2024/2025

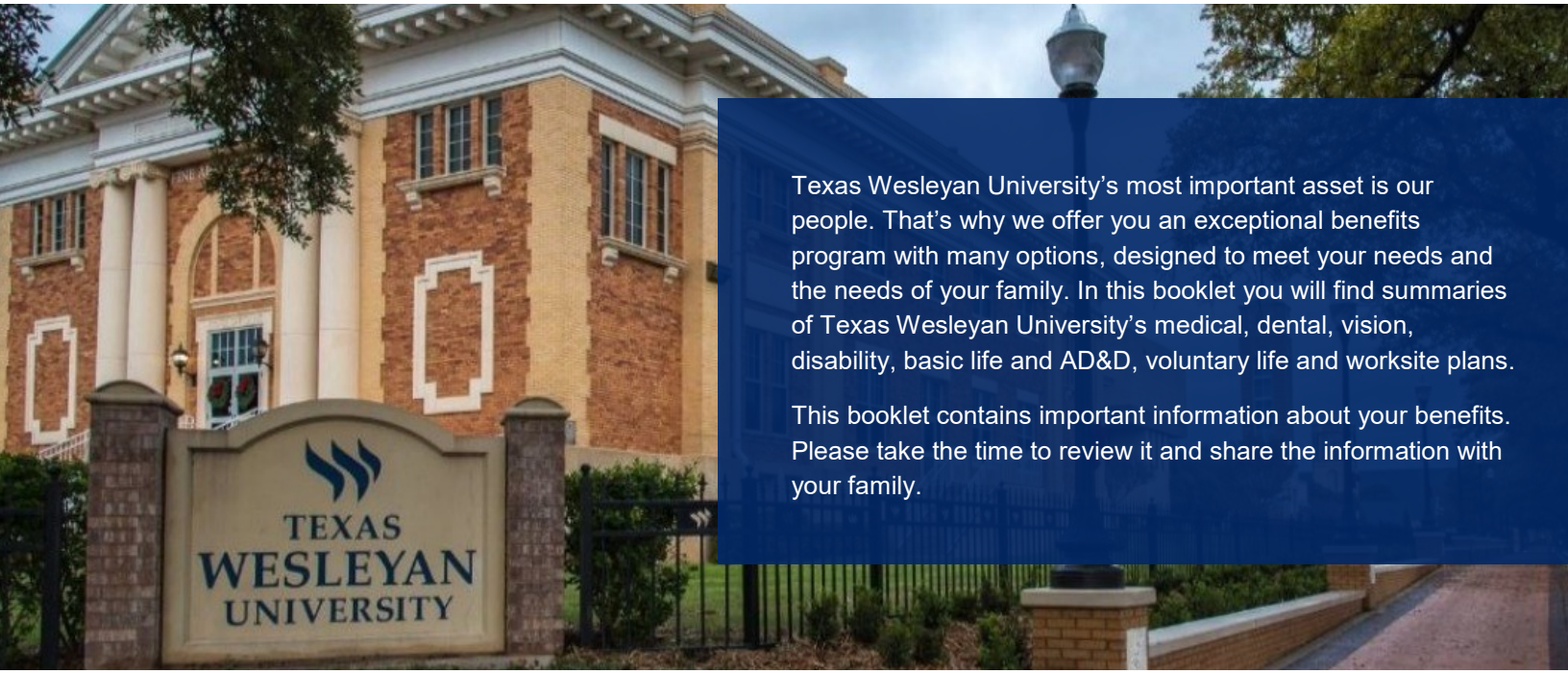
EMPLOYEE BENEFITS

Texas Wesleyan UNIVERSITY

Important Contacts

BENEFIT	CONTACT	PHONE NUMBER	WEBSITE
Medical	Blue Cross Blue Shield	800-521-2227	www.bcbstx.com
Telemedicine	Teladoc	800-TELADOC	www.teladoc.com
HSA	HSA Bank	800-357-6246	www.hsabank.com
Flexible Spending Accounts	McGriff Insurance Services	800-768-4873	www.mcgriffinsurance.com/flex
Dental Discount Program	Quality Care Dental of America	800-229-0304	www.gcdofamerica.com
Dental DHMO & DPPO	Delta Dental	800-422-4234	www.deltadentalins.com
Vision	Surency	866-818-8805	www.surency.com
Life/AD&D Insurance	Blue Cross Blue Shield	877-442-4207	www.bcbstx.com
Short Term & Long Term Disability Insurance	Blue Cross Blue Shield	877-442-4207	www.bcbstx.com
Allstate	Accident / Critical Illness / Whole Life	800-521-3535	www.allstatebenefits.com
The Standard	Hospital Indemnity	888-937-4783	www.standard.com
Retirement	TIAA-CREF	800-842-2252	www.tiaa-cref.org
Texas Wesleyan University	Human Resources	817-531-4403	www.txwes.edu/HR

This brochure highlights the main features of the Texas Wesleyan University Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Texas Wesleyan University reserves the right to change or discontinue its employee benefits plans at any time.



Texas Wesleyan University's most important asset is our people. That's why we offer you an exceptional benefits program with many options, designed to meet your needs and the needs of your family. In this booklet you will find summaries of Texas Wesleyan University's medical, dental, vision, disability, basic life and AD&D, voluntary life and worksite plans.

This booklet contains important information about your benefits. Please take the time to review it and share the information with your family.

Table of Contents

4 Eligibility & Enrollment

5 Medical Coverage

9 Health Savings Account (HSA)

11 Teladoc

12 Flexible Spending Accounts (FSAs)

16 Dental Coverage

19 Vision Coverage

20 Disability Resource Services

21 Life and AD&D Insurance

23 Disability Insurance

24 Accident Coverage

25 Critical Illness

26 Identity Theft

28 Hospital Indemnity

29 Whole Life

30 Planning for Retirement

31 Time Off

32 Additional Benefits

34 Required Notices

Availability of Summary Health Information

Our Employee Benefits Program offers three health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available, which summarizes important information about your health coverage options in a standard format.

Eligibility and Enrollment

Texas Wesleyan University (TXWES) is pleased to offer you a comprehensive benefits package intended to protect your well-being and financial health. This guide will help you learn more about all of the benefits that are available to you and your eligible dependents.

The enrollment decisions you make will remain in effect April 1, 2024 through March 31, 2025. You may make changes to your benefit elections only when you have a Qualified Life Event. After such an event, you can make changes to your coverage within 31 days; otherwise, you cannot make changes to your benefit coverage until the next Open Enrollment period. Open Enrollment is a time period each year during which you may add or drop your medical insurance or make additional changes to your benefits coverage.

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. Your coverage is effective the first of the month after 30 days of fulltime employment. You may also enroll eligible dependents for benefit coverage. The cost to you for dependent coverage will vary depending on the number of dependents you enroll in the plan and the particular plan you choose. When covering dependents, you must select the same plans for your dependents as you select for yourself.

Eligible Dependents include:

- Your legal spouse
- Children under the age of 26, regardless of student, dependency, or marital status
- Children who are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return, may continue coverage past age 26

Qualified Life Events

Once you elect your benefit options, they remain in effect for the entire plan year until Open Enrollment. You may only change coverage during the plan year if you have a Qualified Life Event and you must do so within 31 days of the event.

Qualified Life Events include:

- Marriage, Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change of employment status by you or your spouse
- A significant change in your or your spouse's health coverage due to your spouse's employment
- Qualification by the Plan Administrator of a Medical Child Support Order

Online Enrollment Instructions

Enroll online at www.Benefitfirst.com

- Login using your login information provided above;
- Review your benefit materials on the homepage;
- Choose **Enroll Now**;
- Select the **Enroll in or Decline Benefits as a Newly Eligible Employee** option; When you get to the last enrollment screen you will be asked to review your elections and certify them by re-entering your password;
- The final step is to click **Submit** to complete your transaction. **That's it…the entire process can take as little as 4 minutes to complete.**

Call the Benefitfirst Customer Care Center – If you have technical questions or would like to enroll by phone, please call **888-322-9374 and use Company ID 765** to speak with an Enrollment Specialist.

