## Important Contacts

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>CONTACT</th>
<th>PHONE NUMBER</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Blue Cross Blue Shield</td>
<td>800-521-2227</td>
<td><a href="http://www.bcbstx.com">www.bcbstx.com</a></td>
</tr>
<tr>
<td>Telemedicine</td>
<td>Teladoc</td>
<td>800-TELADOC</td>
<td><a href="http://www.teladoc.com">www.teladoc.com</a></td>
</tr>
<tr>
<td>HSA</td>
<td>HSA Bank</td>
<td>800-357-6246</td>
<td><a href="http://www.hsabank.com">www.hsabank.com</a></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>McGriff Insurance Services</td>
<td>800-768-4873</td>
<td><a href="http://www.mcgriffinsurance.com/flex">www.mcgriffinsurance.com/flex</a></td>
</tr>
<tr>
<td>Dental Discount Program</td>
<td>Quality Care Dental of America</td>
<td>800-229-0304</td>
<td><a href="http://www.gcdofamerica.com">www.gcdofamerica.com</a></td>
</tr>
<tr>
<td>Dental DHMO &amp; DPPO</td>
<td>Cigna</td>
<td>800-244-6224</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>Vision</td>
<td>Surency</td>
<td>866-818-8805</td>
<td><a href="http://www.surency.com">www.surency.com</a></td>
</tr>
<tr>
<td>Life/AD&amp;D Insurance</td>
<td>Blue Cross Blue Shield</td>
<td>877-442-4207</td>
<td><a href="http://www.bcbstx.com">www.bcbstx.com</a></td>
</tr>
<tr>
<td>Short Term &amp; Long Term</td>
<td>Blue Cross Blue Shield</td>
<td>877-442-4207</td>
<td><a href="http://www.bcbstx.com">www.bcbstx.com</a></td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>Accident / Critical Illness</td>
<td>800-521-3535</td>
<td><a href="http://www.allstatebenefits.com">www.allstatebenefits.com</a></td>
</tr>
<tr>
<td>Retirement</td>
<td>TIAA-CREF</td>
<td>800-842-2252</td>
<td><a href="http://www.tiaa-cref.org">www.tiaa-cref.org</a></td>
</tr>
<tr>
<td>Texas Wesleyan University</td>
<td>Human Resources</td>
<td>817-531-4403</td>
<td><a href="http://www.txwes.edu/HR">www.txwes.edu/HR</a></td>
</tr>
</tbody>
</table>

This brochure highlights the main features of the Texas Wesleyan University Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Texas Wesleyan University reserves the right to change or discontinue its employee benefits plans at any time.
Texas Wesleyan University’s most important asset is our people. That’s why we offer you an exceptional benefits program with many options, designed to meet your needs and the needs of your family. In this booklet you will find summaries of Texas Wesleyan University’s medical, dental, vision, disability, basic life and AD&D, voluntary life and worksite plans. This booklet contains important information about your benefits. Please take the time to review it and share the information with your family.

Table of Contents

4  Eligibility & Enrollment
6  Medical Coverage
10  Health Savings Account (HSA)
12  Teladoc
13  Flexible Spending Accounts (FSAs)
17  Dental Coverage
20  Vision Coverage
21  Disability Resource Services
22  Life and AD&D Insurance
24  Disability Insurance
25  Accident Coverage
26  Critical Illness
27  Identity Theft
29  Planning for Retirement
30  Time Off
31  Additional Benefits
33  Required Notices

Availability of Summary Health Information

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

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

The enrollment decisions you make will remain in effect April 1, 2022 through March 31, 2023. You may make changes to your benefit elections only when you have a Qualified Life Event. After such an event, you can make changes to your coverage within 30 days; otherwise, you cannot make changes to your benefit coverage until the next Open Enrollment period. Open Enrollment is a time period each year during which you may add or drop your medical insurance or make additional changes to your benefits coverage.

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

Eligible Dependents include:

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

Enroll online at www.Benefitfirst.com

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

Call the Benefitfirst Customer Care Center – If you have technical questions or would like to enroll by phone, please call 888-322-0374 and use Company ID 765 to speak with an Enrollment Specialist.

