Texas Wesleyan
UNIVERSITY

2026/2027

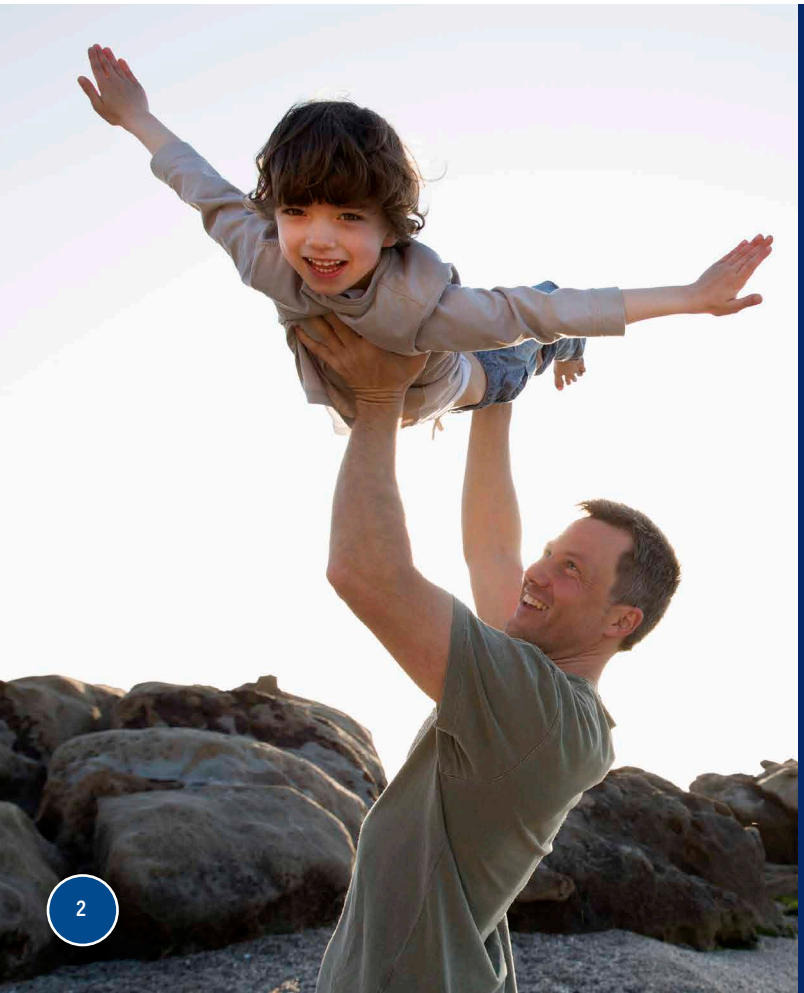
EMPLOYEE BENEFITS

WORKING TOWARDS WELLNESS

A guide to understanding your employee benefits program

IMPORTANT CONTACTS

COVERAGE	CARRIER	PHONE	WEBSITE/EMAIL
Medical Coverage	Blue Cross Blue Shield of Texas	800-521-2227	www.bcbstx.com
Telemedicine	Teladoc MDLIVE	800-TELADOC 888-680-8646	www.teladoc.com www.mdlive.com/bcbstx
Dental Coverage	Mutual of Omaha	800-927-9197	www.mutualofomaha.com
Dental Discount Program	Quality Care Dental of America	800-229-0304	www.qcdofamerica.com
Vision Coverage	Mutual of Omaha	833-279-4358	www.mutualofomaha.com
Health Savings Account	HSA Bank	800-357-6246	www.hsabank.com
Flexible Spending Accounts	Lively	888-576-4837	www.livelyme.com/fsa
Life and AD&D	Mutual of Omaha	800-775-8805	www.mutualofomaha.com
Short and Long Term Disability	Mutual of Omaha	800-775-8805	www.mutualofomaha.com
Whole Life with Long Term Care	The Standard	888-937-4783	
Accident Insurance	Mutual of Omaha	800-775-8805	www.mutualofomaha.com
Critical Illness Insurance	Mutual of Omaha	800-775-8805	www.mutualofomaha.com
Hospital Indemnity Insurance	Mutual of Omaha	800-775-8805	www.mutualofomaha.com
Employee Assistance Program	Mutual of Omaha	800-316-2796	www.mutualofomaha.com/eap
Retirement Plan	TIAA-CREF	800-842-2252	www.tiaa.org/txwes
Travel Assistance	AXA Assistance USA	800-856-9947	
ID Theft Support	AXA Assistance USA	800-856-9947	
Benefits Assistance	Higginbotham Employee Response Center	866-345-TXWU (8998)	texaswesleyanuniversity@eb.higginbotham.net



EMPLOYEE RESPONSE CENTER

Employee benefits can be complicated. The **Higginbotham Employee Response Center** can assist you with the following:

- Benefits information
- Claims and billing questions
- Eligibility issues

Call or text **866-345-TXWU (8998)**.

Email **texaswesleyanuniversity@eb.higginbotham.net**.

Monday through Friday from 7:00 a.m. to 6:00 p.m. CT.

Se habla español.

If you leave a voicemail message after 3:00 p.m. CT, your call will be returned the next business day. You can also email your questions or requests.

WHAT'S INSIDE

INTRODUCTION

We are pleased to offer a full benefits package to you and your eligible dependents. Read this guide to know what benefits are available to you.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

Our benefits program offers one or more medical plan options. To help you make an informed choice, review each plan's Summary of Benefits and Coverage, available from Human Resources.

Your New Benefits Begin

APRIL 1, 2026

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see Important Notices for more details.

ELIGIBILITY

OE: Open Enrollment

QLE: Qualifying Life Event

WHO IS ELIGIBLE FOR BENEFITS

STATUS	NEW HIRE	EMPLOYEE	DEPENDENT(S)
Who is Eligible	▪ A regular, full-time employee working an average of 30 hours or more per week	▪ A regular, full-time employee working an average of 30 hours or more per week	▪ Your legal spouse ▪ Children under age 26 regardless of student, dependency, or marital status ▪ Children age 26 or older 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
When to Enroll	▪ By the deadline given by Human Resources	▪ During OE or for a QLE	▪ During OE or for a QLE ▪ When covering dependents, you must enroll for and be on the same plans
When Coverage Starts	▪ First of the month after completing 30 days of full-time employment	▪ OE: Start of the plan year ▪ QLE: Contact Human Resources	▪ Contact Human Resources at ext. 4403

QUALIFYING LIFE EVENTS

You may only enroll for or make changes to coverage during the plan year if you are a new hire or if you have a QLE, such as:

Marriage

Divorce

Legal separation

Annulment

Death of spouse

Birth

Adoption/placement for adoption

Change in benefits eligibility

Death of child

FMLA, COBRA event, judgment, or decree

Becoming eligible for Medicare, Medicaid, or TRICARE

Receiving a Qualified Medical Child Support Order

Gain or loss of benefits coverage

Change in employment status affecting benefits

Significant change in cost of spouse's coverage

You have 31 days from the event to submit the request in the benefits administration system, Benefitfirst, and submit proof of the qualifying event to Human Resources.

HOW TO ENROLL ONLINE

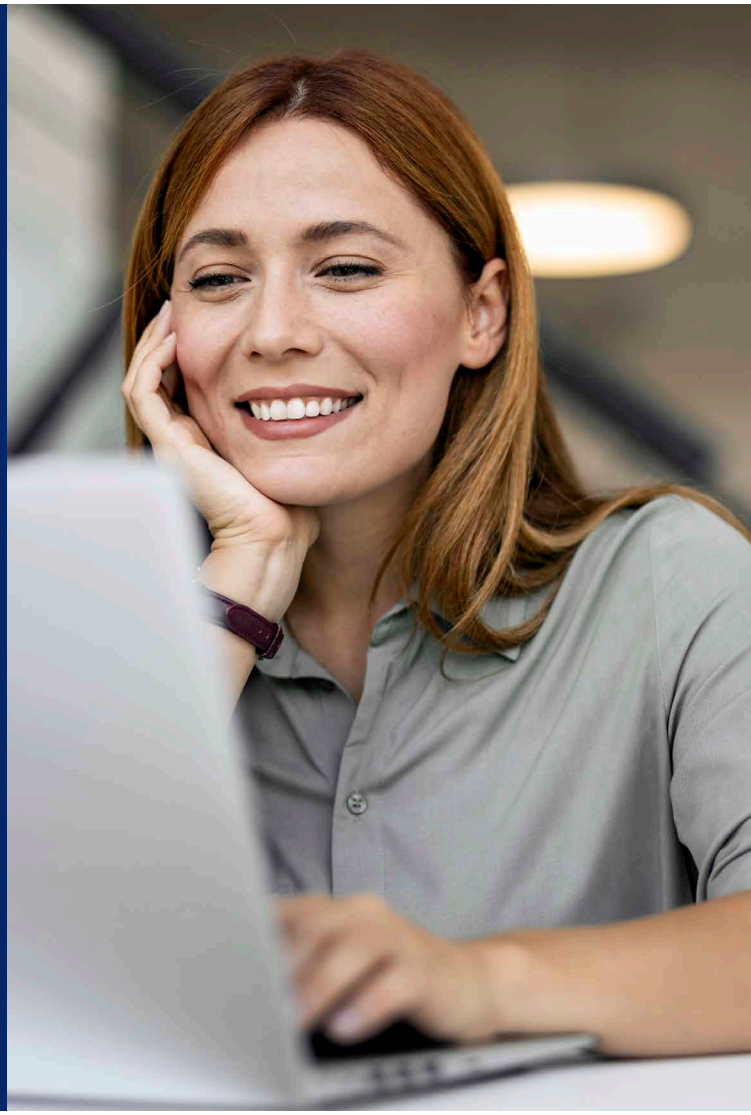
Enrolling in benefits is simple through **Benefitfirst**.

