FORT WORTH MUSEUM
SCIENCE AND HISTORY

2026 – 2027
EMPLOYEE BENEFITS GUIDE

SUPPORTING YOU.
EMPOWERING YOU.



SUPPORTING YOUR HEALTH

SUPPORTING YOUR WELL-BEING

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If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage.
Please see page 23 for more details.

Carrier	Customer Service	Web Site
Medical – BlueCross BlueShield	(877) 299-2377 (HMO) (800) 810-2583 (PPO)	www.bcbstx.com
Dental – BlueCross BlueShield	(877) 442-4207	www.bcbstx.com
Vision – EyeMed	(866) 939-3633	www.eyemedvisioncare.com
Life / Disability / Supplemental – Dearborn	(800) 721-7987	www.mydearborngroup.com
Employee Assistance Program – Guidance Resources	(866) 899-1363	www.guidanceresources.com
Employee Response Center – Higginbotham	(866) 419-3518	helpline@higginbotham.net

Welcome

We are pleased to offer a full benefits package to help protect your well-being and financial health. Read this guide to learn about the benefits available to you and your eligible dependents starting **October 1, 2026**.

Each year during Open Enrollment, you may make changes to your benefit plans. The benefit choices you make this year will remain in effect through **September 30, 2027**. Take time to review these benefit options and select the plans that best meet your needs. After Open Enrollment, you may only make changes to your benefit elections if you have a Qualifying Life Event.

Eligibility

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. **New hires**, your coverage is effective the **first of the month following 30 days** of employment. You will need **to complete enrollment within the first 15 days** of employment. **Current employees**, your open enrollment will occur annually. You may also enroll eligible dependents for benefits coverage. The cost to you for dependent coverage will vary depending on the number of dependents you enroll in the plan and the specific plans you choose. When covering dependents, you must select the same plans for your dependents as you select for yourself.

If you terminate your employment, your medical, dental, and vision benefits will terminate at midnight on the last day of the month of your termination date. Life and disability plans will terminate on date of termination.

Eligible Dependents Include

- Your legal spouse
- Children under the age of 26, regardless of student, dependency, or marital status
- Children over the age of 26 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

Availability of Summary Health Information

Your plan offers 3 health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available by contacting Human Resources.

Qualifying Life Events

Once you elect your benefit options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, some of which include:

- Marriage, divorce, legal separation, or annulment
- Birth, adoption, or placement for adoption of an eligible child
- Death of your spouse or child
- Change in your spouse's employment status that affects benefits eligibility
- Change in your child's eligibility for benefits
- Significant change in benefit plan coverage for you, your spouse, or child
- FMLA leave, COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order (QMCSO)

If you have a Qualifying Life Event and want to change your elections, you must notify Human Resources and complete your changes within 30 days of the event. You may be asked to provide documentation to support the change. Contact Human Resources for details.

Medical Coverage

The medical plan options through **BlueCross BlueShield** protect you and your family from major financial hardship in the event of illness or injury. You have a choice of 3 plans:

- **MTBCP626H**– This plan is a PPO HDHP.
- **MTBPA301H**– This plan is an HMO HDHP.
- **MTBEE568**– This plan is an HMO.

Preferred Provider Organization (PPO)

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

High Deductible Health Plan (HDHP)

An HDHP allows you to see any provider when you need care, and you will pay less for care when you go to in-network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account (see page 8)

Find an In-Network Provider

- Visit **www.bcbstx.com/go/bcppo**
- Call **800-810-2583**

Health Maintenance Organization (HMO)

With an HMO, you must seek care from in-network providers in the **BlueCross BlueShield** HMO network. The selection of a primary care physician is required, and you need a referral to see a specialist. Always confirm that your doctors and specialists are in-network before seeking care.