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

Qualified Life Events

Once you elect your benefit options, they remain in effect for the entire plan year until Open Enrollment. You may only change coverage during the plan year if you have a Qualified Life Event and you must do so within 30 days of the event.

Qualified Life Events include:

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

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

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

Employee contributions are made on a pre-tax basis through payroll deductions. Actual take-home pay is determined by the level of coverage selected. Note: Benefits deducted on a pre-tax basis lower your earnings and may reduce Social Security benefits. There is a new Buy-Up PPO option that provides a richer benefit to you.

How to find Your BCBS Providers

1. Log onto the BCBS website at [www.bcbs.tx.com](http://www.bcbs.tx.com) on your computer.
2. You are now in the Blue Access for Members. You can search by name or provider type.

<table>
<thead>
<tr>
<th>Health Coverage Reminder</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Patient Protection and Affordable Care Act (PPACA) requires most individuals that have minimum essential health coverage. You may obtain coverage through your employer or through the Marketplace. Visit <a href="http://www.healthcare.gov">www.healthcare.gov</a> for Marketplace information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical and Prescription Monthly Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS HSA</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Employee Only</td>
</tr>
<tr>
<td>$58.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
</tr>
<tr>
<td>Employee + Family</td>
</tr>
</tbody>
</table>

**REMINder:** You may only purchase insurance through the Marketplace during Open Enrollment OR if you experience a qualifying event. The Federal Marketplace Open Enrollment dates are from November 1 through December 15th. Additionally, an executive order has been passed by President Biden that opens up a Special Open Enrollment from March 7th to March 11th, 2022 for Marketplace eligible consumers.
If you elect to purchase a Formulary/Non-Formulary Brand Name drug when “Brand Medically Necessary” is not indicated and a Generic equivalent is available, you will be required to pay the difference between the cost of the Generic and Formulary/Non-Formulary Brand Name drug, plus the Formulary Brand Name copay.

- To locate a Retail Pharmacy, go to [www.myprime.com](http://www.myprime.com)
- The Formulary Drug list is available at [www.bcbstx.com/member/rx_drugs.html](http://www.bcbstx.com/member/rx_drugs.html)
- Specialty Drugs are available through Prime Specialty Pharmacy at 877-627-6337

### BCBS HSA

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum (Includes Deductible, Coinsurance and Copays)</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$6,550</td>
</tr>
<tr>
<td>Family</td>
<td>$13,100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance / Copays</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>$0 (Covered at 100%)</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>20% after ded.</td>
</tr>
<tr>
<td>Specialist</td>
<td>20% after ded.</td>
</tr>
<tr>
<td>Diagnostics, X-ray and Lab</td>
<td>20% after ded.</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>20% after ded.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>20% after ded.</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>20% after ded.</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>20% after ded.</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>20% after ded.</td>
</tr>
</tbody>
</table>

### PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Rx – Up to 30-day supply</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Formulary Brand Name</td>
</tr>
<tr>
<td>Non-Formulary Brand Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order Rx – Up to 90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Formulary Brand Name</td>
</tr>
<tr>
<td>Non-Formulary Brand Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Care Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Formulary Brand Name</td>
</tr>
<tr>
<td>Non-Formulary Brand Name</td>
</tr>
</tbody>
</table>
### BCBS Base PPO

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (Includes Deductible, Coinsurance and Copays)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Family</td>
<td>$12,000</td>
<td>$20,000</td>
</tr>
<tr>
<td><strong>Coinsurance / Copays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>$0</td>
<td>40% after ded.</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$30 copay</td>
<td>40% after ded.</td>
</tr>
<tr>
<td>Specialist</td>
<td>$50 copay</td>
<td>40% after ded.</td>
</tr>
<tr>
<td>Diagnostics, X-ray and Lab</td>
<td>$0</td>
<td>40% after ded.</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>20% after ded.</td>
<td>40% after ded.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75 copay</td>
<td>40% after ded.</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Facility: $200 copay + 20% no ded.</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Physician</td>
<td></td>
<td>20% after ded.</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>20% after ded.</td>
<td>40% after ded.</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>20% after ded.</td>
<td>40% after ded.</td>
</tr>
</tbody>
</table>

### PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th></th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Rx – Up to 30-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Formulary Brand Name</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Non-Formulary Brand Name</td>
<td>$70 copay</td>
</tr>
<tr>
<td><strong>Mail Order Rx – Up to 90-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Formulary Brand Name</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Non-Formulary Brand Name</td>
<td>$175 copay</td>
</tr>
<tr>
<td><strong>Specialty Care Rx (Prime Pharmacy Only)</strong></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Formulary Brand Name</td>
<td></td>
</tr>
<tr>
<td>Non-Formulary Brand Name</td>
<td>$100 copay</td>
</tr>
</tbody>
</table>

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

- To locate a Retail Pharmacy, go to [www.myprime.com](http://www.myprime.com)
- The Formulary Drug list is available at [www.bcbstx.com/member/rx_drugs.html](http://www.bcbstx.com/member/rx_drugs.html)
- Specialty Drugs are available through Prime Specialty Pharmacy at 877-627-6337
If you elect to purchase a Formulary/Non-Formulary Brand Name drug when “Brand Medically Necessary” is not indicated and a Generic equivalent is available, you will be required to pay the difference between the cost of the Generic and Formulary/Non-Formulary Brand Name drug, plus the Formulary Brand Name copay.

- To locate a Retail Pharmacy, go to www.myprime.com
- The Formulary Drug list is available at www.bcbstx.com/member/rx_drugs.html
- Specialty Drugs are available through Prime Specialty Pharmacy at 877-627-6337
HSA (Health Savings Account)

What is an HSA Plan?
The Base CDHP is a consumer driven health plan that works in conjunction with a Health Savings Account.

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

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

<table>
<thead>
<tr>
<th>2022 IRS MAX CONTRIBUTIONS</th>
<th>CONTRIBUTION BY TEXAS WESLEYAN INTO EMPLOYEE’S HSA ACCOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Family</td>
</tr>
<tr>
<td>$3,650</td>
<td>$7,300</td>
</tr>
</tbody>
</table>

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

What happens to any remaining money in my HSA account at the end of the year?
Any unused funds in the account automatically roll over year after year. You won’t lose your money if you don’t spend it within the year.

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

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

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

**When will contributions to my account be available for withdrawal?**

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

**What expenses can I pay for with my HSA?**

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

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

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

**How can I keep track of my HSA balance?**

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

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

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

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

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

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

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

**Are there administrative fees associated with an HSA?**

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

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

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

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

Talk to a Doctor Anytime

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

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

When Can I Use Teladoc?

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

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

Get the Care You Need

Teladoc doctors can treat many medical conditions, including:

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

Meet Our Doctors

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

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

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

Talk to a Doctor Anytime ... Get Started Now

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

A great way to plan ahead and save money over the course of a year is to participate in our Flexible Spending Account (FSA) programs. These accounts allow you to put a portion of your salary, on a pre-tax basis, into reimbursement accounts. Pre-tax means the dollars you use for eligible expenses are not subject to Social Security tax, federal income tax and, in most cases, state and local income taxes. The money you would have paid in taxes can then be used to pay qualified expenses. When you enroll, you must decide how much to set aside for each account and you will need to estimate your expenses conservatively, as the law requires that you use your expenses during the plan year with the exception of a $570 rollover amount.

**Health Care Reimbursement Account**

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

**Dependent Care Reimbursement Account**

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

**Limited Health Care Reimbursement Account**

There is also a Limited Health Care Reimbursement for those employees enrolled in the HDHP/HSA Plan. Employees enrolled in this plan are allowed the option of a Limited FSA for which your pre-tax deductions can be used for dental and vision expenses only. Medical expenses should be paid through your HSA Account.
Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time. In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care, and that provider cannot be anyone considered your dependent for income tax purposes.

