# 2024 EMPLOYEE BENEFITS GUIDE

A SUMMARY GUIDE TO YOUR BENEFITS

FORT WORTH MUSEUM
SCIENCE AND HISTORY

# BENEFITS OVERVIEW

CONTENTS:

# IMPORTANT CONTACTS

**Medical**
**BlueCross BlueShield**
**www.bcbstx.com**
877-299-2377 (HMO)
800-810-2583 (PPO)

**Dental**
**Sun Life**
**www.sunlife.com/us**
800-247-6875

**Vision Discount Program**
**VSP**
**www.vsp.com**
800-877-7195

**Life & Disability**
**Unum**
**www.unum.com**
866-679-3054

**Employee Assistance Program**
**Unum**
**www.lifebalance.net**
800-854-1446

**FSA/HRA**
**Higginbotham**
**flexservices.higginbotham.net**
866-419-3519

**Employee Response Center**
**Higginbotham**
866-419-3518

# WELCOME

## Our employees are our most valuable asset

This is why Fort Worth Museum of Science and History is committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

At Fort Worth Museum of Science and History we offer a comprehensive benefits package intended to protect your well-being and financial health. This guide is your opportunity to learn more about the benefits available to you and your eligible dependents beginning **October 1, 2024**.

Each year during Open Enrollment, you have the opportunity to make changes to your benefit plans. The enrollment decisions you make this year will remain in effect through **September 30, 2025**. You may make changes to your benefit elections only when you have a Qualifying Life Event. After such an event, you can make changes to your health care coverage within 30 days; otherwise, you cannot make changes to your benefits coverage until the next Open Enrollment period.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 24 for more details.

## 2024 HIGHLIGHTS

- **NEW!! Medical:** Medical coverage is moving to **BlueCross BlueShield**.
- **Dental:** Dental coverage will remain with **Sun Life**.
- **Vision:** Vision coverage will remain with **VSP**.
- **Company Paid Benefits:** Fort Worth Museum of Science and History will provide Basic Life/AD&D and Long-Term Disability coverage at no cost to you. Coverage will remain with **Unum**.
- **Voluntary Life/AD&D and Short-Term Disability:** For an additional cost, you may purchase coverage for yourself and family. Voluntary Life/AD&D and STD coverage will be provided by **Unum**.

# ELIGIBILITY

## WHO IS ELIGIBLE?

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 date of employment. **Current employees**, your open enrollment will occur annually during the month of September. 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 particular 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.

## ELIGIBILE DEPENDENTS

- Your legal spouse.
- Children under the age of 26, regardless of student status, dependency or marital status.
- Children who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return; coverage may continue past age 26.
- An unmarried child age 26 or older who is or becomes disabled and who is dependent upon you. A Statement of Dependent Eligibility must be completed and approved by the carriers.
- A child for whom healthcare coverage is required through a qualified medical child support order, other court order, or administrative order.

## ANNUAL ENROLLMENT & QUALIFYING LIFE EVENTS

The choices you make during Annual Enrollment will be effective from **October 1, 2024 through September 30, 2025**. Once you elect your benefit options, they will remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you experience a "**Qualifying Event**" and you must notify Human Resources within 30 days of the event. Be prepared to provide documentation to support the Qualifying Event.

## QUALIFYING LIFE EVENTS INCLUDE:

- Marriage, divorce, legal separation.
- Birth, adoption or placement for adoption of an eligible child.
- Death of a spouse or child.
- Change in your spouse's employment that affects benefits eligibility.
- Change in your child's eligibility for benefits (reaching the age limit).
- Change in residence that affects your eligibility for coverage.
- Significant change in coverage or cost in your, your spouse's or child's benefit plans.
- FMLA leave, COBRA event, Court Judgment or decree.
- Becoming eligible for Medicare or Medicaid.
- Receiving a Qualified Medical Child Support Order.