The Benefitfirst Customer Care Center is available Monday through Friday, 8:30 a.m. to 5:00 p.m.EST

Medical Benefits provided through Blue Cross Blue Shield

Our medical plan provides you access to in-network and out of network providers. All covered services are subject to medical necessity, as determined by the plan. Medical coverage is provided by Blue Cross Blue Shield (BlueChoice Network). Go to **www.bcbstx.com** for tools and resources, such as:

- Check claims and claims history
- View your Explanation of Benefits (EOBs)
- View your benefits and covered dependents
- Find a physician, hospital or urgent care facility
- Request a new ID card

How to find Your BCBS Providers

1.Log onto the BCBS website at **www.bcbstx.com** on your computer.

2.You are now in the Blue Access for Members. You can search by name or provider type.

Medical and Prescription Monthly Contributions*			
	BCBS HSA	BCBS Base PPO	BCBS Buy-Up PPO
	Monthly Employee Cost	Monthly Employee Cost	Monthly Employee Cost
Employee Only	$66.53	$201.82	$319.24
Employee + Spouse	$862.93	$1,210.99	$1,447.26
Employee + Child(ren)	$712.68	$1,116.27	$1,328.91
Employee + Family	$1,120.67	$1,887.79	$2,219.00

*Employee contributions are made on a pre-tax basis through payroll deductions.

Health Coverage Reminder

The Patient Protection and Affordable Care Act (PPACA) requires most individuals that have minimum essential health coverage. You may obtain coverage through your employer or through the Marketplace. Visit **www.healthcare.gov** for Marketplace information.

REMINDER: You may only purchase insurance through the Marketplace during Open Enrollment OR if you experience a qualifying event. The Federal Marketplace Open Enrollment dates are from November 1st through December 15th.

BCBS HSA		
	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	
	You Pay	
Deductible		
Individual	$3,200	$6,000
Family	$6,400	$20,000
Out-of-Pocket Maximum (Includes Deductible, Coinsurance and Copays)		
Individual	$6,550	$13,100
Family	$13,100	$26,200
Coinsurance / Copays		
Preventive Care	$0 (Covered at 100%)	40% after ded.
Primary Care Physician	20% after ded.	40% after ded.
Specialist	20% after ded.	40% after ded.
Diagnostics, X-ray and Lab	20% after ded.	40% after ded.
Complex Imaging	20% after ded.	40% after ded.
Urgent Care	20% after ded.	40% after ded.
Emergency Room	20% after ded.	
Inpatient Hospital Care	20% after ded.	40% after ded.
Outpatient Surgery	20% after ded.	40% after ded.
PRESCRIPTION DRUGS		
	You Pay	
Retail Rx – Up to 30-day supply		
Generic	20% after ded.	
Formulary Brand Name	20% after ded.	
Non-Formulary Brand Name	20% after ded.	
Mail Order Rx – Up to 90-day supply		
Generic	20% after ded.	
Formulary Brand Name	20% after ded.	
Non-Formulary Brand Name	20% after ded.	
Specialty Care Rx		
Generic	20% after ded.	
Formulary Brand Name	20% after ded.	
Non-Formulary Brand Name	20% after ded.	

If you elect to purchase a Formulary/Non-Formulary Brand Name drug when “Brand Medically Necessary” is not indicated and a Generic equivalent is available, you will be required to pay the difference between the cost of the Generic and Formulary/ Non- Formulary Brand Name drug, plus the Formulary Brand Name copay.

- To locate a Retail Pharmacy, go to **www.myprime.com**
- The Formulary Drug list is available at https://www.bcbstx.com/rx-drugs/drug-lists/drug-lists
- Specialty Drugs are available through Accredo at 833-721-1619

BCBS Base PPO		
	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	
	You Pay	
Deductible		
Individual	$3,000	$5,000
Family	$6,000	$10,000
Out-of-Pocket Maximum (Includes Deductible, Coinsurance and Copays)		
Individual	$6,000	$10,000
Family	$12,000	$20,000
Coinsurance / Copays		
Preventive Care	$0	40% after ded.
Primary Care Physician	$30 copay	40% after ded.
Specialist	$50 copay	40% after ded.
Diagnostics, X-ray and Lab	$0	40% after ded.
Complex Imaging	20% after ded.	40% after ded.
Urgent Care	$75 copay	40% after ded.
Emergency Room	Facility: $200 copay + 20% no ded.	
Emergency Room Physician	20% after ded.	
Inpatient Hospital Care	20% after ded.	40% after ded.
Outpatient Surgery	20% after ded.	40% after ded.
PRESCRIPTION DRUGS		
	You Pay	
Retail Rx – Up to 30-day supply		
Generic	$20 copay	$20 copay, minus 40% , no ded.
Formulary Brand Name	$40 copay	$40 copay, minus 40%, no ded.
Non-Formulary Brand Name	$70 copay	$70 copay, minus 40%, no ded.
Mail Order Rx – Up to 90-day supply		
Generic	$50 copay	n/a
Formulary Brand Name	$100 copay	n/a
Non-Formulary Brand Name	$175 copay	n/a
Specialty Care Rx (Prime Pharmacy Only)		
Generic	$100 copay	$100 copay, minus 40%, no ded.
Formulary Brand Name		
Non-Formulary Brand Name		

If you elect to purchase a Formulary/Non-Formulary Brand Name drug when “Brand Medically Necessary” is not indicated and a Generic equivalent is available, you will be required to pay the difference between the cost of the Generic and Formulary/ Non- Formulary Brand Name drug, plus the Formulary Brand Name copay.

- To locate a Retail Pharmacy, go to **www.myprime.com**
- The Formulary Drug list is available at https://www.bcbstx.com/rx-drugs/drug-lists/drug-lists
- Specialty Drugs are available through Accredo at 833-721-1619

BCBS Buy-Up PPO		
	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	
	You Pay	
Deductible		
Individual	$1,000	$2,000
Family	$2,000	$4,000
Out-of-Pocket Maximum (Includes Deductible, Coinsurance and Copays)		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Coinsurance / Copays		
Preventive Care	$0	40% after ded.
Primary Care Physician	$25 copay	40% after ded.
Specialist	$40 copay	40% after ded.
Diagnostics, X-ray and Lab	$0	40% after ded.
Complex Imaging	20% after ded.	40% after ded.
Urgent Care	$75 copay	40% after ded.
Emergency Room	Facility: $200 copay + 20% no ded.	
Emergency Room Physician	20% after ded.	
Inpatient Hospital Care	20% after ded.	40% after ded.
Outpatient Surgery	20% after ded.	40% after ded.
PRESCRIPTION DRUGS		
	You Pay	
Retail Rx – Up to 30-day supply		
Generic	$20 copay	$20 copay, minus 40% , no ded.
Formulary Brand Name	$40 copay	$40 copay, minus 40%, no ded.
Non-Formulary Brand Name	$70 copay	$70 copay, minus 40%, no ded.
Mail Order Rx – Up to 90-day supply		
Generic	$50 copay	n/a
Formulary Brand Name	$100 copay	n/a
Non-Formulary Brand Name	$175 copay	n/a
Specialty Care Rx (Prime Pharmacy Only)		
Generic	$100 copay	$100 copay, minus 40%, no ded.
Formulary Brand Name		
Non-Formulary Brand Name		

If you elect to purchase a Formulary/Non-Formulary Brand Name drug when “Brand Medically Necessary” is not indicated and a Generic equivalent is available, you will be required to pay the difference between the cost of the Generic and Formulary/ Non- Formulary Brand Name drug, plus the Formulary Brand Name copay.

- To locate a Retail Pharmacy, go to **www.myprime.com**
- The Formulary Drug list is available at https://www.bcbstx.com/rx-drugs/drug-lists/drug-lists
- Specialty Drugs are available through Accredo at 833-721-1619

HSA (Health Savings Account)

What is an HSA Plan?

The Base CDHP is a consumer driven health plan that works in conjunction with a Health Savings Account.

What is a Health Savings Account (HSA)?