FIRST-TIME USERS

Go to **www.benefitfirst.com**.

1. Enter Company ID 765.
2. Log in using the user ID and temporary password from your welcome letter. You will be prompted to change your temporary password upon the first login.
3. Select *Enroll Now* on the homepage.
4. Choose *Elect* or *Decline benefits* for each benefit option.
5. Review all your benefit selections carefully. To finalize, you will be asked to re-enter your password and certify your choices.
6. Click *Submit* to complete your enrollment.
7. Make sure you receive a confirmation message. You can also print or save a copy of your enrollment summary.

If you are a returning user, log in to the enrollment website and select *Enroll Now* on the homepage to begin and follow steps 4 through 7.



ENROLLMENT QUESTIONS

If you have technical questions or want to enroll by phone, call the **Benefitfirst Customer Care Center** at **888-322-9374** and use Company ID 765 to speak with an enrollment specialist. The Benefitfirst Customer Care Center is available Monday through Friday, 7:30 a.m. to 4:00 p.m. CT.

SCAN FOR BENEFIT INFORMATION

PRIVACY.FLOWCODE.COM

MEDICAL COVERAGE

Protects you and your family from major financial hardship in the event of illness or injury.

Carrier:	Networks:
Blue Cross Blue Shield of Texas	Blue Choice (HDHP/PPO) Blue Essentials (HMO)

You have a choice of three medical plans:

- HDHP with HSA Plan
- HMO Plan
- PPO Plan

HIGH DEDUCTIBLE HEALTH PLAN

A High Deductible Health Plan (HDHP) allows you to see any provider when you need care, and you will pay less when you go to in-network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account.

HEALTH MAINTENANCE ORGANIZATION

With a Health Maintenance Organization (HMO) plan, you must seek care from in-network providers in the HMO network. The selection of a primary care physician is required, and you need a referral to see a specialist. Always confirm that your doctors and specialists are in-network before seeking care.

PREFERRED PROVIDER ORGANIZATION

A Preferred Provider Organization (PPO) plan allows you to see any provider when you need care. When you see in-network providers, you will pay less and get the highest level of benefits. You will pay more for care if you use out-of-network providers. When you see in-network providers, your office visits, urgent care visits, and prescription drugs are covered with a copay, and most other services are covered at the deductible and coinsurance level.

FIND AN IN-NETWORK PROVIDER

Visit **https://mybam.bcbstx.com**.

Call **800-521-2227**.

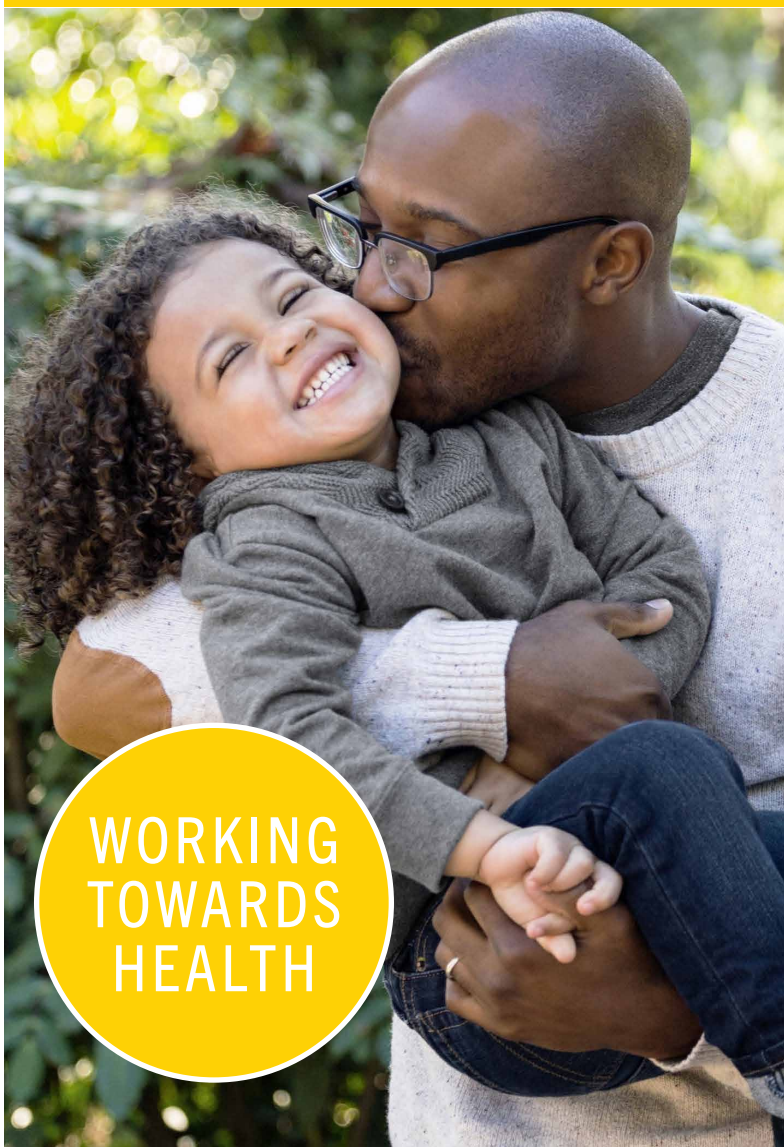
Download the **BCBSTX app**.

CHOOSING A PROVIDER

Log into the website and select one of these networks:

- BlueChoice if you elected the HDHP or PPO plans.
- BlueEssentials if you elected the HMO plan.

You will then be taken to Blue Access for Members to search by name or provider type.



MEDICAL BENEFITS SUMMARY

	HDHP WITH HSA PLAN		HMO PLAN		PPO PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible						
▪ Individual	$3,400	$6,000	$3,000	Not covered	$1,000	$2,000
▪ Family	$6,800	$20,000	$6,000	Not covered	$2,000	$4,000
Out-of-Pocket Maximum Includes deductible						
▪ Individual	$6,550	$13,100	$6,000	Not covered	$3,000	$6,000
▪ Family	$13,100	$26,200	$12,000	Not covered	$6,000	$12,000
	YOU PAY		YOU PAY		YOU PAY	
Preventive Care	$0	40%[1]	$0	Not covered	$0	40%[1]
Telemedicine						
▪ Teladoc	$55 copay	Not covered	$0	Not covered	$0	Not covered
▪ MDLIVE	20%[1]	40%[1]	$30 copay	Not covered	$25 copay	40%[1]
Primary Care Physician	20%[1]	40%[1]	$30 copay	Not covered	$25 copay	40%[1]
Specialist	20%[1]	40%[1]	$50 copay	Not covered	$40 copay	40%[1]
Diagnostic Lab and X-ray	20%[1]	40%[1]	20%[1]	Not covered	$0	40%[1]
Complex Imaging CT/PET scan, MRI	20%[1]	40%[1]	20%[1]	Not covered	20%[1]	40%[1]
Urgent Care	20%[1]	40%[1]	$75 copay	Not covered	$75 copay	40%[1]
Emergency Room	20%[1]		$200 copay + 20%[1] (copay waived if admitted)		$150 copay + 20% (copay waived if admitted)	
Inpatient Hospital Services	20%[1]	40%[1]	20%[1]	Not covered	20%[1]	40%[1]
Outpatient Services	20%[1]	40%[1]	20%[1]	Not covered	20%[1]	40%[1]
Prescription Drugs – Retail Up to 30-day supply						
▪ Generic	20%[1]	20%[1]	$20 copay	Not covered	$20 copay	$20 copay + 40%
▪ Preferred brand name	20%[1]	20%[1]	$40 copay	Not covered	$40 copay	$40 copay + 40%
▪ Non-preferred brand name	20%[1]	20%[1]	$70 copay	Not covered	$70 copay	$70 copay + 40%
▪ Specialty	20%[1]	20%[1]	$100 copay	Not covered	$100 copay	$100 copay + 40%
Prescription Drugs – Mail Order Up to 90-day supply						
▪ Generic	20%[1]	20%[1]	$50 copay	Not covered	$50 copay	Not covered
▪ Preferred brand name	20%[1]	20%[1]	$100 copay	Not covered	$100 copay	Not covered
▪ Non-preferred brand name	20%[1]	20%[1]	$175 copay	Not covered	$175 copay	Not covered

EMPLOYEE MONTHLY CONTRIBUTIONS			
Employee	$92.40	$117.50	$364.46
Employee & Spouse	$960.99	$1,102.68	$1,618.40
Employee & Child(ren)	$798.36	$1,024.97	$1,477.10
Employee & Family	$1,122.44	$1,575.74	$2,219.19

[1] The amount you pay after the deductible is met.

PRESCRIPTION DRUGS

Your medical coverage includes prescription benefits for retail, mail order (home delivery), and specialty drugs.

Carrier:

Prime Therapeutics

PRESCRIPTION DRUG LIST

Your medical carrier controls prescription drug costs by negotiating discounts on medications. Covered drugs are listed in the Prescription Drug List. If you take maintenance medications, review the list with your doctor to see which ones are covered and available. If your medication is not listed, call the phone number on your member ID card.

RETAIL

Use any participating retail pharmacy to fill short-term, non-specialty medications. Retail pharmacies often fill or refill 30- to 90-day supplies.

HOME DELIVERY

If you take medication on a daily basis, consider using home delivery. It is a convenient, low-cost option that delivers up to a 90-day supply right to your home. You will need to set up an online pharmacy account and/or download the app to easily manage your prescriptions.

SPECIALTY

If you need a specialty drug to treat a complex or chronic condition, you will be asked to enroll in a specialty drug program. It offers support to ensure the medication works well for you and costs as little as possible. If you do not enroll in the program, the specialty drug may not be covered. Certain exclusions and limitations apply.