Find an In-Network Provider

- Visit **www.bcbstx.com/go/bpa**
- Call **877-299-2377**



Medical Coverage – HSA PPO

MTBCP626H		
Network	Blue Choice PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible • Individual • Family	 $5,500 $11,000	 $11,000 $22,000
Out-of-Pocket Maximum Includes deductible • Individual • Family	 $7,500 $15,000	 Unlimited Unlimited
	You Pay	
Preventive Care	$0	40%[1]
Telemedicine	$30 after deductible	N/A
Primary Care Physician	$30 after deductible	40%[1]
Specialist	$60 after deductible	40%[1]
Diagnostic Lab and X-ray	20% after deductible	40%[1]
Complex Imaging	20% after deductible	40%[1]
Urgent Care	20% after deductible	40%[1]
Emergency Room	20% after deductible	
Inpatient Hospital Services	20% after deductible	40%[1]
Outpatient Services	20% after deductible	40%[1]
Prescription Drugs – Retail Up to 30-day supply • Preferred generic • Non-preferred generic • Preferred brand name • Non-preferred brand name	 $5/$15[2] after deductible $15/$25[2] after deductible $50/$70[2] after deductible $100/$120[2] after deductible	 $15 + 50%[1] $25 + 50%[1] $700 + 50%[1] $120 + 50%[1]
Prescription Drugs – Mail Order Up to 90-day supply • Preferred generic • Non-preferred generic • Preferred brand name • Non-preferred brand name	 $15 after deductible $45 after deductible $150 after deductible $300 after deductible	 N/A N/A N/A N/A
Prescription Drugs – Specialty Up to 30-day supply • Preferred specialty • Non-preferred specialty	 $250 after deductible $350 after deductible	 $250 + 50%[1] $350 + 50%[1]

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

[2] The amount you pay at a preferred in-network pharmacy vs. a non-preferred in-network pharmacy. Visit **www.bcbstx.com** to locate preferred in-network pharmacies.

BlueCross BlueShield of Texas

Medical Coverage – HMO

MTBEE568	
Network	Blue Essentials
	In-Network
Calendar Year Deductible • Individual • Family	 $7,000 $14,000
Out-of-Pocket Maximum Includes deductible • Individual • Family	 $9,200 $18,400
	You Pay
Preventive Care	$0
Telemedicine	$40
Primary Care Physician	$40
Specialist	$60
Diagnostic Lab and X-ray	20% after deductible
Complex Imaging	20% after deductible
Urgent Care	$75
Emergency Room	$750 + 20% after deductible
Inpatient Hospital Services	20% after deductible
Outpatient Services	$100 + 20% after deductible
Prescription Drugs – Retail Up to 30-day supply • Preferred generic • Non-preferred generic • Preferred brand name • Non-preferred brand name	 $0/$10[1] $10/$20[1] $50/$70[1] $100/$120[1]
Prescription Drugs – Mail Order Up to 90-day supply • Preferred generic • Non-preferred generic • Preferred brand name • Non-preferred brand name	 $0 $30 $150 $300
Prescription Drugs – Specialty Up to 30-day supply • Preferred specialty • Non-preferred specialty	 $150 $250
Out-of-Network Benefits	Emergency Only Out-of-Network benefits

[1] The amount you pay at a preferred in-network pharmacy vs. a non-preferred in-network pharmacy. Visit www.bcbstx.com to locate preferred in-network pharmacies.

BlueCross BlueShield of Texas

Medical Coverage – HSA HMO

MTBPA301H	
Network	Blue Premier Access
	In-Network
Calendar Year Deductible • Individual • Family	 $7,500 $15,000
Out-of-Pocket Maximum Includes deductible • Individual • Family	 $7,500 $15,000
	You Pay
Preventive Care	$0
Telemedicine	$0 after deductible
Primary Care Physician	$0 after deductible
Specialist	$0 after deductible
Diagnostic Lab and X-ray	$0 after deductible
Complex Imaging	$0 after deductible
Urgent Care	$0 after deductible
Emergency Room	$0 after deductible
Inpatient Hospital Services	$0 after deductible
Outpatient Services	$0 after deductible
Prescription Drugs – Retail Up to 30-day supply • Preferred generic • Non-preferred generic • Preferred brand name • Non-preferred brand name	 $0 after deductible $0 after deductible $0 after deductible $0 after deductible
Prescription Drugs – Mail Order Up to 90-day supply • Preferred generic • Non-preferred generic • Preferred brand name • Non-preferred brand name	 $0 after deductible $0 after deductible $0 after deductible $0 after deductible
Prescription Drugs – Specialty Up to 30-day supply • Preferred specialty • Non-preferred specialty	 $xx $xx
Out-of-Network Benefits	Emergency Only Out-of-Network benefits

BlueCross BlueShield of Texas

Health Savings Account

A Health Savings Account (HSA) is a tax-exempt tool to supplement your retirement savings and to cover current and future health costs.