An HSA is an alternative to traditional health insurance; it is a savings product that offers a different way for consumers to pay for their health care. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis.

- You and Texas Wesleyan University can make contributions to your HSA account. Texas Wesleyan will contribute $350 to your account at the beginning of the plan year. You must participate in the Base High Deductible Health Plan to be eligible for contributions.
- All investment earnings are tax-free for the employee and HSA money is tax-free as long as it is used to pay for any qualified health care expense.
- You can withdraw money from your HSA to cover qualified medical expenses, or allow the account to grow over time and use it to help pay for future health-related expenses, such as long-term care insurance premiums and COBRA premiums.

2024 IRS MAX CONTRIBUTIONS	
Employee	**Family**
$4,150	**$8,300**

CONTRIBUTION BY TEXAS WESLEYAN INTO EMPLOYEE'S HSA ACCOUNT
$350

Who is eligible for the HSA?

To be eligible, you must be covered by a high deductible health plan. You cannot have other health insurance coverage (including a spouse's plan) that is not a high deductible plan. An employee cannot be enrolled in Medicare or be a dependent on another person's tax return.

What happens to any remaining money in my HSA account at the end of the year?

Any unused funds in the account automatically roll over year after year. You won't lose your money if you don't spend it within the year.

What happens to my HSA if I leave my health plan or job?

You own your account, so you keep your HSA, even if you change health plans or jobs. The HSA balance, including all of your contributions as well as those from the employer, is yours to keep. There are no vesting requirements or forfeiture provisions for employer contributions. HSAs are not subject to COBRA continuation coverage.

Who can contribute to my HSA?

Any person can contribute to your account on your behalf (up to the annual contribution limit). You can have set contribution amounts deducted from your paycheck on a pre-tax basis or you can make lump-sum contributions of any amount any time, up to the maximum limit.

Who can contribute to my HSA?

Any person can contribute to your account on your behalf (up to the annual contribution limit). You can have set contribution amounts deducted from your paycheck on a pre-tax basis or you can make lump-sum contributions of any amount any time, up to the maximum limit.

When will contributions to my account be available for withdrawal?

HSA contributions will be available for withdrawal when funds are deposited. The availability of funds depends on how much has been contributed and varies by individual. **Please note: You can only be reimbursed for the amount of money in your account.**

What expenses can I pay for with my HSA?

Your HSA can be used to pay for "qualified medical expenses", as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan copays and deductibles at doctors, pharmacies, medical labs, dentists, orthodontists, medical supply stores, chiropractors, hospitals, vision centers podiatrists, diagnostic service centers, over-the-counter drugs, LASIK eye surgery, eye glasses, contact lenses, prescription drugs and some nursing services. For a complete listing of the IRS-allowable expenses, you can request a copy of IRS Publication 502 by calling the IRS at 1-800-829-3676, or visit the IRS website at **www.irs.gov** and click on "Forms and Publications".

Can I use my HSA to pay for non-health-related expenses?

Yes. You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and an additional penalty tax on the amount withdrawn.

How can I keep track of my HSA balance?

You should receive statements from your bank that show any contributions to, withdrawals from, and interest earned on your account.

Do the qualified expenses have to be incurred by the employee?

No. Health care expenses can be for the employee, eligible spouse or eligible dependent children.

What process do employees use to pay or be reimbursed for health care expenses?

You can mail/fax a reimbursement request form to be reimbursed or if your bank offers the debit card feature for your HSA account, you can use that to pay for health care expenses. The employee must keep supporting receipts and records to document for the IRS whether the funds were used to pay for qualified health care expenses (in case of an audit).

Who determines if HSA distributions are used exclusively for qualified health care expenses?

It is the employee's responsibility to maintain records of expenses to show that the distributions have been made exclusively for qualified health care expenses.

Are there administrative fees associated with an HSA?

Typically, yes there are administrative fees with an HSA bank account just like fees you may have on your other bank accounts. Please check with the bank to determine their fees for the account.

How is an HSA different from a Flexible Spending Account (FSA)?

With a Flexible Spending Account, employees also make pre-tax contributions to pay for health care expenses. However, there are several differences. 1) Employees do not earn interest on the money in an FSA account. 2) With an FSA, employees must use all of the funds in the account by the end of the year or forfeit them – the "use it or lose it" rule. 3) FSAs do not allow contributions from both the employee and employer. 4) FSA balances are not portable; you can't roll the money over to another account. 5) FSAs allow pre-tax dollars to be used for dependent daycare expenses.

Please keep in mind that any H.S.A Contribution elected is for the plan year. The IRS limits listed above are for the calendar year. You can adjust your contributions as needed throughout the year.

TELADOC™

Talk to a Doctor Anytime

Teladoc gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. This is a great alternative to Urgent Care and ER visits since services you receive through Teladoc are 100% paid by TXWES for employees enrolled in the PPO medical plan.

Those enrolled in the HDHP/HSA Plan will have access to Teledoc, however due to IRS rules, there will be a $55 copay per call for those on this plan.

When Can I Use Teladoc?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care:

- When you need care
- If you're considering the ER or Urgent Care center for a non-emergency issue
- If you're on vacation, on a business trip, or away from home
- For short-term prescription refills

Get the Care You Need

Teladoc doctors can treat many medical conditions, including:

- Cold and flu symptoms
- Urinary tract infection
- Allergies
- Respiratory infection
- Bronchitis
- Sinus problems

Meet Our Doctors

Teladoc is a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a Doctor Anytime ... Get Started Now

- Visit **www.Teladoc.com** and click on Set Up Account
- Call 800-Teladoc (835-2362)
- Go to **www.Teladoc.com/mobile** to download the mobile app

Flexible Spending Accounts provided through McGriff

A great way to plan ahead and save money over the course of a year is to participate in our Flexible Spending Account (FSA) programs. These accounts allow you to put a portion of your salary, on a pre-tax basis, into reimbursement accounts. Pre-tax means the dollars you use for eligible expenses are not subject to Social Security tax, federal income tax and, in most cases, state and local income taxes. The money you would have paid in taxes can then be used to pay qualified expenses. When you enroll, you must decide how much to set aside for each account and you will need to estimate your expenses conservatively, as the law requires that you use your expenses during the plan year with the exception of a $640 rollover amount.

Health Care Reimbursement Account

A Health Care Reimbursement Account enables you to take control of your out-of-pocket health expenses by contributing pre-tax money to your account to pay for everyday eligible expenses. The result can be savings of up to 40 percent on hundreds of products and services not covered by your medical, dental or vision plan such as copayments, coinsurance deductibles, prescription expenses, lab exams and tests, contact lenses, eyeglasses and more. For a list of eligible expenses, go to **www.mcgriffinsurance.com/flex**. When you incur an expense, you will be reimbursed the full amount at that time.

Dependent Care Reimbursement Account

A Dependent Care Reimbursement Account helps pay for dependent/elder care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. The dependent must be a child under age 13 and claimed as a dependent on your federal income tax return, or a disabled dependent, of any age, incapable of caring for him- or herself, and who spends at least eight hours a day in your home.

Limited Health Care Reimbursement Account

There is also a Limited Health Care Reimbursement for those employees enrolled in the HDHP/HSA Plan. Employees enrolled in this plan are allowed the option of a Limited FSA for which your pre-tax deductions can be used for dental and vision expenses only. Medical expenses should be paid through your HSA Account.

Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time. In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care, and that provider cannot be anyone considered your dependent for income tax purposes.

ACCOUNT TYPE	ELIGIBLE EXPENSES	ANNUAL CONTRIBUTION LIMITS
Health Care Reimbursement Account	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over-the-counter medications)	Maximum contribution is $3,200 per year
Dependent Care Reimbursement Account	Dependent care expenses (such as day care, after-school programs or elder care programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)

How FSAs Work:

- Estimate what you will need for eligible out-of-pocket health care and/or dependent care expenses for the plan year or a portion thereof, depending upon your effective date of coverage. Estimate carefully and contribute only as much as you think you will need, subject to the plan limit.
- Divide your total estimated expenses by the number of paychecks you receive yearly, or portion thereof depending on your effective date of coverage. This is the amount that will be deducted from each paycheck and deposited into your non-interest-bearing account(s).