### How FSAs Work:

- **Estimate** what you will need for eligible out-of-pocket health care and/or dependent care expenses for the plan year or a portion thereof, depending upon your effective date of coverage. Estimate carefully and contribute only as much as you think you will need, subject to the plan limit.

- **Divide** your total estimated expenses by the number of paychecks you receive yearly, or portion thereof depending on your effective date of coverage. This is the amount that will be deducted from each paycheck and deposited into your non-interest-bearing account(s).

### Claims Forms and Direct Deposit

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

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

### Over-the-Counter Item Rule Reminder

Health care reform legislation requires that certain over-the-counter (OTC) items require a “prescription” in order to be considered an eligible Health Care Spending Account expense. You will only need to obtain a one-time prescription per OTC item for the 2022-2023 plan year.

<table>
<thead>
<tr>
<th>ACCOUNT TYPE</th>
<th>ELIGIBLE EXPENSES</th>
<th>ANNUAL CONTRIBUTION LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Reimbursement Account</td>
<td>Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over-the-counter medications)</td>
<td>Maximum contribution is $2,850 per year</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account</td>
<td>Dependent care expenses (such as day care, after-school programs or elder care programs) so you and your spouse can work or attend school full-time</td>
<td>Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)</td>
</tr>
</tbody>
</table>
FSAs Help You Save on Your Taxes

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

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

FSA Eligible Expenses

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

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

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

- **Hearing**
  - Hearing aids and batteries
  - Hearing exams

- **Lab Exams/Tests**
  - Blood and metabolism tests
  - Body scans
  - Cardiograms
  - Laboratory fees
  - X-rays

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

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

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

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

- **Therapy**
  - Alcohol and drug addiction
  - Counseling
  - Exercise programs
  - Hypnosis
  - Massage (medically necessary)
  - Occupational
  - Physical
  - Smoking cessation programs
  - Speech
  - Weight loss programs
Using The Mobile App

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

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

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

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

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

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

McGriff Insurance Services Benefit Access Visa Card

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

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

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

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

Dental Discount Program

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>You Pay*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exam</td>
<td>$9</td>
</tr>
<tr>
<td>Teeth Cleaning</td>
<td>$24</td>
</tr>
<tr>
<td>Full Mouth X-ray</td>
<td>$28</td>
</tr>
<tr>
<td>Amalgam (1 Surface)</td>
<td>$28</td>
</tr>
<tr>
<td>Root Canal</td>
<td>$185</td>
</tr>
<tr>
<td>Porcelain with Metal Crown</td>
<td>$350</td>
</tr>
<tr>
<td>Upper or Lower Denture</td>
<td>$400</td>
</tr>
</tbody>
</table>

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

1. [www.mycigna.com](http://www.mycigna.com)
2. Create username/password, or login with existing account information
3. Select Find Care and Costs
4. Click Doctor by Type
5. Select Dentist
6. An aggregate list by zip code will populate, please pick zip code.
7. Select Plan
   - If you are on the DHMO plan, select Cigna Dental Care Access
   - If you are on the DPPO, select Cigna Dental PPO or EPO
   - If you want to search for a particular provider, you may do so as well
8. Select Choose
9. Select from General Dentist, Pediatric Dentist or Orthodontist
10. A list of providers will generate

### DENTAL HMO (DHMO)

<table>
<thead>
<tr>
<th>Policy Year Maximum Benefit</th>
<th>DHMO (In-Network Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per person</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Policy Year Deductible</td>
<td>You Pay</td>
</tr>
<tr>
<td>Covered Services</td>
<td>None</td>
</tr>
</tbody>
</table>

- **Routine Office Visit**: $0
- **Preventive Services**: Scheduled Copay
- **X-ray**: Scheduled Copay
- **Routine Prophylaxis**: Scheduled Copay
- **Endodontics**: Scheduled Copay
- **Periodontics**: Scheduled Copay
- **Orthodontics**: (Adult and Child) Scheduled Copay

Please note that the DHMO has enhanced benefits effective 4/1/2022
### DENTAL PPO (DPPO)