An HSA is a type of personal savings account that is always yours, even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and is spent tax-free if used to pay for current or future qualified medical expenses. There is no "use it or lose it" rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

HSA Eligibility

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

- Enrolled in an HSA-eligible HDHP (MTBCP626H and MTBPA301H)
- Not covered by another plan that is not a qualified HDHP, such as your spouse's health plan
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits

You can also use HSA funds to pay health care expenses for your dependents, even if they are not covered by the HDHP.

Opening an HSA

If you meet the eligibility requirements, you may open an HSA administered by the financial institution of your choice. You will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA.

Maximum Contributions

Your HSA contributions may not exceed the annual maximum amount established by the Internal Revenue Service. The 2026 annual contribution maximum is based on the coverage option you elect.

- **Individual** – $4,400
- **Family** – $8,750

You decide whether to use the money in your account to pay for qualified expenses or let it grow for future use. If you are 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 at any time during the plan year, you are eligible to make the catch-up contribution for the entire plan year.

Important HSA Information

- Always ask your network doctor to file claims with your medical, dental, or vision carrier so you will get the highest level of benefits. You can pay the doctor with your HSA debit card for any balance due.
- You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.
- You may open an HSA at the financial institution of your choice.

BCBSTX Resources

Blue Access for Members

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

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

To get started, log on to **www.bcbstx.com** and use the information on your BCBSTX ID card to complete the registration process.

Mobile App

The BCBSTX mobile app can help you stay organized and in control of your health anytime, anywhere. Log in from your mobile device to access your BAM account, including:

- Track account balances and deductibles
- Access ID card information
- Find doctors, dentists, and pharmacies

Well onTarget

Well onTarget gives you the tools and resources to create your personal journey no matter where you may be on your path to wellness.

The heart of Well onTarget is the member portal, available at **wellontarget.com**. It links you to a suite of inviting programs and tools.

It's easy to join the Fitness Program! Just call the toll-free number 888-762-BLUE (2583) Monday through Friday, between 7 a.m. and 7 p.m. CT

Wellness Program Questions?

Call Customer Service at **877-806-9380**

VIRTUAL VISITS

Get 24/7 Care, Anywhere

Call your doctor's office first. They may also offer telehealth consultations by phone or via video.

With virtual visits, the doctor is always in. Get 24/7 non-emergency care from a board-certified doctor by phone, online video, or mobile app from the privacy and comfort of your own home. Don't risk crowded waiting rooms, expensive urgent care or ER bills, or waiting weeks or more to see a doctor, when you can speak with a Virtual Visits within minutes.

The Virtual Visits benefit is a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Cold/Flu
- Fever
- Headaches
- Nausea
- Sinus Infections

Virtual visits with a licensed behavioral health therapist are available by appointment. Get virtual care for:

- Anxiety
- Depression
- Stress Management
- And more

Virtual Visit doctors can even send an e-prescription to your local pharmacy.



Health Care Options

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

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

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

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. You may participate in the FSA programs even if you waive Fort Worth Museum of Science and History medical benefits. We offer three different FSAs: two for health care expenses and one for dependent care expenses. **Higginbotham** is our FSA plan administrator. Plan Year runs January 1st through December 31st.

Health Care FSA

The Health Care FSA covers qualified medical, dental and vision expenses for you or your eligible dependents. You may contribute up to **$3,400** annually to a Health Care FSA and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may not contribute to a Health Care FSA if you make contributions to a Health Savings Account (HSA).

Limited Purpose Health Care FSA

A Limited Purpose Health Care FSA is available if you enrolled in the HDHP medical plan and contribute to an HSA. You can use a Limited Purpose Health Care FSA to pay for eligible out-of-pocket dental and vision expenses only, such as:

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

Dependent Care FSA

The Dependent Care FSA helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full-time. You can use the account to pay for day-care or babysitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.