Claims Forms and Direct Deposit

Use your Benefit Access Visa Debit Card for easy payment to the provider. The debit card give you immediate, electronic access to funds stored in your health care of dependent daycare accounts. Using your debit card eliminates the need for filing claim forms; however, itemized receipts may need to be submitted, if requested.

You may file a manual claim electronically by using the consumer portal (**www.mcgriffinsurance.com/flex**) or through the McGriff Insurance Services Benefit Access Mobile App on your phone. You will simply complete the claim form and take a picture of your receipt, and upload both through your phone.

Over-the-Counter Item Rule Reminder

Health care reform legislation requires that certain over-the-counter (OTC) items require a “prescription” in order to be considered an eligible Health Care Spending Account expense. You will only need to obtain a one-time prescription per OTC item for the 2024-2025 plan year.

FSAs Help You Save on Your Taxes

Here is an example of how much you can save when you use the FSAs to pay for your predictable health care and dependent care expenses.

ACCOUNT TYPE	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pre-tax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes	$11,701	$12,355
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses and taxes	$36,299	$35,645
Tax savings with the Medical and Dependent Care FSA	$654	N/A

FSA Eligible Expenses

Your Health Care FSA dollars can be used for a variety of out-of-pocket health care expenses. The following is based on a list of eligible and ineligible expenses created by the IRS. It is not an all-inclusive list, but provides many examples of eligible expenses. Some eligible expenses require a Note of Medical Necessity from your health care provider to qualify for reimbursement.

Dental

- Dental X-rays
- Dentures and bridges
- Exams and teeth cleaning
- Extractions and fillings
- Oral surgery
- Orthodontia
- Periodontal services

Eyes

- Eye exams
- Eyeglasses and contact lenses
- Laser eye surgeries
- Prescription sunglasses
- Radial keratotomy

Hearing

- Hearing aids and batteries
- Hearing exams

Lab Exams/Tests

- Blood and metabolism tests
- Body scans
- Cardiograms
- Laboratory fees
- X-rays

Medications

- Insulin
- Prescription drugs

- Medical equipment supplies
- Air purification equipment
- Arches and orthotic inserts
- Contraceptive devices
- Crutches, walkers, wheel chairs
- Exercise equipment
- Hospital beds
- Mattresses
- Medic alert bracelet or necklace
- Nebulizers
- Orthopedic shoes
- Oxygen
- Post-mastectomy clothing
- Prosthetics
- Syringes

Medical Procedures/Services

- Acupuncture
- Alcohol and drug/substance abuse
- Ambulance
- Fertility enhancement and Treatment
- Hair loss treatment
- Hospital services
- Immunization
- In vitro fertilization
- Physical examination
- Service animals
- Sterilization/sterilization reversal
- Transplants (to include donor)
- Transportation

Obstetrics

- Lamaze class
- OB/GYN exams
- OB/GYN maternity fees
- Pre and postnatal

Practitioners

- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath
- Optometrist
- Osteopath
- Physician
- Psychiatrist or psychologist

Therapy

- Alcohol and drug addiction
- Counseling
- Exercise programs
- Hypnosis
- Massage (medically necessary)
- Occupational
- Physical
- Smoking cessation programs
- Speech
- Weight loss programs

Using The Mobile App

Want to check your health care account balances and submit receipts anywhere, anytime? There's an app for that! Want to submit a dependent day care claim anywhere, anytime? There's an app for that!

It enables you to easily and securely access your health care spending accounts. You can view account balances and detail, submit health care account claims, and capture and upload pictures of your receipts anytime, anywhere on any iPhone, Android or tablet device. You can also sign up to receive account alerts by text message.

The McGriff Insurance Services Benefit Access App from MIS provides time-saving features for you to:

- Check current account balances; FSA and HSA
- View account activity and receive alerts by text message
- View FSA and HSA transaction details
- File new claims with receipt images
- Review expense information
- Enter a new expense
- Submit health care claims and upload receipts using the mobile device's camera
- Manage expense receipts
- Promptly file claims for their reimbursement accounts

The McGriff Insurance Services Benefit Access App provides you with seamless account access to the MIS portal – and doesn't require you to set up any additional credentials. By using your smartphone you can assess your FSA and HSA account balances, and you'll know how much money you have available to spend on qualified medical expenses at the time of purchase.

Conveniently manage your health care information when you want, from wherever you want. Simply download the McGriff Insurance Services Benefit Access App for your Android or iPhone (also compatible with iPad® and iPod touch®) and log in using the same password you use to access the MIS consumer portal.

McGriff Insurance Services Benefit Access Visa Card

Use your **McGriff Insurance Services Access Visa® Debit Card** when paying for eligible out-of-pocket expenses. When paying for services with your debit card, you should keep all receipts or your Explanation of Benefits (EOB) because you may be asked to provide additional substantiation as required by the IRS. The online portal offers an easy, secure way to keep your receipts, should you need to provide documentation. You may also speak to a Benefit Representative by calling 800-768-4873 or 800-930-2441 Monday–Friday, 8 a.m.–8 p.m. ET.

You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies and vision service providers. The card cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. Should you need to submit a receipt for substantiation, you will receive an email or be mailed a Receipt Notification. Always retain receipts for your records. **Note:** Your debit card cannot be used for dependent care expenses.

Dental Coverage provided through Quality Care Dental of America and Delta Dental

Taking care of your teeth is as important as taking care of the rest of your body. Some medical problems, such as diabetes and cardiovascular disease, may be linked to oral health. To maintain good oral health, you should brush your teeth at least twice a day, replace your toothbrush every three to four months, floss daily, and schedule regular dental checkups.

Our dental plan offers three affordable options to best fit your needs. We offer a reduced fee-for-service program through Quality Care Dental of America (QCD), Dental HMO (DHMO) and Dental PPO (DPPO) now through Delta Dental.

Dental Discount Program

The dental program offered through QCD is not insurance, but a discount program. The plan has no deductibles, coverage maximums or claim forms. You and your eligible dependents pay the negotiated discounted rate if you seek care from an In-Network provider. For a list of providers, call QCD at 800-229-0304 or visit **www.qcdofamerica.com**.

QCD	
	Discount Program
	In-Network Only
	You Pay*
Oral Exam	$9
Teeth Cleaning	$24
Full Mouth X-ray	$28
Amalgam (1 Surface)	$28
Root Canal	$185
Porcelain with Metal Crown	$350
Upper or Lower Denture	$400

* A fee of $8 is charged per appointment. There will be an additional charge for all lab fees less a 20% discount.

Find a Dental Provider

1. www.deltadentalins.com or call 800-422-4234
2. Create username/password, or login with existing account information
3. Select Find a dentist
4. Enter Location by address, city or Zip code
5. Enter network
   - If you are on the DHMO plan, select DeltaCare USA
   - If you are on the DPPO, select Delta Dental Premier
   - If you want to search for a particular provider, you may do so as well
6. Select find a dentist to generate your search.
7. A list of providers will generate
8. If you choose you may enter refine your search by additional filters.

DENTAL HMO (DHMO) Available in AR, FL, IL, MS, OH, & TX	
	DHMO
	In-Network Only
Policy Year Maximum Benefit	
Per person	Unlimited
	You Pay
Policy Year Deductible	
	None
Covered Services	
Routine Office Visit	$0
Preventive Services	Scheduled Copay
X-ray	Scheduled Copay
Routine Prophylaxis	Scheduled Copay
Endodontics	Scheduled Copay
Periodontics	Scheduled Copay
Orthodontics (Adult and Child)	Scheduled Copay

DENTAL PPO (DPPO)		
	DPPO	
	In-Network	Out-of-Network*
Calendar Year Maximum Benefit		
Per person	$1,100	$1,100
Orthodontic Lifetime Maximum Benefit	$1,000	$1,000
	You Pay	You Pay
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Covered Services		
Class I Preventive & Diagnostic Care Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers	$0 (deductible waived)	$0 (deductible waived)
Class II Basic Restorative Care Full Mouth X-rays, Panoramic X-rays, Fillings, Oral Surgery, Simple Extractions	20%**	20%**
Class III Major Restorative Care Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	50%**	50%**
Class IV Orthodontics (Up to age 19) (12-Month Waiting Period)	50%**	50%**

* You may seek care from an out-of-network provider. Services will be paid based on usual, reasonable and customary rates. You are responsible for charges in excess of eligible expenses.