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Maximum Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per person</td>
<td>$1,100</td>
<td>$1,100</td>
</tr>
<tr>
<td>Orthodontic Lifetime Maximum Benefit</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Covered Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class I Preventive &amp; Diagnostic Care</td>
<td>$0 (deductible waived)</td>
<td>$0 (deductible waived)</td>
</tr>
<tr>
<td>Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class II Basic Restorative Care</td>
<td>20%**</td>
<td>20%**</td>
</tr>
<tr>
<td>Full Mouth X-rays, Panoramic X-rays, Fillings, Oral Surgery, Simple Extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class III Major Restorative Care</td>
<td>50%**</td>
<td>50%**</td>
</tr>
<tr>
<td>Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class IV Orthodontics</td>
<td>50%**</td>
<td>50%**</td>
</tr>
</tbody>
</table>

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

** After deductible

### DENTAL MONTHLY CONTRIBUTIONS

<table>
<thead>
<tr>
<th></th>
<th>QCD</th>
<th>Cigna DHMO</th>
<th>Cigna DPPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Only</strong></td>
<td>$0.00</td>
<td>$12.27</td>
<td>$23.61</td>
</tr>
<tr>
<td><strong>Employee + Spouse</strong></td>
<td>$8.00</td>
<td>$20.85</td>
<td>$46.65</td>
</tr>
<tr>
<td><strong>Employee + Child(ren)</strong></td>
<td>$10.00</td>
<td>$21.59</td>
<td>$48.31</td>
</tr>
<tr>
<td><strong>Employee + Family</strong></td>
<td>$12.00</td>
<td>$30.00</td>
<td>$67.11</td>
</tr>
</tbody>
</table>
Vision Coverage provided through Surency

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

### VISION COVERAGE SUMMARY

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Base Plan</th>
<th>Buy-Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>You Pay</td>
<td>Reimbursement</td>
</tr>
<tr>
<td>Routine Eye Exam</td>
<td>$10 copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Materials</td>
<td>$25 copay</td>
<td>None</td>
</tr>
<tr>
<td>Single Lenses</td>
<td>$25 copay</td>
<td>Up to $25</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>$25 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>$25 copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Frames</td>
<td>$130 allowance</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Contacts</td>
<td>$130 allowance, 15% off balance over $130</td>
<td>Up to $90</td>
</tr>
</tbody>
</table>

**Benefit Frequency** - Frames and Contact allowance can be utilized in same benefit year.

- Exams: Once per 12 months
- Lenses: Once per 12 months
- Frames: Once per 24 months
- Contacts: Once per 12 months

### VISION MONTHLY CONTRIBUTIONS

<table>
<thead>
<tr>
<th></th>
<th>Base Plan</th>
<th>Buy-Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$4.36</td>
<td>$6.23</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$8.27</td>
<td>$11.85</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$8.71</td>
<td>$12.47</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$12.80</td>
<td>$18.33</td>
</tr>
</tbody>
</table>
Disability Resource Services™

Extra Help When It’s Needed Most

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

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

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

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

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

To Access Your Services

**Call:** 866-899-1363

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

**Online:** GuidanceResources.com

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

Disability Resource Services™

In the U.S. and Canada call
866-899-1363
TDD: 800-697-0353
guidanceresources.com
Enter Your Company ID: DISRES

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

**Basic Life and AD&D**

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

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

**Designating a Beneficiary**

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

**Voluntary Life**

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

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit</td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$10,000 increments up to $500,000 not to exceed 5x base annual earnings</td>
</tr>
<tr>
<td>Spouse</td>
<td>$5,000 increments up to the lesser of $250,000 or 50% of employee amount</td>
</tr>
</tbody>
</table>
| Child                  | Birth to 6 months: $1,000
                        | Age 6 months to 26 years: $2,000 increments up to $10,000               |

**Guarantee Issue**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$100,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>$25,000</td>
</tr>
<tr>
<td>Child</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