Dependent Care FSA Guidelines

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 midyear, you may only request reimbursement for the part of the year when the child is under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

Important FSA Rules

- The maximum per plan year you can contribute to a Healthcare or Limited Purpose FSA is **$3,400**. The maximum per plan year you can contribute to a Dependent Care FSA is **$7,500** when filing jointly or head of household and **$3,750** when married filing separately.
- You cannot change your election during the year unless you experience a Qualifying Life Event.
- Your Health Care or Limited Purpose FSA debit card can be used for health care expenses only. If cannot be used to pay for dependent care expenses.
- The IRS has amended the “use it or lose it rule” to allow you to carry over up to **$680** in your Health Care FSA into the next plan year. The carryover rule does not apply to your Dependent Care FSA.

Flexible Spending Accounts

How the Health Care and Limited Purpose FSAs Work

When you incur a qualified health care expense, you can choose one of two reimbursement methods:

1. Use your FSA debit card to pay doctor visit and prescription copays. Your FSA will be charged the amount, and you will not need to submit a reimbursement request. Please note that if you use the debit card for anything other than a copay amount, you will need to submit an itemized receipt or an Explanation of Benefits. This information will be requested from you if necessary, and you will have 60 days to submit.
2. You can pay out of pocket, then submit your receipts to Higginbotham either online or by email.

How to Use the Debit Card

The FSA debit card allows you to pay for eligible health care expenses at the point of service and deducts funds directly from your Health Care Spending Account. This allows you to avoid waiting for reimbursement. 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 complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied. Should you need to submit a receipt for substantiation, you will receive an email or a Receipt Notification by mail. Always retain receipts for your records.

The debit card is automatically sent to new participants. If you are already a participant, keep your current card.

Your debit card cannot be used for dependent care expenses.

Higginbotham Portal

The Higginbotham Portal provides information and resources to help you manage your FSAs.

- Access plan documents, letters and notices, forms, account balances, contributions, and other plan information
- Update your personal information
- Look up qualified expenses
- Submit claims

Register on the Higginbotham Portal

Visit **https://flexservices.higginbotham.net** and click *Get Started*. Follow the instructions and scroll down to enter your information.

- Enter your Employee ID, which is your Social Security number with no dashes or spaces.
- Follow the prompts to navigate the site.
- If you have any questions or concerns, contact Higginbotham:
  - Phone – **866-419-3518**
  - Email – **flexclaims@higginbotham. net**
  - Fax – **866-419-3516**

Grace Period

You may continue to incur expenses through December 31, 2026, and must submit all claims by January 31, 2027, in order to qualify for reimbursement.

2027 FSA Enrollment

Your 2027 Flexible Spending Account open enrollment will occur annually in December.

Higginbotham Flex Mobile App

- **View accounts**: Includes detailed account and balance information
- **Card Activity**: Account information
- **SnapClaim**: File a claim and upload receipt photos directly from your smartphone
- **Manage Subscriptions**: Set up email notifications to keep up-to-date on all account and Health Care FSA debit card activity

Dental Coverage

Our dental plans help you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Coverage is provided through **BlueCross BlueShield**.

DPPO Plan

Two levels of benefits are available with the DPPO plan: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with in-network providers. You could pay more if you use an out-of-network provider. Deductible runs from January 1, 2027, to December 31, 2027

Find an In-Network Dentist

- **Visit** www.bcbstx.com and click on *Find Care*
- **Call** 877-442-4207

	Dental High Plan	Dental Low Plan
Network	BlueCare Dental	BlueCare Dental
Calendar Year Benefit Maximum Per Individual	$3,000	$1,000
Calendar Year Deductible • Individual • Family	 $25 $75	 $50 $150
	You Pay	**You Pay**
Type I - Preventive Services Exams, Routine Cleanings, Sealants, Space Maintainers	100%	100%
Type II - Basic Services	80% after deductible	80% after deductible
Type III – Major Services	50% after deductible	50% after deductible
Type IV - Orthodontia (Adult and children to age 19)	50% $2,000 lifetime maximum	Not Covered
Waiting Period	None	None
Out of Network Reimbursement	90th R&C[1]	90th R&C[1]

[1] Payment for covered services received from an out-of-network dentist is based on the 90th percentile of the usual and customary charge. BlueCross BlueShield bases the provider payment on what 90% of the dentists in your area or zip code charge, meaning you will pay more when you select an out-of-network provider.