** After deductible

DENTAL MONTHLY CONTRIBUTIONS			
	QCD	Delta Dental DHMO	Delta Dental DPPO
Employee Only	$0.00	$12.84	$18.18
Employee + Spouse	$8.00	$21.81	$35.92
Employee + Child(ren)	$10.00	$22.58	$37.20
Employee + Family	$12.00	$31.38	$51.68

Vision Coverage provided through Surency

Vision exams can help identify certain medical conditions such as diabetes or high cholesterol. To help you manage your health, we offer vision coverage through Surency. Under this plan, you may use the eye care professional of your choice. However, when you use a participating network provider, you receive higher levels of coverage. For a list of providers, call Surency at 866-818-8805 or visit **www.surency.com/vision**.

VISION COVERAGE SUMMARY				
	Base Plan		Buy-Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	You Pay	Reimbursement	You Pay	Reimbursement
Covered Services				
Routine Eye Exam	$10 copay	Up to $35	$10 copay	Up to $35
Materials	$25 copay	None	$25 copay	None
Single Lenses	$25 copay	Up to $25	$25 copay	Up to $25
Bifocal Lenses	$25 copay	Up to $40	$25 copay	Up to $40
Trifocal Lenses	$25 copay	Up to $55	$25 copay	Up to $55
Frames	$130 allowance	Up to $55	$150 allowance	Up to $75
Contacts	$130 allowance, 15% off balance over $130	Up to $90	$150 allowance, 15% off balance over $150	Up to $90
Benefit Frequency - Frames and Contact allowance can be utilized in same benefit year				
Exams	Once per 12 months			
Lenses	Once per 12 months			
Frames	Once per 24 months			
Contacts	Once per 12 months			

VISION MONTHLY CONTRIBUTIONS		
	Base Plan	Buy-Up Plan
Employee Only	$4.36	$6.23
Employee + Spouse	$8.27	$11.85
Employee + Child(ren)	$8.71	$12.47
Employee + Family	$12.80	$18.33

Disability Resource Services™

Extra Help When It's Needed Most

When personal problems arise, many people may choose to cope alone, resulting in negative consequences at home and the workplace. This is why we have teamed with ComPsych® Corporation to offer Disability Resource Services to employees covered by our long-term disability (LTD) policy. Disability Resource Services provides convenient resources to help address emotional, legal and financial issues.

Disability Resource Services™

In the U.S. and Canada call
866-899-1363

TDD: 800-697-0353

guidanceresources.com
Enter Your Company ID: DISRES

BlueCross BlueShield of Texas

Face-to-Face Sessions

Disability Resource Services provides long-term disability insured employees with three face-to-face sessions in a geographically accessible location to address behavioral issues.

Unlimited Telephonic Counseling

Disability Resource Services also provides long-term disability insured employees with unlimited telephonic counseling (24 hours a day, 7 days a week) to help address behavioral issues. Master's degree level counselors use a conversational approach to identify issues, assess needs and refer participants to specialists to help resolve their issues.

Web-Based Services

GuidanceResources® Online (guidanceresources.com) is a secure, password-protected website that contains self-assessments, extensive content on personal health and powerful tools to help with personal, relational, legal, health and financial concerns. This service is free of charge to employees who are insured with us for long-term disability insurance. It covers many topics and personal concerns, such as:

- Alcohol and drug abuse
- Depression
- Divorce and family law
- Estate planning
- Getting out of debt
- Grief and loss
- Job pressures
- Managing debt obligations
- Marital and family conflicts
- Retirement planning
- Saving for college
- Stress and anxiety
- Tax questions
- Real estate buying and selling

To Access Your Services

Call: 866-899-1363

- You will be asked what type of insurance policy you have: LTD, STD or life insurance. If you are unsure, consult with your HR representative.

Online: GuidanceResources.com

- Click "Register" to create a new account.
- Enter Your Company ID: DISRES

Life and Accidental Death and Dismemberment Insurance

Life insurance is an important part of your financial security, especially if others depend on you for support. Even if you are single, your beneficiary can use your Life insurance to pay off your debts, such as credit cards, mortgages, and other final expenses.

Basic Life and AD&D

Basic Life insurance and Accidental Death and Dismemberment (AD&D) coverage are provided —at no cost to you. You are automatically covered at $20,000 and have the option to purchase Voluntary Life insurance for you, your spouse and dependent children through Blue Cross Blue Shield.

BASIC LIFE AND AD&D INSURANCE	
Benefit	$20,000
Age Reduction	None
Accelerated Death Benefit	75%
Premium Waiver	Yes

AD&D coverage helps protect you and your family from the unforeseen financial hardship of a serious accident that causes death or dismemberment. AD&D insurance provides you specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary(ies).

Designating a Beneficiary

Designating a beneficiary ensures how your Life and AD&D insurance benefits are paid in case of your death. You can name more than one beneficiary, and you can change beneficiaries at any time. If you name more than one beneficiary, identify the share for each. Be sure all names are correct on the Benefitfirst website. See page 5 for log in instructions.

Voluntary Life

In addition to Basic Life and AD&D, eligible employees may purchase Voluntary Life insurance at favorable group rates. You pay for this coverage with after-tax dollars. You must elect Voluntary coverage for yourself in order to elect coverage for your spouse or children. If you leave TXWES, you may take the insurance with you by paying premiums directly to the insurance company.

BENEFIT	COVERAGE
Benefit	
Employee	$10,000 increments up to $500,000 not to exceed 5x base annual earnings
Spouse	$5,000 increments up to the lesser of $250,000 or 50% of employee amount
Child	Birth to 6 months: $1,000
Guarantee Issue*	
Employee	$100,000
Spouse	$25,000
Child	$10,000
Additional Information	
Portable	Yes
Conversion	Yes
Accelerated Death Benefit	75% of benefit up to $250,000

* If you request an amount more than the Guarantee Issue amount, you will need to provide Evidence of Insurability (proof of good health) before the amount over the Guarantee Issue amount becomes effective.

VOLUNTARY LIFE MONTHLY RATES		
AGE	**MONTHLY EMPLOYEE RATE PER $10,000**	**MONTHLY SPOUSE RATE PER $10,000**
	Uni-Smoker	**Uni-Smoker**
<24	$0.53	$0.75
25-29	$0.53	$0.75
30-34	$0.55	$0.80
35-39	$0.77	$1.16
40-44	$1.15	$1.73
45-49	$1.90	$2.79
50-54	$3.03	$4.49
55-59	$5.10	$6.94
60-64	$7.99	$12.16
65-69	$13.66	$20.69
70-74	$24.50	$36.57
75-79	$44.80	$72.73
MONTHLY CHILD LIFE RATE PER $2,000: $0.460 **EMPLOYEE AD&D PER $1,000 : $0.020** **SPOUSE AD&D PER $1,000 : $0.060** **CHILD AD&D PER $1,000 : $0.020**		

***Please keep in mind, employees are able to increase coverage by 1 increment ($10,000) up to the guaranteed issue without Evidence of Insurability .**

Accident Coverage

While you can't predict life's unexpected events, you can plan for them by choosing benefits that can help protect your financial future.

Accidental Injury insurance can provide you – and your family – with the coverage and additional financial protection you may need for expenses associated with an unexpected covered accident. The plan pays you (or whoever you designate) a fixed cash benefit amount. What you do with the money is all up to you.

Use the Payment for What Matters Most

We know that everyone has different needs and different ways of coping with the unplanned. This benefit can help you pay for out-of-pocket medical and nonmedical costs such as:

- Medical copays and deductibles
- Travel to see a specialist
- Child care
- Help around the house
- Alternative treatment

Filing a claim is easy.