PERFORMANCE DRUG LIST

- Visit **www.myprime.com** or **www.bcbstx.com**.
- Scan the QR code.

SIGN UP FOR HOME DELIVERY

Visit **www.myprime.com**.

Call **833-715-0942**.

Download the **BCBSTX app**.

SAVE MONEY. BUY GENERIC DRUGS!

Generic drugs are a safe and effective option to brand-name drugs – and they cost much less! They have the same active ingredients, strength, and dosage as brand-name drugs, and they also meet the same rigorous quality and safety standards set by the Food and Drug Administration.

PREVENTIVE CARE

WORKING TOWARDS HEALTH

Your medical plan offers **$0 preventive care** for everyone.

Preventive care is the care you receive to help prevent chronic illness or disease. It includes exams, lab work, screenings, immunizations, and counseling to prevent health problems, such as diabetes or heart disease.

PREVENTIVE CARE COVERAGE INCLUDES

ADULTS	TEENS	CHILDREN
Cholesterol screening	Physical exam	Autism screening
Blood pressure screening	Blood tests for iron and cholesterol	Blood screening
Colorectal cancer screening	Anxiety screening	Depression screening
Lung cancer screening	Growth screening	Developmental screening
Hepatitis B screening	Hearing screening	Hearing screening
Well visits	Hepatitis B screening	Obesity screening and counseling
Bone density screening	Depression screening	Hypothyroidism screening
Obesity screening	Alcohol, tobacco, and drug use assessments	Behavioral assessments
Diabetes type 2 screening	Tuberculosis screening	Well visits
Depression screening	Immunizations	Immunizations
Mammograms	Dental cleanings and exams	Dental cleanings and exams
Cervical cancer screening	Vision screening	Oral health risk assessment
Immunizations		Vision screening
Dental cleanings and exams		
Vision screening		

Some preventive care may be subject to age requirements.

FREQUENTLY ASKED QUESTIONS

Why should I get preventive care?

Preventive care is the fastest and best way to uncover potential risks and avoid chronic health conditions.

Are all screenings, tests, and procedures covered under preventive care?

No. Your doctor will be able to advise you as to the preventive care you need or should obtain, based on your medical and family history.

Why did I get a bill for preventive care?

Diagnosis codes on the doctor's bill must meet certain insurance company conditions for them to be processed as preventive and covered at 100%. If you have a medical complaint, or your doctor finds a specific medical issue during your preventive care doctor's visit, a diagnosis code for that issue or complaint will be on your bill. As a result, the insurance company may process the bill for a specific medical condition, not preventive care. In this case, you must pay the copay or portion of your deductible.

TELEMEDICINE

Your benefits plan offers two telemedicine options — one through Teladoc and one through MDLIVE. Telemedicine makes it easy to connect anytime day or night with a board-certified doctor via your mobile device or computer.

Carriers:

Teladoc and **MDLIVE**

While telemedicine does not replace your primary care physician, it is a convenient and cost-effective option when you need care and:

- Have a non-emergency issue and are considering an after-hours health care clinic, urgent care clinic, or emergency room for treatment
- Are on a business trip, vacation, or away from home
- Are unable to see your primary care physician

WHEN TO USE TELEMEDICINE

Use telemedicine for minor conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold/flu
- Mental health issues
- Allergies
- Dermatology
- Primary care
- Fever
- Urinary tract infections

Do not use telemedicine for serious or life-threatening emergencies.

YOU HAVE A CHOICE!

When you use Teladoc, you will pay less for care and have more convenience.

GET MORE INFORMATION OR REGISTER

Skip the trip to your doctor! Register for an account so you can get on-demand medical care.

TELADOC

Visit **www.teladoc.com**.

Call **800-TELADOC (835-2362)**.

Download the **Teladoc app**.

MDLIVE

Visit **www.mdlive.com/bcbstx**.

Call **888-680-8646**.

Download the **BCBSTX app**.

YOUR COST PER VISIT

TELADOC	MDLIVE
HDHP – $55	HDHP – 20% after deductible
HMO – $0	HMO – $30
PPO – $0	PPO – $20

HEALTH CARE OPTIONS

Becoming familiar with your options for medical care can save you time and money.

HEALTH CARE PROVIDER	SYMPTOMS	AVERAGE COST	AVERAGE WAIT
NON-EMERGENCY CARE			
 **TELEMEDICINE** **Access to care via phone, online video, or mobile app** whether you are home, work, or traveling; medications can be prescribed. 24 hours a day, 7 days a week	Allergies Cough/cold/flu Rash Stomachache	**$0-$**	**2-5 minutes**
 **DOCTOR'S OFFICE** Generally, the **best place for routine preventive care**; established relationship; able to treat based on medical history. Office hours vary	Infections Sore and strep throat Vaccinations Minor injuries/sprains/strains	**$**	**15-20 minutes**
 **RETAIL CLINIC** Usually **lower out-of-pocket cost** than urgent care; when you can't see your doctor; located in stores and pharmacies. Hours vary based on store hours	Common infections Minor injuries Pregnancy tests Vaccinations	**$**	**15 minutes**
 **URGENT CARE** When you need **immediate attention**; walk-in basis is usually accepted. Generally includes evening, weekend, and holiday hours	Sprains and strains Minor broken bones Small cuts that may require stitches Minor burns and infections	**$$**	**15-30 minutes**
EMERGENCY CARE			
 **HOSPITAL ER** **Life-threatening or critical conditions; trauma treatment**; multiple bills for doctor and facility. 24 hours a day, 7 days a week	Chest pain Difficulty breathing Severe bleeding Blurred or sudden loss of vision Major broken bones	**$$$$**	**4+ hours**
 **FREESTANDING ER** Services do not include trauma care; can look similar to an urgent care center, but **medical bills may be 10 times higher**. 24 hours a day, 7 days a week	Most major injuries except trauma Severe pain	**$$$$$**	**Varies**

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

BCBSTX RESOURCES

BCBSTX MEMBER PORTAL AND APP

Blue Access for Members (BAM) is the secure BCBSTX member website where you can:

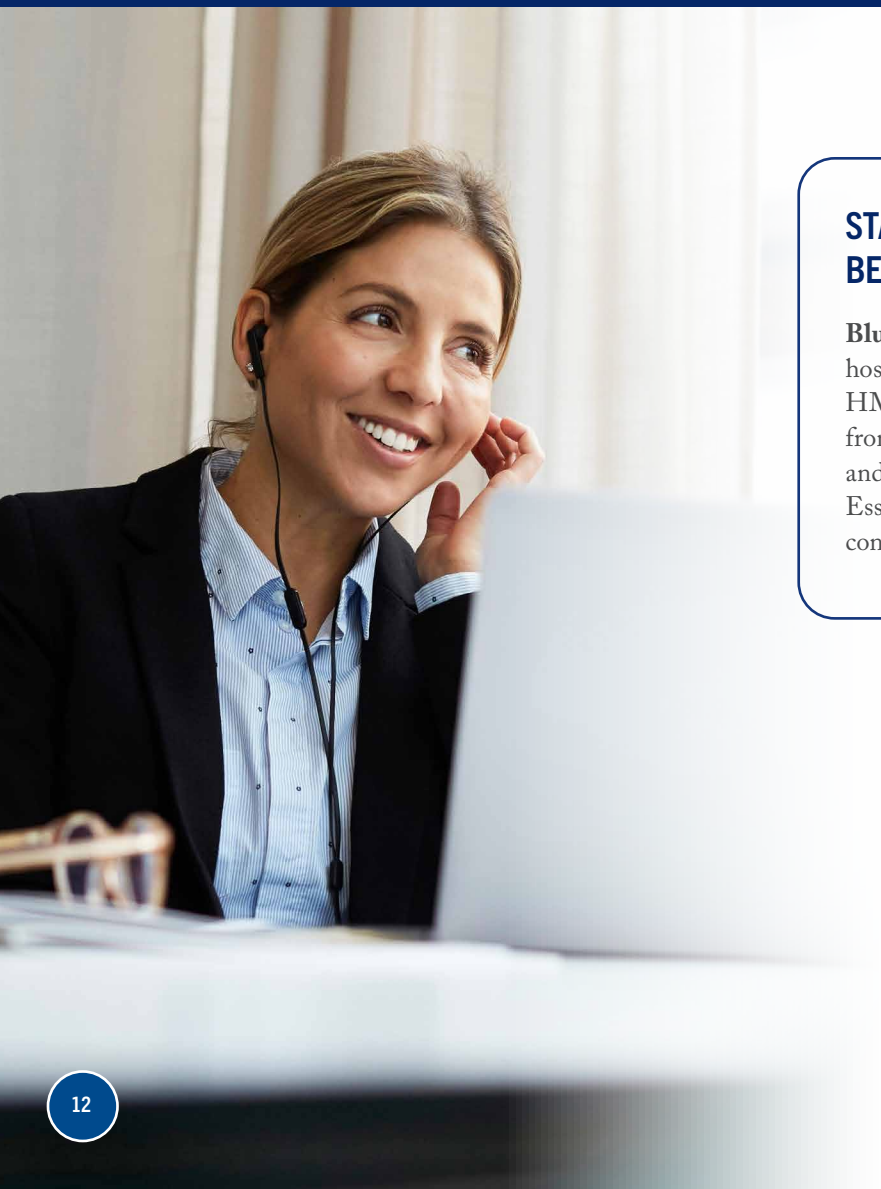
- Check claim status or history
- Confirm dependent eligibility
- Sign up for electronic Explanation of Benefits statements
- Locate in-network providers
- Print or request an ID card
- Review your benefits
- Get tips to live and eat healthier

Get the **BCBSTX app** for easy access to your information. Log in from your mobile device to access your BAM account.