**AVAILABILITY OF SUMMARY HEALTH INFORMATION**

Your plan offers four health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available summarizing important information about your health coverage options in standard format. The SBC is available online at www.bcbstx.com or by contacting Human Resources.

# MEDICAL COVERAGE - *BlueCross BlueShield*

*Deductible runs from January 1, 2024 - December 31, 2024*

| Benefit | HSA QUALIFED PLANS | |
|---|---|---|
| **Type of Plan** | **HSA PPO** | **HSA HMO** |
| **Network** | **Blue Choice** | **Blue Advantage** |
| **Lifetime Maximum** | Unlimited | |
| **General Level of Coverage** | 100% | |
| **Calendar Year Deductible**<br>Individual / Family | $6,650 / $13,300 | $6,000 / $12,000 |
| **Maximum Out-of-Pocket**<br>Individual / Family | $6,650 / $13,300 | $6,000 / $12,000 |
| **Preventative Care** | Covered 100% | |
| **Physician Services**<br>Primary Care<br>Specialist Care<br>Virtual Visits | <br>100% after Deductible<br>100% after Deductible<br>100% after Deductible | |
| **Hospital/Emergency Services**<br>Inpatient<br>Emergency Room<br>Urgent Care | <br>100% after Deductible<br>100% after Deductible<br>100% after Deductible | |
| **Outpatient Services**<br>Diagnostic Lab & X-Ray<br>Outpatient Surgery<br>Complex Imaging | <br>100% after Deductible<br>100% after Deductible<br>100% after Deductible | |
| **Prescription Drugs***<br>Rx Deductible<br>Tier I<br>Tier II<br>Tier III<br>Tier IV<br>Mail Order (90 day supply) | Preferred / Non-Preferred<br>Integrated with Medical—After Deductible<br>100% after Deductible<br>100% after Deductible<br>100% after Deductible<br>100% after Deductible<br>100% after Deductible | |
| **OUT-OF-NETWORK BENEFITS** | | |
| Deductible (Individual/Family)<br>Out of Pocket Maximum (Ind/Fam)<br>Coinsurance | *$13,300 / $26,000*<br>*Unlimited*<br>*50/50* | *No Out-of-Network Benefits* |

**Lower copay if use Preferred Pharmacy. Preferred Pharmacies: Albertsons LLC, Brookshire's, HEB, Walgreens, Walmart/Sam's Club. CVS and Target are NOT contracted with BCBS. For a complete list of pharmacies, visit www.bcbstx.com*

**Blue Advantage HMO:** You must seek care from network providers in the Blue Advantage network. Member is required to designate a primary care physician (PCP) and obtain referrals to see specialists. Always confirm that your doctor and all specialists are in-network before seeking care. The plan does not include out-of-network coverage.

**Blue Choice PPO:** The member is not required to designate a primary care physician (PCP) and can utilize both in-network and out-of-network provider or facility.

# MEDICAL COVERAGE - *BlueCross BlueShield*

*Deductible runs from January 1, 2024 - December 31, 2024*

| Benefit | COPAY PLANS | |
|---|---|---|
| **Type of Plan** | **PPO** | **HMO** |
| **Network** | **Blue Choice** | **Blue Advantage** |
| **Lifetime Maximum** | Unlimited | |
| **General Level of Coverage** | 70/30 | |
| **Calendar Year Deductible**<br>Individual / Family | $3,000 / $9,000 | |
| **Maximum Out-of-Pocket**<br>Individual / Family | $7,350 / $14,700 | |
| **Preventative Care** | Covered 100% | |
| **Physician Services**<br>Primary Care<br>Specialist Care<br>Virtual Visits | <br>$50<br>$100<br>$0 | |
| **Hospital/Emergency Services**<br>Inpatient<br>Emergency Room<br>Urgent Care | <br>Deductible + 30%<br>$500 + Deductible + 30%<br>$75 | |
| **Outpatient Services**<br>Diagnostic Lab & X-Ray<br>Outpatient Surgery<br>Complex Imaging | <br>$0<br>Deductible + 30%<br>Deductible + 30% | |
| **Prescription Drugs***<br>Rx Deductible<br>Tier I<br>Tier II<br>Tier III<br>Tier IV<br>Mail Order (90 day supply) | Preferred / Non-Preferred<br>None<br>$0 / $10<br>$10 / $20<br>$50 / $70<br>$100 / $120<br>3 X Preferred Copay | |
| **OUT-OF-NETWORK BENEFITS** | | |
| Deductible (Individual/Family)<br>Out of Pocket Maximum (Ind/Fam)<br>Coinsurance | *$6,000 / $18,000*<br>*Unlimited*<br>*50/50* | *No Out-of-Network Benefits* |

