscomb, Ochiltree and Wheeler) are considered non-network.

What network benefits are available for employees and retirees living or traveling outside Texas? A&M System employees and retirees have access to network doctors nationwide through BlueCross BlueShield’s BlueCard program. Your ID card has a toll-free number you can call to get information on providers in your area. Unless you are eligible for Medicare and not working for the A&M System, you must use a network provider to receive the highest level of benefits.

How do the network and out-of-network deductibles and out-of-pocket maximums work together if I sometimes go to network doctors and sometimes to out-of-network doctors? Any expenses you have at an out-of-network provider will apply to both the out-of-network and network deductibles and out-of-pocket maximums. However, network expenses will apply only to the network deductible and out-of-pocket maximum.

Why are out-of-network deductibles more than network and non-network deductibles? A&M Care participants pay the higher, out-of-network deductible only when they live in a network area but choose to visit a care provider not in the network. This provision encourages plan participants to visit network providers, with whom BlueCross BlueShield of Texas has contracted to provide certain services at lower costs, and helps hold down the premium costs for all employees.

How do I get prescription medicine through the A&M Care plans?

Express Scripts is the drug plan administrator for the A&M Care plans. If you enroll in one of the A&M Care plans, you will receive an Express Scripts drug card. You can use this card at more than 55,000 chain and independent pharmacies throughout the U.S. for a 30-day supply of medicine. You pay a $50 deductible on your first prescription drug purchases each year for each covered family member (three person maximum).
Then you pay $10 for each generic prescription, $35 for each brand-name formulary prescription and $60 for each brand-name non-formulary prescription if you buy drugs at a local pharmacy. You can also order up to a 90-day supply of maintenance medications through Express Scripts mail-order program, Express Scripts by Mail. If you use the mail-order program, you pay two copayments for a 90-day supply after the $50 annual deductible. If you buy a brand-name drug when a generic is available, you pay the difference in cost in addition to the $35 or $60 brand-name copayment, unless your doctor provides information in advance that you cannot take the generic drug for a documented medical reason and Express Scripts approves the brand-name drug. For more information on obtaining prescription medicines, call Express Scripts toll-free at (866) 544-6970.

Under the A&M Care plans, do I need to file a claim to get reimbursed for short-term drugs? You file a claim only if you use a pharmacy that is not in Medco’s network. Out-of-network pharmacies require you to pay the full cost of the drug at the time of purchase.

How does the hearing-aid benefit offered by the HMOs work? The HMOs have some differences in the hearing aid benefits they offer. However, at a minimum, most provide a $500 benefit for a hearing aid for each ear every three years.

My doctor has prescribed a particular medicine for me, but my health plan says it’s not on the plan’s formulary. What does that mean? All of our health plans use formularies. Formularies are lists of drugs the health plan prefers that you take for various illnesses. Each health plan has its own formulary, so a drug may be on the formulary of one plan, but not on another. These drugs cost less for the health plan to dispense because they are purchased in bulk with special discounted pricing from the manufacturer. A&M System health plans, including the A&M Care plans, have a three or four-tier copayment system. These consists of three or four copayment levels with the lowest copayment for a generic drug, a higher copayment for a brand-name drug on the formulary, and a higher copayment for a brand-name drug not on the formulary, and in some cases, a coinsurance amount for very expensive injectable or biogenetic drugs. The formulary may change during the year, but the Texas Department of Insurance now requires health plans to notify you 90 days in advance if they will be removing a drug you are taking from the formulary list, so you will have a chance to try another drug or request an appeal.

If I’m an A&M Care plan participant, can I get prescriptions filled at my favorite pharmacy? The Medco network is a nationwide network of more than 55,000 pharmacies. To see if your pharmacy belongs to the Medco network, or to locate a participating pharmacy near you, call Medco toll-free at (866) 544-6970, or access Medco’s web site at www.medco.com.

What happens if I use an out-of-network pharmacy? As an A&M Care plan member, you must pay, up front, the full cost of a prescription if you use a pharmacy that is out of Medco’s network of pharmacies. You must then file a claim with Medco to be reimbursed for covered medications. After you’ve met your deductible, your copayment is deducted and then Medco will reimburse you 75% of the remaining reasonable and customary cost. Contact your Human Resources office for out-of-network claim forms or call Medco toll-free at (866) 544-6970.