- Claim forms are available both on Benefitfirst or on www.Allstatebenefits.com.
- You may **fax** your claim to **1-866-424-8482**.
- You may mail your claim to:

  American Heritage Life Insurance Company
  P.O. Box 43067
  Jacksonville, Florida 32203-3067

- Additional claim forms are available on our website at www.AllstateBenefits.com.
- If you are filing a claim within the first 12 months your policy is in force, additional information may be required.

ACCIDENT MONTHLY CONTRIBUTIONS	
Employee	$14.24
Employee + Spouse	$24.61
Employee + Child(ren)	$36.18
Family	$47.38

Disability Insurance provided through Blue Cross Blue Shield

If you suddenly become ill or are in an accident and are unable to work, it is easy to fall behind on your rent or mortgage, car payment and other expenses. That's why a salary replacement plan is an important benefit for you and your family.

Disability insurance is available to full-time, regular employees first of the month after 90 days of continuous employment. TXWES will provide 100% compensation for the first 30 calendar days of continuous disability after notification and documentation by a physician that you are disabled. Compensation for the first 30 calendar days of continuous disability includes utilization of all accrued sick days and vacation days.

Short Term Disability begins on the 31st day of disability.

Employees become eligible for Disability Benefits 1st of the Month following 30 days of continuous employment.

Short Term Disability Insurance

If you were to become disabled tomorrow due to a non-occupational accident or sickness (including pregnancy) and couldn't work for two or three months, would you have enough savings to cover your living expenses during that time? Short Term Disability (STD) coverage is provided by Blue Cross Blue Shield— at no cost to you.

Long Term Disability Insurance

Becoming disabled can have devastating financial implications by stripping you of your ability to make a living. TXWES values your service and wants to ensure you and your families are protected with income replacement benefits in the event of a life changing accident or disability and provides Long Term Disability (LTD) insurance through Blue Cross Blue Shield— at no cost to you.

COVERAGE FOR	BENEFIT
Short Term Disability/ Salary Continuation	Covers 60% of your base annual earnings, up to $1,155 maximum per week for 22 weeks. * Benefit begins after 30 days of disability.
Long Term Disability	Covers 60% of your base annual earnings, up to $10,000 maximum per month. Benefit begins after 180 days of disability and continues to age 65 standard ADEAII.

Pre-Existing Condition

LTD — A sickness or injury treated three months before your coverage begins is considered a pre-existing condition and will not be insured for the first twelve months of coverage.

Critical Illness

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels.

You choose benefits to protect yourself and any family members if diagnosed with a critical illness. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

Payable Conditions Include:

- Stroke
- End Stage Renal Failure (kidney failure)
- Major Organ Transplant
- Coronary Artery Bypass Surgery
- Cancer (In Situ & Invasive)

You have two choices of benefit ($10,000 Plan 1 & $20,000 Plan 2). Dependents receive 50% of the employee's selected benefit amount.

ATTAINED AGE MONTHLY PREMIUMS					
	PLAN 1 MONTHLY			**PLAN 2** MONTHLY	
	EE/EE+CH EE+SP/F			**EE/EE+CH EE+SP/F**	
AGE	**Uni-Tobacco**		AGE	**Uni-Tobacco**	
18-24	$6.34	$11.53	18-24	$8.54	$14.85
25-29	$7.06	$12.67	25-29	$9.94	$17.00
30-34	$8.36	$14.68	30-34	$12.50	$20.85
35-39	$10.97	$18.65	35-39	$17.53	$28.49
40-44	$13.62	$22.74	40-44	$22.61	$36.22
45-49	$17.73	$29.08	45-49	$30.50	$48.22
50-54	$23.13	$37.41	50-54	$40.85	$63.98
55-59	$29.62	$47.37	55-59	$53.24	$82.85
60-64	$39.96	$63.25	60-64	$73.22	$113.16
65-69	$54.16	$85.02	65-69	$100.71	$154.87
70-74	$72.06	$112.34	70-74	$135.69	$207.75
75-79	$97.82	$151.30	75-79	$186.53	$284.34
80+	$146.68	$224.72	80+	$283.95	$430.64
EE + CH = Employee + Child(ren); and F= Family					

Experian Identity Theft

IdentityWorks℠ – World-Class Identity Protection from Experian℠

Safeguard Your Identity For a Brighter Future

Over 160 million records were exposed in 2017 due to data breaches. That's why IdentityWorks checks constantly for signs that you might be at risk for identity theft. We closely monitor your personal information. We alert you to new activity in your name. Then we help you recover.

Multiple levels of vital detection and support

Daily Credit Monitoring and Timely Alerts

- Early warning Surveillance Alerts™ notify members of key credit report changes covering 50 potential indicators of fraud.
- Information on new accounts, medical collections, and other activity allows members to understand when their identities may be at risk.
- Timely notification empowers members to quickly and efficiently respond to potential identity theft.

U.S.-based Fraud Resolution Team

- Can help to investigate and address both credit and non-credit related fraud.
- Are highly trained professionals that can contact credit grantors to dispute charges, close accounts, and provide additional assistance as needed.

$1 Million Identity Theft Insurance[2]

- Provides coverage for lost wages, legal fees, and funds lost due to unauthorized electronic fund transfers.
- Zero deductible upon enrollment.

Experian Credit Report

- Members can check for past inaccuracies and signs of identity theft.

Experian Identity Theft

BCBSXX provides identity protection services to eligible members and their families at no cost to them through Experian®, an independent company.

The IdentityWorks program includes:

- Credit monitoring
- Identity restoration
- Up to $1 million in Identity Theft Insurance

On Blue Access for Members (BAM), the member will obtain an activation code allowing them access to the program for one year. Each member over 18 will be required to enroll in the program to receive its offering; however, adults can enroll their minor dependents.

Enrollment Steps for Adults & Minors:

1	**You must enroll online. Members should not call Experian to enroll.** Use your computer to log into your BAM account and click on "Coverage" and then "Coverage and Benefits." Scroll down until you see "Identity Protection" in the "All My Benefits" list. Click on the arrow to review information and get your activation code. **NOTE:** Obtaining an activation code is not available on BAM Mobile.
2	After clicking on Identity Protection under Coverage and Benefits, you will see the Identity Protection information in the All My Benefits list.
3	Click "Get Code" to get your activation code to enroll in the program. You can enroll up to 10 dependents (18 yrs. of age or younger) per activation code. If more than 10 minor dependents are eligible to be enrolled, select "Enrolling more than 10 dependents?" to get additional codes per number of dependents on your plan.
4	Once you have your activation code, click "Get started with adult enrollment" or "Get started with minor dependent enrollment." You will be directed to the Experian website to activate/reenroll in your membership.
5	Once you have enrolled in the Experian IdentityWorks or IdentityWorks Minor Plus program, you will not need to use your activation code again. **NOTE**: Even after you enroll, you will still see your activation code under the Identity Protection in BAM, but there's nothing else you need to do.
6	Members must complete this enrollment process each year, which means creating a new login/password for IdentityWorks services annually.

Hospital Indemnity

Hospital Indemnity Insurance offers peace of mind and financial protection if you or a family member are hospitalized. With today's higher deductible plans and overall healthcare costs, many people are concerned about having to pay the deductible all at once if they're hospitalized. This coverage can help pay your deductible and other out-of-pocket costs associated with hospital confinement.

Key Benefits

Annual Health Screening Benefit (Includes COVID Testing)	**$100**
Hospital Admission Once per covered sickness or accident per calendar year	$1,000
Hospital Confinement Maximum confinement period: 15 days	$150
Critical Care Maximum confinement period: 15 days	$150
Pre-Existing Limitation	None

- **$100 Annual Health Screening Benefit per covered family member**
- Guarantee Issue: No evidence of insurability is required
- No Waiting periods or pre-existing limitations
- **Covers Hospital Stays For; Maternity, Sickness, Accidents, COVID 19**
- Can help with out-of-pocket medical costs associated with deductibles and co-insurance
- Portable

Amount payable based on the benefits for Hospital Admission ($1,000) and Hospital Daily Benefit ($150 per day).