Vision Coverage

Our vision plan offers quality care to help preserve your health and eyesight. Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems. You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see an in-network provider. Coverage is provided through **Dearborn** using the **EyeMed** vision network.

Find an In-Network Vision Provider

- **Visit** www.eyemedvisioncare.com
- **Call** 866-939-3633

Vision Plan Summary		
	In-Network You Pay	**Out-of-Network Reimbursement**
Exam	$10 copay	Up to $30
Lenses • Single vision • Lined bifocals • Lined trifocals • Lenticular	 $25 copay $25 copay $25 copay $25 copay	 Up to $25 Up to $40 Up to $55 Up to $55
Frames	20% off balance over $130 allowance	Up to $65
Contacts In lieu of frames and lenses • Medically Necessary • Elective	 Covered in full $130 allowance	 Up to $210 Up to $104
Benefit Frequency		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contacts	Once every 12 months	







Life and AD&D Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance through **Dearborn** are important to your financial security, especially if others depend on you for support or vice versa. With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts, such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies). Life and AD&D coverage amounts reduce by 35% at age 70 and an additional 15% at age 75.

Basic Life and AD&D

Basic Life and AD&D insurance are provided at ***no cost to you***. You are automatically covered up to 2 x's Annual Salary and can go up to $300,000 for each benefit. Benefits terminate at retirement.

Voluntary Life and AD&D

You may buy more Life and AD&D insurance for you and your eligible dependents. If you do not elect Voluntary Life and AD&D insurance when first eligible or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before you may elect coverage for your spouse or children. If you leave the company, you may be able to take the insurance with you.

Guaranteed Issue Amount applies to new hires and employees/dependents currently covered. All full-time benefits eligible employees may elect up to the Guarantee Issue amount at initial enrollment with no medical questions. Currently enrolled employees may increase coverage by $10,000 with no medical questions, up to the guaranteed issue amount.

Voluntary Life and AD&D	
Employee	• Increments of $10,000 up to a maximum of 5X your salary or $500,000 (whichever is less) • Guaranteed Issue: $50,000
Spouse	• Increments of $5,000 up to a maximum of $500,000 (Not to exceed 100% of employee amount). • Guaranteed Issue: $25,000
Child(ren)	• Birth to 6 months: $100 • 6 months to age 19 or to age 25 if a full-time student: May be purchased in $2,000 increments up to $10,000 (each child).
Plan Features	**Life Coverage**
Accelerated Death Benefit	You may receive up to 50% of your life benefit if you are terminally ill
Conversion	You may continue coverage on a direct pay basis should you leave FWMSH. You must apply and pay the premium within 30 days of termination.

Designating a Beneficiary

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

Voluntary Life and AD&D Rates

Voluntary Life and AD&D Rates			
Age	Employee per $10,000 Benefit		Spouse[1] per $,1000 Benefit
	Non-Tobacco	Tobacco	
<24	$0.94	$1.58	$0.112
25-29	$0.94	$1.58	$0.112
30-34	$1.08	$2.00	$0.136
35-39	$1.63	$3.02	$0.210
40-44	$2.26	$5.05	$0.358
45-49	$3.90	$8.67	$0.594
50-54	$7.02	$15.47	$0.952
55-59	$12.12	$20.55	$1.322
60-64	$17.38	$26.71	$1.880
65-69	$28.85	$52.94	$2.808
70-74	$44.55	$72.43	$4.678
75+	$119.15	$156.94	$11.24
Child(ren) per $1,000 Benefit			
To age 25		$0.267	

[1] Spouse rate is based on employee's age.
[2] Rates will automatically calculate in Benefits in Hand at the time of enrollment

Disability Insurance

Disability insurance through **Dearborn** provides partial income protection if you are unable to work due to a covered accident or illness. We offer Short Term Disability (STD) insurance for you to purchase, and Long-Term Disability (LTD) insurance is provided at no cost to you.