Under the A&M Care plans, how do I determine whether to have my prescriptions filled at my local pharmacy or the mail-order pharmacy? Your local pharmacy should be used for short-term or acute medications such as antibiotics or pain relief medications. For long-term or maintenance medications, you should use the mail-order pharmacy, Medco by Mail. Using the mail-order pharmacy, you can get up to a 90-day supply of your medication for only two copayments. Be sure your physician writes the prescription for 90 days’ worth of medicine, plus any needed refills. However, if you are getting a brand-name drug when a generic is available, you will have to pay the cost difference between the generic and brand-name in addition to the copayments. The only exception is if, before you submit the prescription, your doctor sends Medco a
completed prior authorization form, available at www.medco.com, explaining why it is medically necessary for you to have the brand-name drug. Medco must approve the request.

I understand that there is a 90-day waiting period for the employer contribution for medical insurance coverage for new faculty/staff. Would there be a waiting period for my Spouse and stepchildren after the wedding? No, there is no new waiting period when you add a new dependent to your coverage.

If I’m a graduate student, do I have to enroll in the Graduate Student Health Plan to have health coverage? No. You can choose between the Graduate Student Health Plan, the two A&M Care plans (350 and 1250) and any HMOs available in your area.

What are the pre-existing condition limitations associated with the Graduate Student Health Plan? When you turn in a claim for treatment of a condition (including pregnancy), the carrier will check to see if you have received treatment for that condition during the 12 months before the treatment date and before you became covered by the plan. If you have, you can receive up to $1,000 in benefits for that condition during your first 12 months of coverage. Once you have been covered under the Graduate Student Health Plan for 12 months, you can begin receiving regular benefits for treatment of the condition. Treatment includes diagnosis and taking prescription medication. If you are covered by a typical group or individual health plan immediately before enrolling in the Graduate Student Health Plan, the 12-month pre-existing condition period will be offset by the number of months you were continuously enrolled in that plan. This means that if you were enrolled in another plan for at least 12 months immediately before enrolling in the Graduate Student Health Plan, the pre-existing condition limitations will not apply to you. Participation in health coverage provided by a foreign country or organization does not offset your pre-existing condition period.

Does the Graduate Student Health Plan’s repatriation benefit meet the visa requirements for foreign nationals? Yes, the Graduate Student Health Plan is the only A&M System health care plan that offers repatriation benefits, and those benefits do meet the visa requirement for foreign nationals. However, the Basic Life plan also offers repatriation benefits, so if you enroll in any health plan through the A&M System you will have Basic Life and therefore medical evacuation and repatriation coverage.

**Vision Care**

If I have vision coverage through my health plan and through EyeMed, how do the benefits coordinate? When you use a network provider, you pay your copayment (and any non-covered expenses) and the plan pays the rest. If you use a network provider and are filing your vision claim under your medical plan, you will have to submit a claim to EyeMed Vision Care with your Explanation of Benefits or statement from your provider. If you use a non-network provider, you pay the full cost to the provider and submit a claim, including the original bill, to EyeMed Vision Care for reimbursement of the covered amount. If you have receipts for services and materials purchased on different dates, you must submit the receipts at the same time and within 12 months of the date of service.

Where can I get a list of EyeMed network providers? Locate a provider at www.eyemed.com, choose the “SELECT” network of providers in the drop-down menu. Search by zip code. Provider information is also available by calling 1-866-804-0982.

I wear trifocal lenses. Are these covered by EyeMed for the $15 materials copayment, or do I have to pay extra? What about contact lenses? See the following table of benefits. **EyeMed Co-Payments**

**Flexible Spending Accounts**

What is a Flexible Spending Account (FSA) and how do they work?
The spending account allows you to set aside money from your paycheck (on a pretax basis) to use for eligible expenses for you, your spouse and your tax dependents. Detailed information over the plans may be found at [www.healthhub.com](http://www.healthhub.com).

There are two types of FSAs:

**Health care account**

**Dependent Daycare account**

You do not pay Federal income or Social Security taxes on this money.

**Why should you enroll in an FSA?**

An FSA helps reduce your taxes and increase your take-home pay.

If I have braces put on and pay the full cost upfront, can I be reimbursed the full amount from my account? Orthodontia services are the only type of services that can be considered “incurred” when you make a prepayment. You must be reimbursed in the plan year in which the payment was made with the understanding that the services will begin at that time.

Are there limitations on the kind of expenses I can claim through my Flexible Spending Account? Yes. IRS publications 502 and 503 list most of the services that can be claimed. One exception is over-the-counter drugs and medical supplies. Certain over-the-counter drugs and medical supplies can be claimed through your Health Care Spending Account but not on your income tax return. A list of eligible and ineligible expenses can be found at [www.healthhub.com](http://www.healthhub.com).