NURSELINE

Call **800-581-0368** for access to registered nurses who can answer general health questions, make appointments with your doctor, and help determine where to go for emergency health care services. You can also access an audio library of more than 1,000 health-related topics in both English and Spanish.

Visit **www.bcbstx.com** to register.



STATEWIDE HMO PROVIDER NETWORK AND BENEFIT SUPPORT

Blue Essentials offers you access to a statewide network of hospitals and doctors and helps you understand and use your HMO medical benefits. The primary care doctor you select from the Blue Essentials network will coordinate your care and refer you to in-network specialists. When you use Blue Essentials, you will know what you will pay for care, have consistent copays, and get $0 preventive care.

BCBSTX RESOURCES

SCAN FOR BENEFIT INFORMATION

PRIVACY.FLOWCODE.COM

BLUE365 DISCOUNTS

Blue365 can save you money on health and wellness products and services not covered by insurance. There are no claims to file, and you do not need a referral or preauthorization. Visit **www.blue365deals.com/bcbstx** to sign up and receive weekly featured deals by email. Discount categories include:

- Apparel and footwear
- Fitness
- Hearing and vision
- Home and family
- Nutrition
- Personal care

BCBSTX RESOURCES

AT RISK DIABETES AND HIGH BLOOD PRESSURE MANAGEMENT

If you are at risk of diabetes and/or high blood pressure, **Omada** helps you change the habits that put you most at risk for developing a chronic condition. A virtual care team will work with you to create a program to reduce your risk and build healthy habits. You will receive weekly support and connect with a small group of peers, all from the comfort of your own home. If you have any health claims that show you may be at risk for diabetes or high blood pressure, Omada will reach out to you directly.

CHRONIC DIABETES AND HIGH BLOOD PRESSURE MANAGEMENT

Livongo offers digital solution programs to help you manage chronic diabetes and high blood pressure (hypertension). Participation is FREE and available to you and your family members.

DIABETES MANAGEMENT PROGRAM

Manage Type 1 and Type 2 diabetes by using:

- Advanced blood glucose meter
- Unlimited strips and lancets at NO COST
- Real-time tips and 24/7 support

HIGH BLOOD PRESSURE MANAGEMENT PROGRAM

Livongo offers personal support by monitoring your blood pressure using:

- A wireless, connected blood pressure cuff
- 24/7 support and coaching with licensed professionals
- Notifications and reminders
- Blood pressure reading reports

GET MORE INFORMATION

OMADA

Visit **www.omadahealth.com/bcbstx**.

LIVONGO

Visit **https://get.livongo.com/txhealth/register**.

Call **800-945-4355**.

Text **GO TXHEALTH** to **85240**.

Use registration code **TXHEALTH** when prompted.

CONNECT TO CARE

By invitation to those with high-risk, qualifying conditions.

CHRONIC CONDITION MANAGEMENT

Connect to Care is a free, digital care management program for chronic conditions like diabetes, asthma, heart disease, and mental health concerns. If you have a high-risk, qualifying condition and you have a BAM account, you will be invited to join the program and be under the guidance of a nurse. The secure, app-free portal offers educational content, health surveys, and tools to set and track personalized goals.

- Free for invited members with qualifying health conditions
- Educational content, surveys, and progress tracking
- Personalized support from a clinician for high-risk members
- Self-scheduling, chat access, and goal management
- Rewards for completing health milestones

BCBSTX RESOURCES

BACK AND JOINT PAIN

If you suffer from constant back and joint pain, **Hinge Health** can help without drugs or surgery. Get personal therapy, unlimited support, a computer tablet, and wearable sensors – **all for free**! Average results show 68% pain reduction.

WEIGHT LOSS

If you would like to lose weight and change how your body stores and uses energy, **Wondr** may be right for you. Its digital weight loss program teaches you how to eat your favorite foods and still lose weight, have energy, stress less, and sleep better.

WELLNESS PROGRAM

Well onTarget provides the support you need to make healthy choices. Access personalized tools and resources on the secure Well onTarget website, including:

- Health assessment
- Digital self-management programs
- Fitness program
- Health resources and information
- Tools and trackers
- Health assessments
- Wellness coaching

Get a discounted monthly gym membership – for you and your family (ages 16 and older) – from a nationwide network of thousands of fitness locations. Digital home fitness is also available if you prefer to work out at home.

SCAN FOR BENEFIT INFORMATION

PRIVACY.FLOWCODE.COM

GET MORE INFORMATION

HINGE HEALTH

Visit **https://www.hingehealth.com/bcbstx**.

WONDR

Visit **https://wondrhealth.com/bcbstx**.

WELL ONTARGET

Visit **www.wellontarget.com**.

Download the **AlwaysOn app**.

ADVANCED LAB TESTS AND HEALTH SCREENINGS

NEW! FUNCTION MEMBERSHIP

Get a deeper understanding of your body and spot potential issues early.

Your benefit plan includes the opportunity for you and your family to enroll for a Function membership. Function empowers you to own your health through affordable access to advanced lab testing. A Function membership evaluates five times more biomarkers than the average physical, helping you gain a deeper understanding of what's going on in your body, monitor for early indicators of disease, and track your health as it evolves.

The membership includes:

- Access to 100+ lab tests at the start of your membership.
- Access to an additional 60+ midyear follow-up tests to track your progress.
- Detailed clinician notes highlighting areas of focus.
- A targeted action plan to help improve your health.
- Results stored on one secure platform for easy access anytime.

HOW THE PROCESS WORKS

After signing up for Function, you will get an email and text message to schedule a convenient time and location for your lab visit. Tests take less than 30 minutes and are done at one of more than 2,000 partner lab locations nationwide. You will then get a detailed summary of your results and a targeted action plan to help you reach your health goals. All results are stored in one secure location for you to access anytime. You can retest in six months to see how you are progressing. Non-routine tests (e.g., advanced MRI, early detection of multiple cancers, allergies, heavy metals, and more) may be added for an additional cost.

TEST MORE. KNOW MORE.

Advanced testing across:

- Heart
- Immunity
- Metabolics
- Hormones
- Nutrients
- Heavy Metals
- Liver
- Kidneys
- Pancreas
- Prostate
- Sexual Health
- Electrolytes
- Thyroid
- Autoimmunity
- Urine
- Blood

HOW TO ENROLL

Enroll anytime during the year. You will pay the membership fee(s) directly to Function.

Visit **https://www.functionhealth.com/aep/higginbotham**.

THE COST FOR AN INDIVIDUAL ANNUAL MEMBERSHIP* IS $335!

Carrier:

Function

FSA/HSA ELIGIBLE

Funds from your Flexible Spending Account (FSA) or Health Savings Account (HSA) may be used to pay for your membership. Reimbursement is not guaranteed, so please contact your FSA/HSA provider in advance to confirm the terms of reimbursement. If you do not have an FSA or HSA, use a personal credit card.

*Function membership includes prepaid access to 160+ lab tests each year at a Quest Diagnostics site. Due to state regulations, members testing in New York and New Jersey will be charged an additional fee directly by Quest for each lab visit. We cannot accommodate lab testing in Hawaii or Rhode Island at this time. You can schedule lab testing in a neighboring state.

VISION COVERAGE

Helps detect certain medical issues, prolong your eyesight, and correct vision or eye problems.

Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems. You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see in-network providers. You have a choice of two plans. You will not receive an ID card. Give your provider your name and date of birth to verify coverage.

VISION BENEFITS SUMMARY

	BASE PLAN		BUY-UP PLAN	
	IN-NETWORK YOU PAY	OUT-OF-NETWORK REIMBURSEMENT	IN-NETWORK YOU PAY	OUT-OF-NETWORK REIMBURSEMENT
Exam	$10 copay	Up to $37	$10 copay	Up to $37
Lenses				
▪ Single vision	$25 copay	Up to $20	$25 copay	Up to $20
▪ Lined bifocals	$25 copay	Up to $36	$25 copay	Up to $36
▪ Lined trifocals	$25 copay	Up to $64	$25 copay	Up to $64
▪ Lenticular	$25 copay	Up to $64	$25 copay	Up to $64
Frames	15% off balance over $130 allowance	Up to $66	20% off balance over $150 allowance	Up to $66
Contacts				
In lieu of frames and lenses				
▪ Fitting and evaluation	$0	Up to $40	$0	Up to $40
▪ Elective	15% off balance over $130 allowance	Up to $89; Disposable up to $104	15% off balance over $130 allowance	Up to $102; Disposable up to $120
▪ Medically necessary	$0	Up to $210	$0	Up to $210
Benefit Frequency				
▪ Exam	Once every 12 months		Once every 12 months	
▪ Lenses	Once every 12 months		Once every 12 months	
▪ Frames	Once every 24 months		Once every 24 months	
▪ Contacts	Once every 12 months		Once every 12 months	
EMPLOYEE MONTHLY CONTRIBUTIONS				
Employee	$4.24		$6.06	
Employee & Spouse	$8.04		$11.52	
Employee & Child(ren)	$8.47		$12.12	
Employee & Family	$12.44		$17.82	

Carrier: Mutual of Omaha

Network: EyeMed Insight

FIND AN IN-NETWORK PROVIDER

Visit **https://eyedoclocator.eyemedvisioncare.com/mutual/en-us**.

Call **833-279-4358**.

DENTAL COVERAGE

Our dental plans help you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work.

FIND AN IN-NETWORK PROVIDER

Visit **https://clients.go2dental.com/mutualomaha/SearchProv**.

Call **800-927-9197**.

DPPO PLANS

Two levels of benefits are available with the DPPO plans: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with in-network providers. You could pay more if you use an out-of-network provider.