	Per Pay (24)	Monthly (12)	Annual Cost	Annual Screening Benefit
Employee	$7.98	$15.96	$191.52	$100.00
Employee/Spouse	$13.79	$27.58	$330.96	$200.00
Employee + Child(ren)	$11.44	$22.88	$274.56	$200.00
Family	$20.23	$40.45	$485.40	$200.00

**Annual Return on Premium is based on Employee filing the Annual Screening Benefit. For Employee/Spouse, Employee/Children, and Family levels, at least 2 family members file for the Annual Screening Benefit.*

All covered family members are eligible for the Annual Screening Benefit. This is for illustration purposes only

Group Whole Life Insurance with Long-Term Care Benefit

Allstate Permanent Life Insurance with Long-Term Care Benefit is now available for all eligible employees. This new employee benefit is a One-Time Guarantee Issue of up to $100,000 for actively at work employees up to age 70. Your spouse is eligible for a flat $15,000 policy with guarantee issue when you elect coverage.

Allstate Group Whole Life (GWL) is permanent life insurance that is portable at the same rates should you leave employment or retire. This new option combines permanent life insurance with living benefits that can help with the high costs of long-term care services. Living benefits can help pay for home healthcare, assisted living, nursing home, and adult day care services.

(GWL) accumulates a cash value over time which can be accessed in the future to cover annual premiums, take a policy loan, or make a withdraw. A combination of term coverage and permanent portable coverage is a good strategy for many employees' current and post-retirement needs!

- **Rates lock in at current age and will never increase due to age.**
- **No Health Exam is required, you cannot be rated or declined due to health conditions**
- **GWL is portable at the same rates and benefits should you retire or leave employment.**
- **Long-Term Care Benefit (LTC) accelerates 4% of the face amount up to 25 months for care required in an assisted living or long-term care facility, home health care, or adult daycare.**
- **100% of the death benefit is still payable to beneficiaries, even if all the (LTC) benefits are used.**
- **$10,000 Children's Term Rider (CTR) is $4.55 monthly and covers all children to age 26.**
- **Group Whole Life (GWL) builds Cash Value over time that may be accessed in the future.**

	Monthly Premiums						Spouse
Face Amount	**$10,000**	**$20,000**	**$30,000**	**$50,000**	**$70,000**	**$100,000**	***$15,000****
Monthly LTC*	**$400**	**$800**	**$1,200**	**$2,000**	**$2,800**	**$4,000**	***$600***
Age 18-25	$6.01	$12.02	$18.02	$30.04	$42.06	$60.08	$9.01
26-30	$7.52	$15.03	$22.55	$37.59	$52.62	$75.17	$11.28
31-35	$9.57	$19.13	$28.70	$47.84	$66.97	$95.67	$14.35
36-40	$12.49	$24.98	$37.48	$62.46	$87.44	$124.92	$18.74
41-45	$16.38	$32.77	$49.15	$81.92	$114.68	$163.83	$24.57
46-50	$21.90	$43.80	$65.70	$109.50	$153.30	$219.00	$32.85
51-55	$30.12	$60.23	$90.35	$150.59	$210.82	$301.17	$45.18
56-60	$42.63	$85.27	$127.90	$213.17	$298.43	$426.33	$63.95
61-65	$60.56	$121.12	$181.67	$302.79	$423.91	$605.58	$90.84

*Monthly (LTC) Long-Term Care Benefit pays up to 25 months and does not reduce the life insurance amount.
**Spouse Rate for the Guarantee Issue $15,000 policy.

Voluntary term coverage can more than triple in premium from ages 44-55. Insurance reductions to the face amount also begin at age 65. Having the opportunity to purchase a permanent-portable policy with locked-in rates may be a good option for many employees.
Coverage does not replace any employer-provided or optional life coverage.

Planning for Retirement

A consistent savings plan throughout your career is the foundation for security during your retirement years. A 403(b) plan can be a powerful tool in promoting financial security in retirement.

How the Retirement Plans Work

If you are a regular employee, you have the opportunity to participate in TXWES's 403(b) retirement plan. Student employees are not eligible to participate. You may start contributing to your plan on the first day of employment and your contributions may be deducted from each paycheck. You specify the amount you want to contribute into the 403(b) account and you can direct how the contributions are invested.

For 2024, according to federal law — if you are less than 50 years of age, you can defer a maximum of $23,000 into your 403(b) retirement plan. If you are 50 years old or older before calendar year-end, you may contribute a maximum of $30,500. You are immediately 100% vested in the plan.

TXWES also offers a 401(a) retirement savings plan. If you are at least 21 years of age and have worked for TXWES for at least 12 months and 1,000 hours during that 12-month period, you are eligible to participate in the 401(a) retirement savings plan. *All eligible employees receive a 2% universal contribution to the account. TXWES may also match up to an additional 4% to the plan, based on your contribution to your 403(b) plan. Effective December 1,2023 TXWES's discretionary match is 4%. Participants are vested 20% for each year of service and are 100% vested after five years of service. To earn a year of service, you must be credited with at least 1,000 hours of service during a plan year.

- Universal Contribution and Match amounts are reviewed annually and are subject to change.

*See plan document for additional details and exclusions.

Time Off

Vacation and Holidays

TXWES recognizes the importance of time away from work for pleasure, rest and relaxation. Vacation eligibility is dependent on length of service and employment status. Refer to your TXWES employee handbook for the vacation accrual schedule. Holidays and “break days” are observed according to TXWES policy.

TXWES observes and is typically closed on the following holidays:

- New Year’s Day
- Independence Day
- Martin Luther King, Jr.’s Birthday
- Labor Day
- Good Friday
- Thanksgiving Day
- Memorial Day
- Christmas Day
- Juneteenth/Emancipation Day

For more information regarding eligibility for holidays and break days, please see policy 8.2 Holiday, Break Day and closings in the employee handbook.

Eligibility

If you are a full-time, regular employee, you are eligible for holidays and break days provided you are on payroll and work your regularly scheduled hours, or have an excused paid absence one day immediately before and one day immediately after the holiday or break day, with the exception of the Christmas break. Employees must be on payroll at least seven calendar days immediately prior to and immediately after the commencement and conclusion of Christmas break.

If you claim sick time during these time periods, you may be required to provide a health care provider’s statement in order to be paid for the holiday. (This is subject to your supervisor’s approval.)

Leave

TXWES provides full-time regular employees, who have completed 6 months of service, with earned sick leave. Leave accrual and utilization rates vary based on length of service and employment status. TXWES may also grant leaves under the following circumstances: military leave, family medical leave (FMLA), bereavement, jury duty, and other extended leaves of absence. See your TXWES employee handbook for additional information.

Break Days

TXWES also observes break days. If you are a full-time, regular employee, you will not work, but will be compensated at your regular hourly rate for the Tuesday and Wednesday before Thanksgiving Day, the Friday following Thanksgiving Day and the five workdays between Christmas Day and New Year’s Day.

The president may designate other break days. The president may also extend selected break days to all regular part-time staff solely at his or her discretion. Student workers and temporary employees are not eligible for pay on holidays or break days.

If you are on an unpaid leave of absence or on disability leave, you are not eligible for holidays or break days. If you are on a paid leave, you are not eligible for any additional pay or time off.

Note: TXWES may, at its discretion, designate any or all holidays, break days or closings as paid or unpaid, or as normal business days.

Additional Benefits

Tuition Waiver

If you are an eligible employee, you, your spouse and your children (natural, adopted, stepchildren or children under legal guardianship) may take advantage of TXWES's Tuition Waiver benefit. Fees and incidental expenses for you and your dependents are your responsibility. TXWES is proud to offer you this valuable benefit which should be considered part of your total compensation package.

Eligibility for the Tuition Waiver benefit begins the semester following the initial semester of full-time employment. No waiver eligibility will be retroactive to any semester enrolled prior to the eligibility date. Eligible employees are limited to six credit hours per semester with supervisory approval, and Tuition Waiver applications must be accompanied with the employee's class schedule. Other eligible family members may attend full-time.