Once I sign up for Spending Accounts, do I have to keep contributing the same amount each year? No. In fact, you must re-enroll each year even if you want to contribute the same amount as in past years. Each year during Annual Enrollment, you decide whether to participate and how much, if any, to put into each account. If you want to participate one year and drop out the next, you can do it. However, you cannot change your decision in the middle of a plan year unless you have a Change in Status.

Why do I have to re-enroll in the Spending Accounts each year even if I want my contribution amount to stay the same? It is an IRS requirement that you must re-elect this option on a yearly basis.

I’m going to enroll in the Spending Accounts for the first time this year. If I have an expense the first week in September, can I get reimbursed immediately? For the health care spending account, your entire contribution is available at the beginning of the plan year. For the dependent daycare account, expenses are reimbursed based on the amount available in your account.

---

**Personal or Payroll Related Information**

What types of information can be found on HRConnect, and how can I access my information? HRConnect is a comprehensive, online database with your personal, payroll and benefits information, as well as training courses, retirement calculators and links to your benefits documents. You access HRConnect through Single Sign On. If you have never used Single Sign On, follow the instructions provided on the login page at [https://sso.tamus.edu](https://sso.tamus.edu).
I need to change my address and other personal data. What do I do? You can update or correct your residence and/or mailing address and phone number in HRConnect, or you may contact your Human Resources office for the appropriate form. To change or correct your personal data, such as employment address/phone number, e-mail address, gender, marital status, education level, EEO minority code, disabled/handicapped indicator, veteran status and privacy flag, you may submit your changes through HRConnect or complete an Employee Personal Data Form.

I need to change my direct deposit information. What do I do? You can change your direct deposit information in HRConnect. For more information access Payroll.

I would like to change the amount of income tax withholding from my paycheck. Where can I obtain a W-4 form? You can change your withholding through HRConnect. For more information access Payroll.

**Miscellaneous**

**What is the iBenefits system?** The iBenefits system, allows you to make benefit changes online at a secured web site. You can access it at sso.tamus.edu. Through this web site, you can find out what benefits you are currently enrolled in and make changes to your benefits.

In some cases, you will also need to submit paperwork, such as the Life Insurance Enrollment Form, to your Human Resources office. Forms are available on the System Benefits Administration website.

**Can I make any type of change to my benefits using the iBenefits system?** You can make most changes using iBenefits, but a few changes will still require you to send your Human Resources office additional signed paper forms. Some choices on this system will require additional action before August 31:

- Enrolling yourself or dependents in life insurance.
- Enrolling yourself and your spouse in Long-Term Care.
- Enrolling grandchildren, prospective adopted children, foster children or children for whom you are the legal guardian or managing conservator.

As you enroll in these options, the system will guide you to the correct form(s) to complete.

**What if I don’t think iBenefits is giving me the correct information on my current benefits?** E-mail or call your Human Resources office and explain the error. That office can help resolve the problem.

**What online services/information is available?** The HRConnect online information system is located at sso.tamus.edu. You will need to enter your Universal Identification Number (UIN) and a password. If you do not already have a password or do not remember your password, follow the instructions on the login page. HRConnect provides personal, employment, benefits and payroll information on you. The utilities function can help you calculate your TRS and/or Social Security benefits, how your net pay will change if you contribute to (or increase your contribution to) a Tax-Deferred Account and how much you need to be saving to meet your retirement goals.

More information is also available online. Check the System Benefits website at www.tamus.edu/business/benefits-administration/employee-employee-benefits/ for information on benefits and retirement or the System Human resources website www.tamus.edu/business/human-resources/ for information on holidays and employment opportunities.

**How can I be sure the HRConnect System is secure and no one else can see my records?** HRConnect provides personal and confidential information. By asking you to provide both a Universal Identification
I will be getting married/divorced soon. What do I need to do to change my name on my records and/or add/drop dependent(s) on my benefits? You will need to apply for and obtain a new Social Security card reflecting your new name and provide a copy of the card to your Payroll and Human Resources Office along with a completed Change of Name Form. You can access and print the form at http://www.pvamu.edu/fsrv/payroll-services/forms/.

If you want to add or drop dependent(s), complete a Dependent Enrollment Form/Certification. You may also want to update your beneficiary(ies) for Basic/Alternate Basic Life, Optional Life and/or Accidental Death and Dismemberment (AD&D). If you participate in the Teacher Retirement System and you need to change your beneficiary designation, complete the TRS 15 Form or contact TRS at (800) 223-8778 to request this form. If you participate in the Optional Retirement Program (ORP), Tax Deferred Annuity Program, or Deferred Compensation Plan, notify your vendor(s) of your new last name.