DENTAL BENEFITS SUMMARY

	BASE PLAN	BUY-UP PLAN
	IN-NETWORK ONLY	IN-NETWORK AND OUT-OF-NETWORK[1]
Calendar Year Deductible ▪ Individual ▪ Family	 $50 $150	 $50 $150
Calendar Year Benefit Maximum Per Individual	$750	$1,250
	YOU PAY	YOU PAY
Preventive Services Cleanings, complete series X-rays, exams	$0	$0
Basic Services Simple extractions, fillings, palliative treatment	60%	20%
Major Services Bridges, crowns, dentures, oral surgery, endodontics, periodontal maintenance	75%	50%
Orthodontia Children up to age 26	Not covered	50% $1,000 lifetime maximum
EMPLOYEE MONTHLY CONTRIBUTIONS		
Employee	$12.84	$30.70
Employee & Spouse	$21.81	$60.67
Employee & Child(ren)	$22.58	$62.84
Employee & Family	$31.38	$87.31

[1] You will be reimbursed up to the Maximum Allowable Charge (MAC) for services received from an out-of-network dentist. You are responsible for charges in excess of the MAC.

Carrier:	Network:
Mutual of Omaha	Mutually Preferred

DENTAL DISCOUNT PROGRAM

In addition to our DPPO dental options, we offer a reduced fee-for-service program.

Carrier:

Quality Care Dental of America (QCD)

This is a dental discount program, not insurance. The program has no deductibles, coverage maximums, or claim forms. All you will pay is the negotiated discounted rate if you get care from an in-network QCD provider.

DENTAL DISCOUNT PROGRAM BENEFITS SUMMARY

QCD DENTAL DISCOUNT PROGRAM	
	IN-NETWORK ONLY YOU PAY
Per Appointment Fee	$8
Oral Exam	$9
Teeth Cleaning	$24
Full Mouth X-ray	$28
Amalgam (one surface)	$28
Root Canal	$185
Porcelain with Metal Crown	$350
Upper or Lower Denture	$400
Lab Fee	20% off additional charge
EMPLOYEE MONTHLY CONTRIBUTIONS	
Employee Employee & Spouse Employee & Child(ren) Employee & Family	$0 $8.00 $10.00 $12.00

FIND AN IN-NETWORK PROVIDER

Visit **www.qcdofamerica.com**.

Call **800-229-0304**.

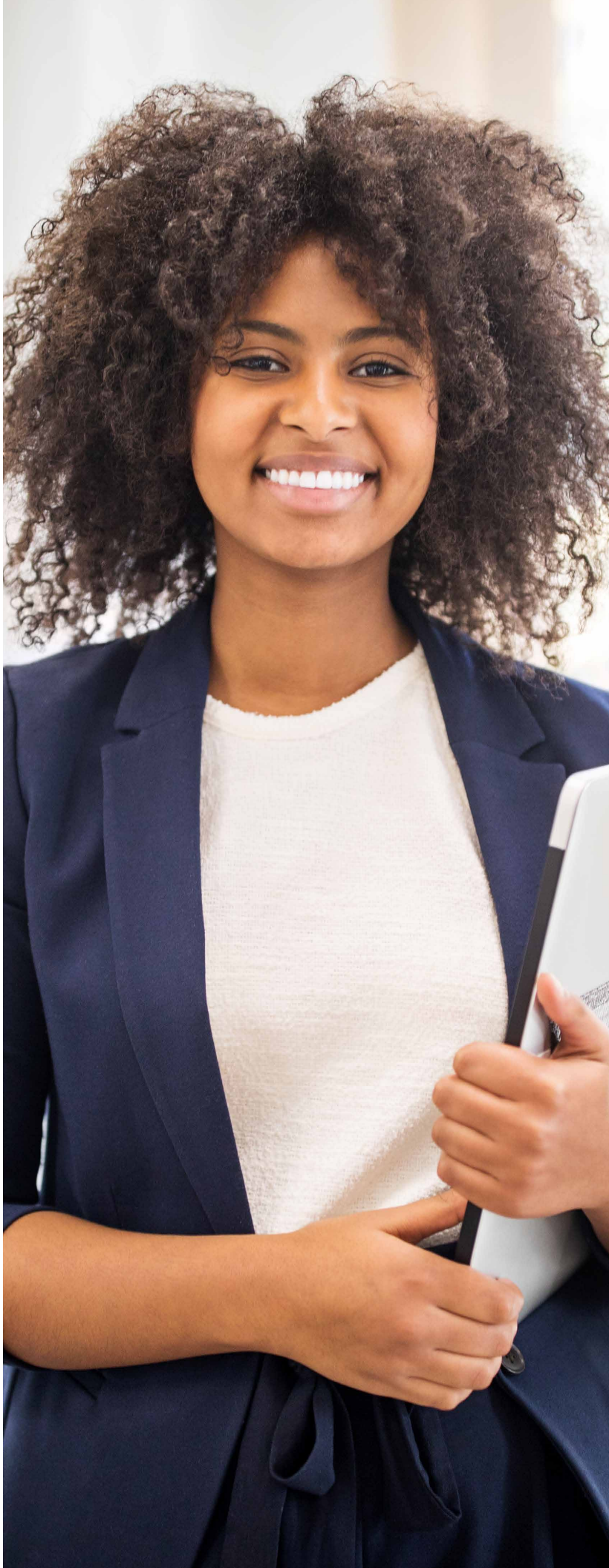
HEALTH SAVINGS ACCOUNT

Offset your HDHP health care costs, reduce your taxes, and get a long-term tax-advantaged savings account.

A Health Savings Account (HSA) is like a personal savings account that allows you to pay for current or future health care expenses with pretax dollars or save the funds for retirement. The funds can also be used for your dependents, even if they are not covered by the HDHP. An HSA is always yours to keep, even if you change health plans or jobs.

TRIPLE TAX BENEFITS

1. Tax-free contributions
2. Tax-free growth
3. Tax-free withdrawals



HEALTH SAVINGS ACCOUNT

Administrator:

HSA Bank

HSA ELIGIBILITY

You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP (e.g., spouse's health plan)
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits

Note: You may have an HSA at the financial institution of your choice, but only accounts opened through HSA Bank are eligible for automatic payroll deductions and company contributions.

TWO WAYS TO USE YOUR HSA

USE THE MONEY NOW

Pay for qualified out-of-pocket medical, dental, and vision expenses as they are incurred.

INVEST OVER TIME

Invest and grow your HSA dollars tax-free. You can use the funds to pay for qualified expenses later.

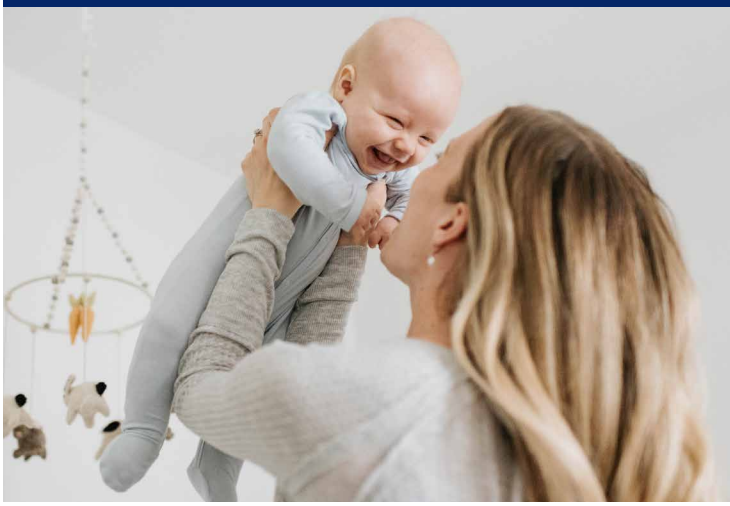
HOW TO PAY OR GET REIMBURSED

- Use your HSA debit card to pay for qualified expenses.
- Pay out-of-pocket and submit your receipts for reimbursement online or through the app.

GET MORE INFORMATION OR SUBMIT RECEIPTS

Visit **www.hsabank.com**.

Call **800-357-6246**.



CONTRIBUTIONS

You may contribute up to the IRS annual maximum. Your employer also makes a contribution to your HSA that totals the following annual amount:

2026 MAXIMUM HSA CONTRIBUTIONS

	EMPLOYER	EMPLOYEE	TOTAL
Individual	$350	$4,050	**$4,400**
Family	$350	$8,400	**$8,750**

If you are age 55 or older, you can contribute an extra $1,000.

Note for new account holders: Once you select the HDHP and elect your desired contribution amount, HSA Bank will contact you to complete the Customer Identification Program. This step must be completed to successfully open your HSA.

FLEXIBLE SPENDING ACCOUNTS

Set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. We offer the following Flexible Spending Accounts (FSAs).

Administrator:

Lively

HEALTH CARE FSA

The Health Care FSA covers qualified medical, dental, and vision expenses for you and your eligible dependents. Eligible expenses include:

- Deductibles, copays, and coinsurance
- Prescription drugs
- Braces, glasses, and contacts
- Hearing aids and batteries

If you enrolled in an HDHP and contribute to an HSA, you may not contribute to a Health Care FSA.

LIMITED PURPOSE HEALTH CARE FSA

If you enroll in the HDHP medical plan and contribute to an HSA, you can use a Limited Purpose Health Care FSA to pay for eligible out-of-pocket dental and vision expenses only, such as:

- Dental and orthodontia care (fillings, X-rays, braces)
- Vision care (eyeglasses, contact lenses, LASIK)

DEPENDENT CARE FSA

The Dependent Care FSA helps pay expenses associated with caring for children under age 13 and elder dependents so you or your spouse can work or attend school full-time.

DEPENDENT CARE FSA GUIDELINES

- To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.
- You can use funds for daycare or babysitter expenses for your children under age 13, but only for the part of the year when the child is under 13.
- Only day camps – not overnight camps – can be considered for reimbursement.
- You can use funds for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

FLEXIBLE SPENDING ACCOUNTS

HOW TO PAY OR GET REIMBURSED

- Use your FSA debit card (excludes the Dependent Care FSA).