Short Term Disability

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

Voluntary Short Term Disability	
Benefits Begin	15th day
Percentage of Earnings You Receive Weekly	60%
Maximum Weekly Benefit	$1,000
Maximum Benefit Period	Up to 24 weeks
Pre-existing Condition Exclusion	xx/xx[1]

Rates per $10 of Weekly Benefit			
Age	**Rate**	**Age**	**Rate**
<20	$0.89	**45-49**	$0.74
20-24	$0.89	**50-54**	$0.86
25-29	$0.99	**55-59**	$1.16
30-34	$0.85	**60-64**	$1.49
35-39	$0.71	**65-69**	$1.69
40-44	$0.70	**70+**	$1.69

Statement of health will be required if you do not sign up during your initial enrollment eligibility period.

Long Term Disability

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 180 days. Benefits begin at the end of an elimination period and continue while you are disabled up to maximum benefit period.

Voluntary Long Term Disability	
Benefits Begin	181st day
Percentage of Earnings You Receive Monthly	60%
Maximum Monthly Benefit	$10,000
Pre-existing Condition Exclusion	3 months prior / 12 months insured







Supplemental Insurance

We offer you and your eligible family members the opportunity to enroll in additional coverage through **BlueCross BlueShield** that complements our traditional health care programs. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs, such as deductibles, coinsurance, travel expenses and non-medical related expenses. If you leave your employment, you can take these policies with you.

Accident Insurance

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

Accident Insurance	
Emergency Room	$150
Ambulance • Air • Ground	 $1,500 $200
Initial Hospitalization	$1,200
Hospital Confinement	$250 per day
Intensive Care Unit	$2,000
Intensive Care Unit Confinement	$500 per day
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	$100 - $12,500

Rates per Pay Period	
Employee	$5.98
EE + Spouse	$9.82
EE + Child(ren)	$11.50
EE + Family	$18.02

Hospital Indemnity Insurance

The Hospital Indemnity plan helps you with the high cost of medical care by paying you a set amount when you have an inpatient hospital stay. Unlike traditional insurance which pays a benefit to the hospital or doctor, this plan pays you directly based on the care or treatment that you receive. These costs may include meals and transportation, childcare or time away from work due to a medical issue that requires hospitalization. The chart below only lists a few benefits. See plan document for complete details.

Hospital Indemnity Insurance	
Initial Hospitalization	$1,000 once per year
Hospital Confinement	$100 per day
Intensive Care Unit	$1,000 once per year
Intensive Care Unit Confinement	$100 per day

Rates per Pay Period	
Employee	$8.73
EE + Spouse	$19.28
EE + Child(ren)	$14.71
EE + Family	$27.35

Supplemental Insurance

We offer you and your eligible family members the opportunity to enroll in additional coverage through **BlueCross BlueShield** that complements our traditional health care programs. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs, such as deductibles, coinsurance, travel expenses and non-medical related expenses. If you leave your employment, you can take these policies with you.

Critical Illness Insurance

Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness or cancer. The plan provides a lump sum benefit payment to you upon first and second diagnosis of any covered critical illness or cancer. The benefit can help cover expenses, such as lost income, out-of-town treatments, special diets, daily living and household upkeep costs. Note, the chart only lists a few of the benefits covered under these plans. See plan document for full details.

Critical Illness Insurance	
Employee	$5,000 increments up to $20,000
Spouse	$2,500 increments; max of $10,000, not to exceed 50% of Employee Amount
Child	$2,500 increments; max of $10,000, not to exceed 50% of Employee Amount
Guarantee Issue Amount	
Employee	$20,000
Spouse	$10,000
Child	$10,000
First Occurrence Benefit	
Full Coverage Alzheimer's Disease, Invasive Cancer, Heart Attack, Stroke, Heart, Kidney or Organ Failure, Heart Transplant, Coma, Paralysis, and more	100% of benefit amount
Partial Coverage Non-invasive Cancer, major heart surgery and more	25% of benefit amount
Wellness Benefit One per covered person per calendar year	$50

Rates per $1,000		
Age	**Employee**	**Spouse**
<30	$0.529	$0.822
30-39	$0.846	$1.186
40-49	$1.683	$2.053
50-59	$3.215	$3.607
60-64	$5.397	$5.794
65+	$8.470	$9.131

Employee Assistance Program

The Employee Assistance Program (EAP) from BlueCross BlueShield helps you and family members cope with a variety of personal or work-related issues. This program provides confidential counseling and support services at little or no cost to you to help with:

- Legal Assistance
- Financial Assistance
- Emotional Assistance
- Substance abuse
- Depression
- Grief and loss
- Stress and anxiety

Call **866-899-1363** or visit www.guidanceresources.com for support at any hour of the day or night.