**Additional Information**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portable</td>
<td>Yes</td>
</tr>
<tr>
<td>Conversion</td>
<td>Yes</td>
</tr>
<tr>
<td>Accelerated Death Benefit</td>
<td>75% of benefit up to $250,000</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>AGE</th>
<th>MONTHLY EMPLOYEE RATE PER $10,000</th>
<th>MONTHLY SPOUSE RATE PER $10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Uni-Smoker</td>
<td>Uni-Smoker</td>
</tr>
<tr>
<td>&lt;24</td>
<td>$0.53</td>
<td>$0.75</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.53</td>
<td>$0.75</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.55</td>
<td>$0.80</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.77</td>
<td>$1.16</td>
</tr>
<tr>
<td>40-44</td>
<td>$1.15</td>
<td>$1.73</td>
</tr>
<tr>
<td>45-49</td>
<td>$1.90</td>
<td>$2.79</td>
</tr>
<tr>
<td>50-54</td>
<td>$3.03</td>
<td>$4.49</td>
</tr>
<tr>
<td>55-59</td>
<td>$5.10</td>
<td>$6.94</td>
</tr>
<tr>
<td>60-64</td>
<td>$7.99</td>
<td>$12.16</td>
</tr>
<tr>
<td>65-69</td>
<td>$13.66</td>
<td>$20.69</td>
</tr>
<tr>
<td>70-74</td>
<td>$24.50</td>
<td>$36.57</td>
</tr>
<tr>
<td>75-79</td>
<td>$44.80</td>
<td>$72.73</td>
</tr>
</tbody>
</table>

MONTHLY CHILD LIFE RATE PER $2,000: $0.460
EMPLOYEE AD&D PER $1,000: $0.020
SPOUSE AD&D PER $1,000: $0.060
CHILD AD&D PER $1,000: $0.020

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

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

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

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

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

Short Term Disability Insurance

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

Long Term Disability Insurance

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

<table>
<thead>
<tr>
<th>COVERAGE FOR</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term Disability/Salary</td>
<td>Covers 60% of your base annual earnings, up to $1,155 maximum per week for 22 weeks.</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>Covers 60% of your base annual earnings, up to $10,000 maximum per month. Benefit begins after 180 days of disability and continues to age 65 standard ADEAll.</td>
</tr>
</tbody>
</table>

Pre-Existing Condition

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

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

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

Use the Payment for What Matters Most

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

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

Filing a claim is easy.

- Claim forms are available both on Benefitfirst or on www.Allstatebenefits.com.
- You may fax your claim to 1-866-424-8482.
- You may mail your claim to:
  
  American Heritage Life Insurance Company  
  P.O. Box 43067  
  Jacksonville, Florida 32203-3067

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

<table>
<thead>
<tr>
<th>ACCIDENT MONTHLY CONTRIBUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
</tr>
<tr>
<td>Employee + Spouse</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>
Critical Illness

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

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

Payable Conditions Include:

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

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

<table>
<thead>
<tr>
<th>ATTAINED AGE MONTHLY PREMIUMS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>AGE</td>
</tr>
<tr>
<td>18-24</td>
</tr>
<tr>
<td>25-29</td>
</tr>
<tr>
<td>30-34</td>
</tr>
<tr>
<td>35-39</td>
</tr>
<tr>
<td>40-44</td>
</tr>
<tr>
<td>45-49</td>
</tr>
<tr>
<td>50-54</td>
</tr>
<tr>
<td>55-59</td>
</tr>
<tr>
<td>60-64</td>
</tr>
<tr>
<td>65-69</td>
</tr>
<tr>
<td>70-74</td>
</tr>
<tr>
<td>75-79</td>
</tr>
<tr>
<td>80+</td>
</tr>
</tbody>
</table>

EE + CH = Employee + Child(ren); and F = Family
Experian Identity Theft

IdentityWorks® – World-Class Identity Protection from Experian®

Safeguard Your Identity For a Brighter Future

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

Multiple levels of vital detection and support

Daily Credit Monitoring and Timely Alerts

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

U.S.-based Fraud Resolution Team

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

$1 Million Identity Theft Insurance²

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

Experian Credit Report

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

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

The IdentityWorks program includes:
- Credit monitoring
- Identity restoration
- Up to $1 million in Identity Theft Insurance

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

**Enrollment Steps for Adults & Minors:**

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

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

How the Retirement Plans Work

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

For 2022, according to federal law—if you are less than 50 years of age, you can defer a maximum of $20,500 into your 403(b) retirement plan. If you are 50 years old or older before calendar year-end, you may contribute a maximum of $27,000. You are immediately 100% vested in the plan.