OR

- Pay out-of-pocket, and submit your receipts for reimbursement.

Health Care FSAs and Limited Purpose Health Care FSAs allow you to carry over up to $680 into the next plan year.

Visit **fsastore.com** for an array of FSA-eligible products.

GET MORE INFORMATION OR SUBMIT RECEIPTS

Visit **www.livelyme.com/fsa**.

Call **888-576-4837**.

MAXIMUM FSA CONTRIBUTIONS

ACCOUNT TYPE	2026 ANNUAL CONTRIBUTION LIMITS
Health Care FSA You have access to all your FSA funds right away.	**$3,400**
Limited Purpose Health Care FSA You have access to all your FSA funds right away.	**$3,400**
Dependent Care FSA Reimbursement is limited to the total amount deposited in your account at that time.	**$7,500** (single parent filing head of household; or married filing jointly) **$3,750** (married filing separately)

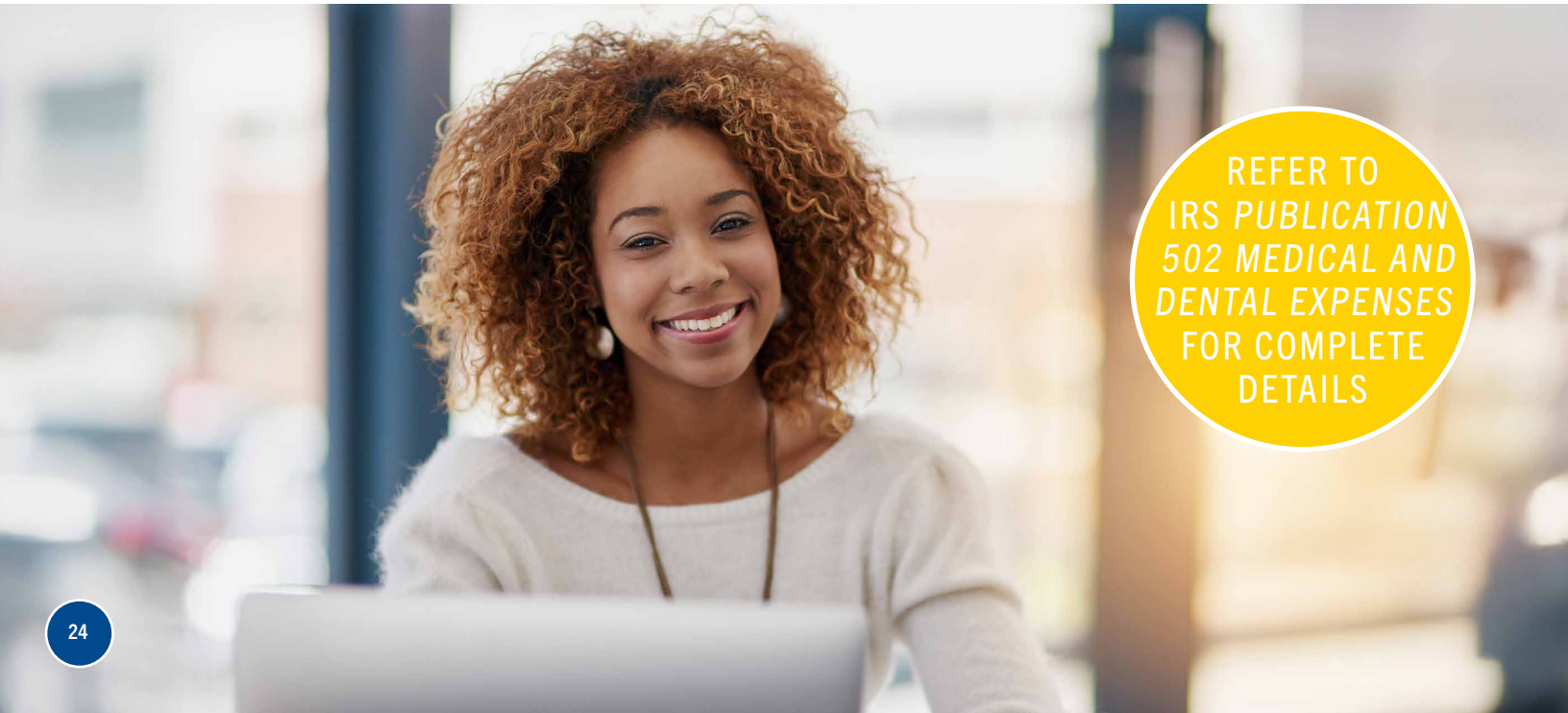
QUALIFIED HSA AND FSA EXPENSES

The list below shows some medical expenses that are eligible for payment under your Health Care FSA, Limited Purpose Health Care FSA, or HSA.*

This list is not all-inclusive; additional expenses may qualify and the items listed may change in accordance with IRS regulations. Refer to IRS *Publication 502 Medical and Dental Expenses* at **www.irs.gov** for complete details.

- Abdominal supports
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Contact lenses
- Convalescent home (for medical treatment only)
- Crutches
- Dental treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultraviolet ray treatment
- Vaccines
- Vitamins (if prescribed)
- Wheelchair
- X-rays

* Excludes Dependent Care FSA.



DISABILITY INSURANCE

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We offer Short Term Disability (STD) and Long Term Disability (LTD) at **no cost to you**. Employees become eligible first of the month after 90 days of employment.

EMPLOYER-PAID SHORT TERM DISABILITY

STD coverage pays a percentage of your weekly salary if you are temporarily disabled and unable to work due to an illness, pregnancy, or non-work-related injury. STD benefits are not payable if the disability is due to a job-related injury or illness. If a medical condition is job-related, it is considered workers' compensation, not STD.

SHORT TERM DISABILITY BENEFITS	
Benefits Begin	31st day
Percentage of Earnings You Receive	60%
Maximum Weekly Benefit	$1,155
Maximum Benefit Period	22 weeks
Pre-existing Condition Exclusion	12/12[1]

[1] Benefits may not be paid for any condition treated within 12 months prior to your effective date until you have been covered under this plan for 12 months.

EMPLOYER-PAID LONG TERM DISABILITY

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for a specific period of time. Benefits begin at the end of an elimination period and continue while you are disabled up to the maximum benefit period.

LONG TERM DISABILITY BENEFITS	
Benefits Begin	181st day
Percentage of Earnings You Receive	60%
Maximum Monthly Benefit	$10,000
Maximum Benefit Period	RBD to SSNRA[1]
Pre-existing Condition Exclusion	3/12[2]

[1] Required Beginning Date or Social Security Normal Retirement Age

[2] Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

Carrier:

Mutual of Omaha

LIFE AND AD&D INSURANCE

COVERAGE IS PORTABLE!

Life and Accidental Death and Dismemberment (AD&D) insurance are important to your financial security, especially if others depend on you for support or vice versa.

Carrier:
Mutual of Omaha

With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies). Life and AD&D coverage amounts reduce to 65% at age 70, and to 50% at age 75.

Both Basic and Voluntary coverages offer an accelerated death benefit (75% of benefit amount).

BASIC LIFE AND AD&D

Basic Life and AD&D insurance are provided at no cost to you. You are automatically covered at $20,000 for each benefit.

DESIGNATING A BENEFICIARY

A beneficiary is the person or entity you elect to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary, and you can change beneficiaries anytime. If you name more than one beneficiary, you must identify how much each beneficiary will receive (e.g., 50% or 25%).

VOLUNTARY LIFE AND AD&D

If you need more coverage than Basic Life and AD&D, you may buy Voluntary Life and AD&D for yourself and your dependent(s). If you do not elect Voluntary Life and AD&D insurance when first eligible, or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before covering your spouse and/or child(ren).

NEW! TRUE OPEN ENROLLMENT

Since we are moving to Mutual of Omaha, you may enroll for or increase your Voluntary Life and AD&D coverage up to the Guaranteed Issue amount without Evidence of Insurability (EOI), or proof of good health. This opportunity is only available at Open Enrollment. If your existing coverage exceeds the Guaranteed Issue amount, it will be grandfathered. If you decline this opportunity and enroll for or increase your coverage at a later date, EOI may be required.

VOLUNTARY LIFE AND ADD	
Employee	▪ Increments of $10,000 up to $500,000 (not to exceed five times base annual earnings) ▪ Guaranteed Issue $100,000
Spouse	▪ Increments of $5,000 up to $250,000 not to exceed 100% of employee amount ▪ Guaranteed Issue $25,000
Child(ren)	▪ Birth to 14 days – $100 ▪ 15 days to 6 months – $1,000 ▪ Six months to age 26 – increments of $2,000 up to $10,000 ▪ Guaranteed Issue $10,000

VOLUNTARY LIFE AND AD&D RATES

LIFE	MONTHLY RATES PER $1,000		
EMPLOYEE AND SPOUSE[1]			
AGE	RATE	AGE	RATE
<29	$0.053	55-59	$0.510
30-34	$0.055	60-64	$0.779
35-39	$0.077	65-69	$1.366
40-44	$0.115	70-74	$2.450
45-49	$0.190	75+	$4.480
50-54	$0.303		
CHILD(REN)			
To age 26	$0.230		

AD&D	MONTHLY RATES PER $1,000
Employee	$0.02
Spouse	$0.02
Child(ren)	$0.02

[1] Spouse rate is based on employee's age.

WHOLE LIFE INSURANCE WITH LONG TERM CARE

Combines Whole Life insurance with living benefits to help with the high cost of Long Term Care (LTC).

Carrier:

The Standard

Group Whole Life (GWL) offers permanent life insurance with a long term care benefit to all eligible employees. Coverage includes living benefits to help pay for home health care, assisted living, nursing home, and adult day care services.