Employee Response Center

Employee Response Center

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

* Enrollment support
* Benefits information
* Claims and billing questions
* Eligibility issues



Call or text **866-419-3518**.

Email **helpline@higginbotham.net**.

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

Se habla español.

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

How to Enroll

To begin the enrollment process, go to **www.benefitsinhand.com**

First time users: Follow steps 1-4

Returning users: Log in and start at step 5.

1	**First time users:** Click on the New User Registration link. Once you register, you will use your username and password to log in.
2	Enter your personal information and Company Identifier of **FWMSH** and click ***Next***.
3	Create a username (work email address recommended) and password, then check the ***I agree to terms and conditions*** *box before you click* ***Finish***.
4	If you used an email address as your username, you will receive a validation email to that address. You may now log in to the system.
5	**Returning users:** Click the ***Start Enrollment*** *button to begin the enrollment process.*
6	Confirm or update your personal information and click ***Save & Continue***.
7	Edit or add dependents who need to be covered on your benefits. Once all dependents are listed, click ***Save & Continue***.
8	Follow the steps on the screen for each benefit to select or decline coverage. To decline coverage, click ***Don't want this benefit?*** *and select the reason for declining.*
9	When you finish making your benefit elections, review your selections. If correct, click the ***Click to Sign*** *button to complete and submit your enrollment choices.*

Employee Contributions

				Your Benefit Costs
Medical – Tier I Those earning $60,000 or less annually				
	MTBCP626H	**MTBEE568**	**MTBPA301H**	
Employee	$238.53	$132.90	$44.39	**$**
EE + Spouse	$823.58	$588.79	$392.08	
EE + Child(ren)	$606.09	$419.31	$262.83	
EE + Family	$1,191.19	$875.24	$610.55	
Medical – Tier I Those earning $60,001 or more annually				
Employee	$276.03	$170.40	$81.89	
EE + Spouse	$861.08	$626.29	$429.58	
EE + Child(ren)	$643.59	$456.81	$300.33	
EE + Family	$1,228.69	$912.74	$648.05	
Dental				
	High Plan	**Low Plan**		
Employee	$25.75	$17.67		**$**
EE + Spouse	$51.47	$35.34		
EE + Child(ren)	$60.67	$41.49		
EE + Family	$94.42	$64.61		
Vision				
Employee	$3.80			**$**
EE + Spouse	$7.22			**$**
EE + Child(ren)	$7.60			**$**
EE + Family	$11.18			**$**
Basic Life and AD&D				
Employee Only	Paid by Fort Worth Museum of Science and History			**$0**
Voluntary Life and AD&D				
	See page 16 for rates			**$**
Disability				
Short Term	See page 17 for rates			**$**
Long Term	Paid by Fort Worth Museum of Science and History			**$**
Supplemental Benefits				
Accident	See page 18 for rates			**$**
Hospital Indemnity	See page 18 for rates			**$**
Critical Illness	See page 19 for rates			**$**
Your Total Benefit Cost				**$**

Legal Notices

Women's Health and Cancer Rights Act of 1998

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

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

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

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

Special Enrollment Rights

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

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

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

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

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Fort Worth Museum of Science and History
Human Resources
1600 Gendy Drive
For Worth, Texas 76107
(817) 255-9322

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Fort Worth Museum of Science and History and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Fort Worth Museum of Science and History has determined that the prescription drug coverage offered by the Fort Worth Museum of Science and History medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. The HSA plan is not considered Creditable Coverage.

Legal Notices

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

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

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

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

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

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

Contact the Human Resources Department at **(817) 255-9322**.