401(a) plan—Suspended as of June 1, 2020

TXWES also offers a 401(a) retirement savings plan. If you are at least 21 years of age and have worked for TXWES for at least 12 months and 1,000 hours during that 12-month period, you are eligible to participate in the 401(a) retirement savings plan. All eligible employees receive a 2% universal contribution to the account. TXWES may also match up to an additional 6% to the plan, based on your contribution to your 403(b) plan. Effective June 2016, TXWES’s discretionary match is 6%. Participants are vested 20% for each year of service and are 100% vested after five years of service. To earn a year of service, you must be credited with at least 1,000 hours of service during a plan year.

- Universal Contribution and Match amounts are reviewed annually and are subject to change.
- The 2% universal contribution was reinstated as of June 1, 2021. The match remains suspended.
**Time Off**

**Vacation and Holidays**

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

TXWES observes and is typically closed on the following holidays:
- New Year’s Day
- Independence Day
- Martin Luther King, Jr.’s Birthday
- Labor Day
- Good Friday
- Thanksgiving Day
- Memorial Day
- Christmas Day

If you are a full-time employee, you will not work on the holidays listed above. You will be compensated at your regular hourly rate, which is based on your regularly scheduled number of hours for the day. If you are a full-time employee who works less than 40 hours on a regularly scheduled basis, you may not exceed your normal number of hours for the week without supervisory approval. That is, you may only exceed the normal workweek for hours actually worked — not including paid holidays hours.

If your regularly scheduled day off falls on a holiday or break day, your next regularly scheduled workday becomes the holiday. You would then be eligible for holiday pay or an additional day off within TXWES guidelines.

**Break Days**

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

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

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

**Eligibility**

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

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

**Leave**

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

**Tuition Waiver**

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

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

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

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

**Credit Union**

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

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

<table>
<thead>
<tr>
<th>Morton Fitness Center Cost (6-Month Membership)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
</tr>
<tr>
<td>Free</td>
</tr>
</tbody>
</table>

Free Services & Discounts

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

- **Library Services** — Faculty and staff members are eligible and encouraged to take advantage of the many free resources available in the library, including extended check-out privileges.

- **Campus Events** — You and your family members may be eligible for discounted admission to campus events, including on-campus fine arts performances and athletic events, as well as local special events and entertainment facilities.

- **Foodservice** — Texas Wesleyan Dining Services — administered by Aramark — offers the $5 Fridays program in Dora’s Café (located in Dora Roberts Hall) during the regular semester that provides all-you-care-to-eat lunch between 10:30 am to 2:00 pm. Meals served in Dora’s Café on other days or during other hours are full fare.

- **Bookstore** — TXWES’s main campus bookstore — managed by Follett College Stores, Inc. — provides you with a 10% discount on most items in the store, and TXWES receives a 20% discount on supplies.

University ID Card & Reserved Parking

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

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

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance. To request special enrollment or obtain more information, contact Risk Management at 817-531-4402.

WHCRA ENROLLMENT/ANNUAL NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Risk Management at 817-531-4402.

NEWBORNS’ ACT DISCLOSURE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for hospital length of stay in connection with childbirth for the mother or new born child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the cesarean section. It is possible that your provider, after consulting with the mother, from discharging the mother or her new born earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA)

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

NOTICE REGARDING WELLNESS PROGRAM FOR EMPLOYEES AND SPOUSES ON THE CITY’S MEDICAL PLAN

The City’s wellness program, is a voluntary wellness program available to all employees and their spouses, enrolled in the City’s medical insurance plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you, the employee, and your spouse (if on the City’s medical insurance plan), will be asked to complete a voluntary annual physical and biometric blood tests.