GWL accrues a cash value over time which can be used to cover annual premiums, take a policy loan, or make a withdraw. Having a combination of term coverage and permanent portable coverage is a good strategy for current and post-retirement needs!

Voluntary term coverage can more than triple in premium from ages 44-55. Insurance reductions to the face amount also begin at age 65. Buying a permanent, portable policy with locked-in rates may be a good option!

This coverage does not replace any employer-provided or optional life coverage.

HIGHLIGHTS

- 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
- Coverage is portable at the same rates and benefits if you retire or leave employment.
- The Long Term Care Benefit 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 LTC benefits are used.
- $10,000 Children's Term Rider is $4.55 monthly and covers all children to age 26.
- GWL builds cash value over time.

NEWLY HIRED ACTIVELY AT WORK EMPLOYEES CAN ELECT UP TO $100,000 TO AGE 70 AND ELECT A FLAT $15,000 POLICY FOR THEIR SPOUSE.

MONTHLY RATES

	EMPLOYEE						SPOUSE
FACE AMOUNT	**$10,000**	**$20,000**	**$30,000**	**$50,000**	**$70,000**	**$100,000**	**$15,000[2]**
MONTHLY LTC[1]	**$400**	**$800**	**$1,200**	**$2,000**	**$2,800**	**$4,000**	**$600**
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

[1] Monthly Long Term Care benefit pays up to 25 months and does not reduce the Life Insurance amount.

[2] New hire spouse rate for the Guarantee Issue $15,000 policy.

SUPPLEMENTAL BENEFITS

ACCIDENT INSURANCE

Accident insurance provides affordable protection against a sudden, unforeseen accident.

Carrier:
Mutual of Omaha

Accident insurance helps offset the direct and indirect expenses such as copayments, deductibles, ambulance, physical therapy, childcare, rent, and other costs not covered by traditional health plans. You will be paid a specific sum of money directly based on the care and services provided for your covered accident. Use the money any way you see fit. **See the plan document for full details.**

ACCIDENT	
Ambulance ▪ Ground ▪ Air	 $300 $1,500
Urgent Care	$225
Emergency Room	$300
Hospital Admission	$2,000
Hospital Confinement	$400 per day up to 365 days
Intensive Care Unit	$800 per day up to 30 days
Specific Sum Injuries Concussions, dislocations, eye injuries, fractures, lacerations, ruptured discs, burns, dental care, and more	$75-$15,000
Accidental Death & Dismemberment[1] ▪ Employee ▪ Spouse ▪ Child(ren)	 $50,000 $25,000 $10,000

EMPLOYEE MONTHLY CONTRIBUTIONS	
Employee	$14.24
Employee & Spouse	$24.61
Employee & Child(ren)	$36.18
Employee & Family	$47.38

[1] Percentage of benefit paid for dismemberment is dependent on type of loss.

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity insurance helps you with the high cost of medical care by paying you a cash benefit when you have an inpatient hospital stay or are admitted to an intensive care unit.

Carrier:
Mutual of Omaha

You decide how to use the cash, whether it's to pay for bills, gas, childcare or eldercare, medication, or other out-of-pocket expenses. **See the plan document for full details.**

HOSPITAL INDEMNITY	
Hospital Admission	$1,000
Intensive Care Unit Admission	$1,000
Hospital Confinement	$150 per day, up to 20 days per policy year
Intensive Care Unit Confinement	$300 per day, up to 20 days per policy year
Newborn Nursery	$75 per day, up to two days per policy year
Health Screening Benefit	$100 per insured person per policy year, up to six per family

EMPLOYEE MONTHLY CONTRIBUTIONS	
Employee	$15.96
Employee & Spouse	$27.58
Employee & Child(ren)	$22.88
Employee & Family	$40.45

SUPPLEMENTAL BENEFITS

CRITICAL ILLNESS INSURANCE

Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness or cancer.

Carrier:
Mutual of Omaha

The plan provides a lump sum benefit payment to you upon first and second diagnosis of any covered critical illness or cancer. The benefit can help cover expenses such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs. **See the plan document for full details.**

CRITICAL ILLNESS	
Employee	$10,000 or $20,000 or $30,000
Spouse	$5,000 up to 100% of employee benefit amount up to $30,000
Child(ren)	Up to 50% of employee benefit amount, up to $15,000

CONDITION	FIRST OCCURRENCE BENEFIT
Full Coverage For conditions such as multiple sclerosis; Parkinson's disease; ALS (aka Lou Gehrig's disease); Alzheimer's disease; benign brain tumor; coma/brain injury; invasive cancer; heart attack; organ failure; loss of sight, speech, or hearing; paralysis; stroke	100%
Partial Coverage For conditions such as carcinoma in situ, cardiac arrhythmia, coronary artery disease, pulmonary embolism, infectious diseases	25%
Wellness Benefit One per covered person per calendar year	$100

MONTHLY RATES PER $1,000			
AGE	RATE	AGE	RATE
<25	$0.427	55-59	$2.662
25-29	$0.497	60-64	$3.661
30-34	$0.625	65-69	$5.036
35-39	$0.877	70-74	$6.785
40-44	$1.131	75-79	$9.327
45-49	$1.525	80+	$14.198
50-54	$2.043		

Employee and spouse premiums are calculated with the employee's age as of the effective date of the plan. Rates are adjusted once each year on the plan anniversary date that coincides with or follows the day an employee reaches the starting age of the next age band. Please note that the employee and spouse premiums are combined and reflected as a single total monthly premium amount.

Child insurance is automatic. A separate premium is not required.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program helps you and family members cope with a variety of personal and work-related issues.

Administrator:

Mutual of Omaha

This program provides confidential counseling and support services at little or no cost to you to help with:

- Relationships
- Work-life balance
- Stress and anxiety
- Will preparation and estate resolution
- Grief and loss
- Childcare and eldercare issues
- Substance abuse
- Financial and legal matters
- And more

GET MORE INFORMATION

Visit **www.mutualofomaha.com/eap**.

Call **800-316-2796**.

SUPPORT AT ANY HOUR OF THE DAY OR NIGHT

THE EAP IS AVAILABLE TO YOU AT NO COST

GET THREE IN-PERSON OR VIRTUAL COUNSELING SESSIONS PER YEAR (PER HOUSEHOLD) FROM AN EXCLUSIVE PROVIDER NETWORK.

RETIREMENT PROGRAMS

A 401(a) plan and a 403(b) plan can be powerful tools to help you be financially secure in retirement and help you reach your investment goals.

Administrator:
TIAA

401(A) PLAN

You are eligible to participate in the 401(a) plan if you are age 21 or older and have worked for TXWES for at least 12 months and have 1,000 hours of service during that 12-month period.

ENROLLMENT

You will be automatically enrolled when you become eligible. TIAA will notify you in writing when your enrollment is complete. The summary plan description will be distributed by Human Resources.

CONTRIBUTIONS

If you are an eligible employee, you will get a 2% universal contribution for your account (see plan document for details and exclusions). TXWES may also match up to an additional 6% to the plan, based on your contribution to your 403(b) plan. TXWES's discretionary match is up to 6%.

401(A) VESTING

You are always 100% vested in your own contributions. You are 100% vested in matching company contributions after five years of service.

401(A) VESTING SCHEDULE	
COMPLETED YEARS OF SERVICE[1]	PERCENT VESTED
1 Year	20%
2 Years	40%
3 Years	60%
4 Years	80%
5 Years	100%

[1] To earn a year of service, you must be credited with at least 1,000 hours of service during a plan year.

403(B) PLAN

If you are a regular employee, you can 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 have contributions deducted from each paycheck.

ENROLLMENT

You are eligible upon hire but must enroll via the TIAA portal at **www.tiaa.org/txwes**. Enrollment in the 403(b) plan is not automatic.

CONTRIBUTIONS

You specify the amount you want to contribute into the 403(b) account and direct how the contributions are invested.

2026 403(B) IRS CONTRIBUTION LIMITS

- $24,500
- $32,500 (ages 50-59 and 64+)
- $35,750 (ages 60-63 as of December 31 each year)

403(B) VESTING

You are immediately 100% vested in the plan.

GET MORE INFORMATION

Visit **www.tiaa.org/txwes**.

Call **800-842-2252**.

UNIVERSAL CONTRIBUTION AND MATCH AMOUNTS ARE REVIEWED ANNUALLY AND ARE SUBJECT TO CHANGE.

ADDITIONAL BENEFITS

TUITION WAIVER

TXWES is proud to offer eligible employees a **Tuition Waiver** benefit, which should be considered part of your total compensation package. This benefit is available to you, your spouse, and your children (natural, adopted, stepchildren or children under legal guardianship). Fees and incidental expenses are not included.

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 at **www.txwes.edu/hr** or in the Offices of Human Resources. 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. Contact the Office of Financial Aid at **817-531-4420** or visit **www.txwes.edu/financialaid** for details.

CREDIT UNION

As a TXWES employee, you may open banking account(s) with **Educational Employees Credit Union (EECU)**. Membership is available with a $5 share deposit and includes payroll deduction for savings. Loans are also available. Contact Human Resources for details.

TEXAS WESLEYAN DINING SERVICES

Texas Wesleyan Dining Services – administered by Aramark – offers a staff and faculty meal plan that is $110 for 20 meals. The meal plan may be used from August through May every academic year. The meal plan is designed to encourage community gathering with a deeply discounted rate that can be used throughout the semester. To purchase the meal plan, please visit the cashier's stand in Dora's Café.

UNIVERSITY ID CARD AND 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 ID cards must be surrendered upon request or at termination of employment.

If you are a full-time faculty or staff employee, 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.

ADDITIONAL BENEFITS

FITNESS CENTER

The following are available for you to use at no cost:

- TXWES's recreational facilities in the Sid W. Richardson Center (gym and pool).
- Tennis courts on the north side of the main campus.
- Exercise equipment in TXWES's Morton Fitness Center.