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

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

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

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

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

Fort Worth Museum of Science and History
Human Resources
1600 Gendy Drive
For Worth, Texas 76107
(817) 255-9322

Notice of HIPAA Privacy Practices

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

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

Legal Notices

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

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

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

I. Contact Information

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

Fort Worth Museum of Science and History
Human Resources
1600 Gendy Drive
For Worth, Texas 76107
(817) 255-9322

II. Effective Date

This Notice is effective February 15, 2026.

III. Our Responsibilities

We are required by law to:

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

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

IV. How We May Use and Disclose Your PHI

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

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

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

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

Legal Notices

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

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

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

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

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

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

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

V. Special Situations

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

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

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

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

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

1. to prevent or control disease, injury, or disability;
2. to report births and deaths;
3. to report child abuse or neglect;
4. to report reactions to medications or problems with products;

5. to notify people of recalls of products they may be using;

6. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

7. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

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

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

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

1. in response to a court order, subpoena, warrant, summons, or similar process;

2. to identify or locate a suspect, fugitive, material witness, or missing person;

3. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;

4. about a death that we believe may be the result of criminal conduct; and

5. about criminal conduct.

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

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

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

Research. We may disclose your PHI to researchers when:

1. The individual identifiers have been removed; or

2. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

VI. Required Disclosures

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

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

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

VII. Other Disclosures

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

1. You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or

2. Treating such person as your personal representative could endanger you; and

3. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Legal Notices

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

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

VIII. Your Rights

You have the following rights with respect to your PHI:

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

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

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

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

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

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

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

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

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

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

Legal Notices

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

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

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

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

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

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

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

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

IX. Complaints

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Legal Notices

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

Alabama – Medicaid

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

Alaska – Medicaid

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

Arkansas – Medicaid

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

California– Medicaid

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

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

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

Florida – Medicaid

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

Georgia – Medicaid

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

Indiana – Medicaid

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

Iowa – Medicaid and CHIP (Hawki)

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

Kansas – Medicaid

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

Kentucky – Medicaid

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

Legal Notices

Louisiana – Medicaid

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

Maine – Medicaid

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

Massachusetts – Medicaid and CHIP

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

Minnesota – Medicaid

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

Missouri – Medicaid

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

Montana – Medicaid

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

Nebraska – Medicaid

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

Nevada – Medicaid

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

New Hampshire – Medicaid

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

New Jersey – Medicaid and CHIP

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

New York – Medicaid

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

North Carolina – Medicaid

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

North Dakota – Medicaid

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

Oklahoma – Medicaid and CHIP

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

Oregon – Medicaid

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

Pennsylvania – Medicaid and CHIP

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

Rhode Island – Medicaid and CHIP

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

Legal Notices

South Carolina – Medicaid

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

South Dakota - Medicaid

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

Texas – Medicaid

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

Utah – Medicaid and CHIP

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

Vermont– Medicaid

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

Virginia – Medicaid and CHIP

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

Washington – Medicaid

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

West Virginia – Medicaid and CHIP

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

Wisconsin – Medicaid and CHIP

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

Wyoming – Medicaid

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

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Continuation of Coverage Rights Under COBRA

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

Plan Contact Information

Fort Worth Museum of Science and History
Human Resources
1600 Gendy
Drive For Worth,
Texas 76107
(817) 255-9322

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Legal Notices

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services – If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

Legal Notices

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

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

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

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

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

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

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

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

Legal Notices

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

PART B: Information About Health Coverage Offered by Your Employer

For more information about your coverage offered through your employment, please check your health plan's 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 www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

3. Employer Name: Fort Worth Museum of Science and History	
4. Employer Identification Number (EIN): 75-0755335	
5. Employer Address: 1600 Gendy Drive	
6. Employer Phone Number: (817) 255-9322	
7. City: For Worth	
8. State: TX	**9. ZIP Code:** 76107
10. Who can we contact at this job?: Human Resources	

As your employer, we offer a health plan to all eligible employees (see the Eligibility section of this guide). This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

FORT WORTH MUSEUM
SCIENCE AND HISTORY

This brochure highlights the main features of the 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. The right is reserved to change or discontinue the employee benefits plans at any time.

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