You are not required to participate in the blood test or other medical examinations. However, employees and spouses on the City’s medical plan, who choose to participate in the wellness program, will receive an incentive of $50 per month off their medical plan. The program is administered through federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you, the employee, and your spouse (if on the City’s medical insurance plan), will be asked to complete a voluntary annual physical and biometric blood tests.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting: Virgin Pulse at 888.671.9395

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the City may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make...
To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either: U.S. Department of Labor/Health & Human Services / Employee Benefits Security Administration/Centers for Medicare & Medicaid Services, www.dol.gov/agencies/ebsa - www.cms.hhs.gov / 1-866-444-EBSA (3272) - 1-877-267-2323, Menu Option 4, Ext. 61565

NOTICE FROM Texas Wesleyan University ABOUT 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 w ith Texas Wesleyan University and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

· Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

· Texas Wesleyan University has determined that the prescription drug coverage offered by Texas Wesleyan University is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Since your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Texas Wesleyan University coverage will be affected. For those individuals who elect Part D coverage, coverage under Texas Wesleyan University plan will end for the individual and all covered dependents. You can reelect coverage on Texas Wesleyan University plan during the next open enrollment if you later decide to drop the Part D coverage.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your coverage with Texas Wesleyan University and don’t enroll in Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug coverage later. If you go 63 continuous days or longer without creditable prescription drug coverage,
your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until next November to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE Contact our office for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare prescription drug plan, and if this coverage through Texas Wesleyan University changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Name of Entity/Sender: Texas Wesleyan University
Contact Person: Kim Stergio
Address: 1201 Wesleyan Street, Fort Worth, TX 76051
Phone Number: 817-531-4402

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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

What is the Health Insurance Marketplace?: The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2020 for coverage starting as early as January 1, 2021.

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

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

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

How Can I Get More Information?: For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

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

Here is some basic information about health coverage offered by this employer:

- Eligible employees are full time employees who work 30 hours per week.
- Eligible dependents include the employee’s spouse and eligible dependent children up to age 26.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

** NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the following plan(s) (referred to herein as the "Plan") create[s] or receive[s] about you:

TEXAS WESLEYAN UNIVERSITY EMPLOYEE HEALTH BENEFIT PLAN

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan’s privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan’s duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan’s privacy practices.

HOW THE PLAN WILL USE OR DISCLOSE YOUR PHI

Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right. When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI

(1) to the extent practicable, to the limited data set or
(2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual; uses or disclosures that are required by law; uses or disclosures that are for the Plan’s compliance with legal regulations; and uses and disclosures made pursuant to a valid authorization

The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan’s Operations. Your PHI may be used as part of the Plan’s health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances.

The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard. The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

To Individuals Involved in Your Care. The Plan is permitted to disclose your PHI to your family members, other relatives and your close personal friends involved in your health care or the payment for your health care if:
For Public Health Oversight Activities. When required to disclose your PHI when required for public health oversight activities, for example, to investigate complaints against providers or other activities necessary for appropriate oversight of government benefit programs (or, for example, to investigate Medicare or Medicaid fraud).

For Public Health Activities. The Plan may use or disclose your PHI as authorized by and to the extent necessary to comply with any applicable state laws that are more stringent than the Privacy Regulations. The Plan shall comply with all other applicable state laws to the extent such laws are more stringent than the Privacy Regulations.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with all applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

YOUR PRIVACY RIGHTS WITH RESPECT TO PHI

Right to Request Restrictions on PHI Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to health care items or services for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request.
The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set", for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend. You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, effective January 1, 2013, you can request an accounting of all disclosures by the Plan of your electronic PHI during the three years prior to the date of your request. Right to Receive Confidential Communications. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below. A Note About Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual;
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

THE PLAN'S DUTIES WITH RESPECT TO YOUR PHI

The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI. The Plan is required to abide by the terms of the notice that are currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice. The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of your unsecured PHI.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at 806.441.7122. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.
This brochure highlights the main features of the Texas Wesleyan University Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Texas Wesleyan University reserves the right to change or discontinue its employee benefits plans at any time.