Tuition Waivers for graduate degrees for you and your dependents are fully taxable. However, the IRS provides an exclusion on the first $5,250 of Tuition Waiver income. Tuition Waiver forms are available in the Offices of Human Resources or at **www.txwes.edu/HR**. You must complete and submit the forms to the Office of Human Resources at least two full weeks (14 business days) prior to the start of a term.

If you are eligible for the Tuition Waiver, you and your dependents may also be eligible to participate in an undergraduate degree tuition exchange program offered through Tuition Exchange, Inc. and The Council of Independent Colleges. This is not a University provided benefit and eligibility varies each year. For more information, contact the Office of Financial Aid at 817-531-4420 or visit **www.txwes.edu/financialaid**.

Credit Union

As an employee of TXWES, you are eligible to establish banking account(s) with Educational Employees Credit Union (EECU). Membership, including payroll deduction for savings, is available with a $5 share deposit. Loans are available according to credit union guidelines. See Human Resources for additional information.

Fitness Center

You may utilize TXWES's recreational facilities in the Sid W. Richardson Center (gymnasium & swimming pool), as well as the tennis courts on the north side of the main campus at no cost. Contact the Student Life department at 817-531-4872 to confirm hours of operation. Additionally, you may utilize the exercise equipment in TXWES's Morton Fitness Center.

Morton Fitness Center Cost (6-Month Membership)				
Students	**Faculty/Staff**	**Alumni**	**Spouse Only**	**Locker Fee**
Free	Free	$100	$100	$25

Free Services & Discounts

You must present a current, University-issued Staff/Faculty ID card to benefit from the following services and opportunities.

- **Library Services** — Faculty and staff members are eligible and encouraged to take advantage of the many free resources available in the library, including extended check-out privileges.
- **Campus Events** — You and your family members may be eligible for discounted admission to campus events, including on-campus fine arts performances and athletic events, as well as local special events and entertainment facilities.
- **Foodservice** — Texas Wesleyan Dining Services — administered by Aramark — offers the $5 Fridays program in Dora's Café (located in Dora Roberts Hall) during the regular semester that provides all-you-care-to-eat lunch between 10:30 am to 2:00 pm. Meals served in Dora's Café on other days or during other hours are full fare.
- **Bookstore** — TXWES's main campus bookstore provides you with a 10% discount on most items in the store, and TXWES receives a 20% discount on supplies.

University ID Card & Reserved Parking

If you are a main campus employee, each year you must obtain a photo identification card free of charge from the Eunice & James L. West Library. Identification cards are required for library services, discounts, and admission to many campus events. University I.D. Cards must be surrendered upon request or at termination of employment.

If you are a full-time faculty or staff employee, you will be assigned a parking space on campus, which will be reserved between 7:00 a.m. and 5:00 p.m., Monday through Friday. You must register your vehicle and obtain a parking sticker from Security. Two vehicles may be registered at a time. Any more than two registrations will require a $25 fee per vehicle above the first two registrations. The parking sticker should be placed on the driver's side of the rear window.

Women's Health and Cancer Rights Act: If you have had or are going to have a mastectomy, you may be entitled to certain bene- fits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

Newborn's and Mother's Health Protection Act (NMHPA): Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA):
Texas Wesleyan University medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP): If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.tdi.texas.gov/ to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefit Security Administration
www.dol.gov/agencies/ebsa
1.866.444. EBSA (3272)
U.S Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1.877.267.2323, menu Option 4, Ext. 61565

Coverage After Termination (COBRA) - Health Coverage: If you or your dependents have coverage at the time of a qualifying event, you may be eligible to elect continuation of coverage under one or more of the following:

- Medical Plan, Dental Plan, and Vision Plan

You have a legal right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to purchase a temporary extension of your coverage at group rates. However, you must pay the full cost of the coverage, plus a 2% administrative fee.

What is COBRA Continuation Coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect. COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

COBRA & Retirement: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to **Texas Wesleyan University,** and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation of Coverage Available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. **There are also ways in which this 18-month period of COBRA continuation coverage can be extended.**

Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage e if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

(HIPAA) Employee Health Plan Summary Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Uses and Disclosures of Health Information: Texas Wesleyan University uses health information about you for treatment, to pay for treatment, and for other allowable healthcare purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods. Subject to certain requirements, **Texas Wesleyan University** may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. **Texas Wesleyan University** provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and distribute the new notice. You can also request a copy of our full notice at any time. For more information about our privacy practices, contact the Office of the Privacy Officer or the Human Resources Department.

Your Health Information Rights: In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. You also have the right to receive a list of instances where **Texas Wesleyan University** has disclosed health

information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that **Texas Wesleyan University** correct the existing information or add the missing information. You have the right to request that **Texas Wesleyan University** restrict the use and disclosure, then **Texas Wesleyan University** must abide by the request and may only reverse the position after you have been appropriately notified. You have the right to request an alternative means of communication with Texas Wesleyan University and are not required to explain why you want the alternative means of communication.

Privacy Complaints: If you are concerned **Texas Wesleyan University** has violated your privacy rights, or you disagree with a decision Texas Wesleyan University has made about access to your records, you may address them to the Privacy Contact listed in this notice. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Texas Wesleyan University Responsibilities: Texas Wesleyan University is required by law to protect the privacy of your information, provide this notice about **Texas Wesleyan University's** information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Detailed Notice of Privacy Practices: For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Privacy Contact listed in this notice.

Privacy Contact: Address any questions about this notice or how to exercise your privacy rights to the Human Resources Department at 817-531-4403.

Notice Of Opportunity To Enroll In Connection With Extension Of Dependent Coverage To Age 26: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in **Texas Wesleyan University**. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2024. If you would like more information, contact your Plan Administrator.

Notice Lifetime Limit No Longer Applies/ Enrollment Opportunity: The lifetime limit on the dollar value of benefits under Texas Wesleyan University benefit Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. If you would like more information, contact your Plan Administrator.

Your Prescription Drug Coverage and Medicare: Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Texas Wesleyan University** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make e decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage with **Texas Wesleyan University** will not be affected. You and/or your dependents can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with **Texas Wesleyan University** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go n nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage: Contact the plan administrator. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Texas Wesleyan University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage: More detailed information about

Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information: When key parts of the health care law took effect in 2014, this created a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2024 for coverage starting as early as January 1, 2024.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer- offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost.

Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer: This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Here is some basic information about health coverage offered by this employer: Eligible employees are Fulltime employees who work 30 hours per week and have completed the newly eligible 60 day waiting period

Eligible dependents include the employee's spouse and eligible dependent children up to age 26.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace.

The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Special Enrollment Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, if you or an eligible dependent has coverage under a

state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator listed below: Kim Stergio : 817-531-4403.

Notice Informing Individuals About Non Discrimination and Accessibility Requirements Discrimination is against the law: Texas Wesleyan University complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **Texas Wesleyan University** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Texas Wesleyan University:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Human Resources at 817-531-4403. If you believe that **Texas Wesleyan University** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: TWC's Civil Rights Division at https://www.twc.texas.gov/jobseekers/how-submit-employment-discriminationcomplaint#:~:text=TWC's%20Civil%20Rights%20Division's%20programs,against%20in%20an%20employment%20transaction.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Keep your plan informed of address changes: To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan administrator

Consolidated Appropriations Act (CAA) No Surprises Act

Your Rights and Protections Against Surprise Medical Bills When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for: Emergency services If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. [Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate] Certain services at an in-network hospital or ambulatory surgical center when you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. When balance billing isn't allowed, you also have the following protections: You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly. Your health plan generally must cover emergency services without requiring you to get approval for services in advance (prior authorization). Cover emergency services by out-of-network providers. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit. If you believe you've been wrongly billed, you may contact Human Resources at Texas Wesleyan University.

If you believe you've been wrongly billed, you may contact your Human Resources Department. In addition, if you have questions about a provider's network status or you believe you've been wrongly billed, please contact the BCBSTX help line.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Visit www.tdi.texas.gov/ for more information about your rights under state law.

This brochure highlights the main features of the Texas Wesleyan University Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Texas Wesleyan University reserves the right to change or discontinue its employee benefits plans at any time.