MORTON FITNESS CENTER COST 6-MONTH MEMBERSHIP	
Students	$0
Faculty/Staff	$0
Alumni	$100
Spouse Only	$100
Locker Fee	$25

Call the Student Life Department at **817-531-4872** to confirm hours of operation.

TRAVEL ASSISTANCE

AXA Assistance USA provides travel assistance for you and your dependents if you are traveling on any single trip up to 120 days in length, more than 100 miles from home. Contact a representative to get trip planning assistance; translation, interpreter, or legal services; lost baggage assistance; emergency funds; document replacement; medical emergency help; and more. Services are available for business and personal travel.

- For inquiries within the USA, call **800-856-9947**.
- From outside the USA, call **312-935-3658**.

This benefit is available at no cost to you.

IDENTITY THEFT SERVICES

The **Identity Theft Assistance** program, provided by **AXA Assistance** at no additional cost, helps you understand the risks of identity theft and how to prevent it. If your information is compromised, a representative will connect you with the needed resources. Case managers are also available 24/7 to help with an ID theft issue. Call AXA Assistance at **800-856-9947** to learn more. Exclusions and limitations apply.

This benefit is available at no cost to you.

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

For more information regarding eligibility for holidays and break days, please see the holiday, break day, and closings policies in the *TXWES Employee Handbook*.

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:

- Monday, Tuesday, and Wednesday before Thanksgiving Day
- Friday following Thanksgiving Day
- and the five workdays between Christmas Day and New Year's Day.

The president may designate other break days, and may 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.

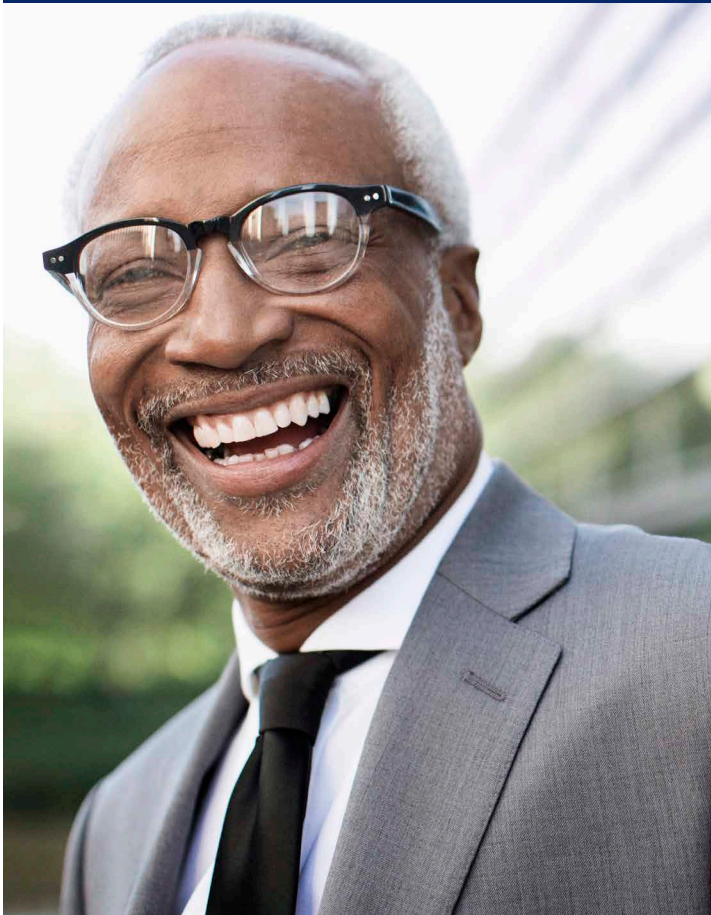
ELIGIBILITY

All full-time regular employees are eligible for Spring Break, Thanksgiving holiday/break, and Christmas holiday/break provided they are on payroll and work their regularly scheduled hours or have an excused paid absence at least seven calendar days immediately prior to and immediately after the commencement and conclusion of the holiday/break.

If you claim sick time during these time periods, you may be required to provide a health care provider's statement to be paid for the holiday.

LEAVE

TXWES provides full-time regular employees 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 the *TXWES Employee Handbook* for details.



IMPORTANT NOTICES

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Texas Wesleyan University
Office of Human Resources
1201 Wesleyan Street
Fort Worth, TX 76105
817-531-4403

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 enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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 the Texas Wesleyan University medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Texas Wesleyan University at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Texas Wesleyan University prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

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

Contact the Human Resources Department at **817-531-4403**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

IMPORTANT NOTICES

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 whether or not you are required to pay a higher premium (a penalty).

April 1, 2026
Texas Wesleyan University
Office of Human Resources
1201 Wesleyan Street
Fort Worth, TX 76105
817-531-4403

Notice of HIPAA Privacy Practices

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Texas Wesleyan University's Group Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

1. Your past, present, or future physical or mental health or condition;
2. The provision of health care to you; or
3. The past, present, or future payment for the provision of health care to you.

I. Contact Information

If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact:

Texas Wesleyan University
Office of Human Resources
1201 Wesleyan Street
Fort Worth, TX 76105
817-531-4403

II. Effective Date

This Notice is effective February 15, 2026.

III. Our Responsibilities

We are required by law to:

1. maintain the privacy of your PHI;
2. provide you with certain rights with respect to your PHI;
3. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
4. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

IV. How We May Use and Disclose Your PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient.

For Treatment. When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

IMPORTANT NOTICES

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Substance Use Disorder (SUD) Treatment Information. Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

As Required by Law. We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose PHI to certain employees of the Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

V. Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your PHI for public health activities. These activities generally include the following:

1. to prevent or control disease, injury, or disability;
2. to report births and deaths;
3. to report child abuse or neglect;
4. to report reactions to medications or problems with products;
5. to notify people of recalls of products they may be using;
6. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
7. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

IMPORTANT NOTICES

Law Enforcement. We may disclose your PHI if asked to do so by a law-enforcement official.

1. in response to a court order, subpoena, warrant, summons, or similar process;
2. to identify or locate a suspect, fugitive, material witness, or missing person;
3. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
4. about a death that we believe may be the result of criminal conduct; and
5. about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your PHI to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your PHI to researchers when:

1. The individual identifiers have been removed; or
2. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

VI. Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

Government Audits. We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

VII. Other Disclosures

Personal Representatives. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or
2. Treating such person as your personal representative could endanger you; and
3. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

VIII. Your Rights

You have the following rights with respect to your PHI:

Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your PHI, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. is not part of the medical information kept by or for the Plan;
2. was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
3. is not part of the information that you would be permitted to inspect and copy; or
4. is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

IMPORTANT NOTICES

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

IX. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

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 and you live in a State listed below, 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.insurekidsnow.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)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2026. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: http://www.myalhipp.com/
Phone: 1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

California– Medicaid

Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

Colorado – Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+)

Health First Colorado website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

Florida – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

IMPORTANT NOTICES

Georgia – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

Kansas – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

Maine – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

Massachusetts – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

Missouri – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana – Medicaid

Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

New Hampshire – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

North Carolina – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

North Dakota – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

Oklahoma – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon – Medicaid

Website: https://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

IMPORTANT NOTICES

Pennsylvania – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/chip/pages/chip.aspx
CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

South Carolina – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota - Medicaid

Website: https://dss.sd.gov
Phone: 1-888-828-0059

Texas – Medicaid

Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

Utah – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

Vermont– Medicaid

Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

Virginia – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

Washington – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

West Virginia – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)

Wisconsin – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

Wyoming – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since **January 31, 2026**, or for more information on special enrollment rights, can contact either:

U.S. Department of Labor
Employee Benefits 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

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the Texas Wesleyan University group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Texas Wesleyan University plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

Texas Wesleyan University
Office of Human Resources
1201 Wesleyan Street
Fort Worth, TX 76105
817-531-4403

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 have not 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 cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- 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 cannot balance bill you and may not ask you to give up your protections not to be balance billed.

IMPORTANT NOTICES

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not 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 have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1, 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

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Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit **www.HealthCare.gov** or call the Marketplace Call Center at **1-800-318-2596**. TTY users can call **1-855-889-4325**.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit **https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/** for more details.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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.

3. Employer Name:
Texas Wesleyan University

4. Employer Identification Number (EIN):
75-0800691

5. Employer Address:
1201 Wesleyan Street

6. Employer Phone Number:
817-531-4403

7. City:
Texas Wesleyan University

8. State:	**9. ZIP Code:**
TX	76105

10. Who can we contact at this job?:
Office of Human Resources

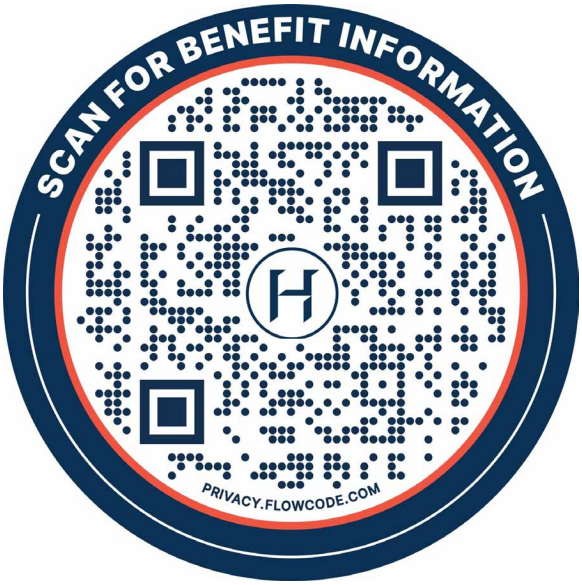
11. Phone Number (if different from above):

12. E-Mail Address:
HR@txwes.edu

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

[1] Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.



Higginbotham™

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 anytime.