**Lower copay if use Preferred Pharmacy. Preferred Pharmacies: Albertsons LLC, Brookshire's, HEB, Walgreens, Walmart/Sam's Club. CVS and Target are NOT contracted with BCBS. For a complete list of pharmacies, visit www.bcbstx.com*

**Blue Advantage HMO:** You must seek care from network providers in the Blue Advantage network. Member is required to designate a primary care physician (PCP) and obtain referrals to see specialists. Always confirm that your doctor and all specialists are in-network before seeking care. The plan does not include out-of-network coverage.

**Blue Choice PPO:** The member is not required to designate a primary care physician (PCP) and can utilize both in-network and out-of-network provider or facility.

# MEDICAL RATES - *Semi-Monthly*

| TIER I - THOSE EARNING $50,000 OR LESS ANNUALLY | | | | |
|---|---|---|---|---|
| COVERAGE LEVEL | 6650 HSA PPO | 6000 HSA HMO | 3000 COPAY PPO | 3000 COPAY HMO |
| Employee Only | $92.61 | $0.90 | $226.03 | $71.01 |
| Employee + Spouse | $511.51 | $307.66 | $808.06 | $463.50 |
| Employee + Child(ren) | $355.80 | $193.63 | $591.71 | $317.61 |
| Employee + Family | $774.70 | $500.39 | $1,173.73 | $710.09 |

| TIER II - THOSE EARNING $50,001-$80,000 ANNUALLY | | | | |
|---|---|---|---|---|
| COVERAGE LEVEL | 6650 HSA PPO | 6000 HSA HMO | 3000 COPAY PPO | 3000 COPAY HMO |
| Employee Only | $127.61 | $35.90 | $261.03 | $106.01 |
| Employee + Spouse | $546.51 | $342.66 | $843.06 | $498.50 |
| Employee + Child(ren) | $390.80 | $228.63 | $626.71 | $352.61 |
| Employee + Family | $809.70 | $535.39 | $1,208.73 | $745.09 |

| TIER III - THOSE EARNING $80,001 OR MORE ANNUALLY | | | | |
|---|---|---|---|---|
| COVERAGE LEVEL | 6650 HSA PPO | 6000 HSA HMO | 3000 COPAY PPO | 3000 COPAY HMO |
| Employee Only | $137.61 | $45.90 | $271.03 | $116.01 |
| Employee + Spouse | $556.51 | $352.66 | $853.06 | $508.50 |
| Employee + Child(ren) | $400.80 | $238.63 | $636.71 | $362.61 |
| Employee + Family | $819.70 | $545.39 | $1,218.73 | $755.09 |

# PROVIDER FINDER

## Know Your Health Plan

**Health plans like Blue Advantage HMO℠ and Blue Choice PPO℠ contract with groups of doctors, hospitals and other health care professionals who provide a full range of covered health care services.** These are called provider networks. When looking for a provider, it's important to know about your network and the choices you have.

- Your health plan or network is shown on the front of your member ID card.
- Call the customer service number on the back of your card if you have questions about your network.


**Only Go to the ER for Emergencies**

If your illness or injury is serious or life-threatening, call 911 or go to the nearest emergency room – you don't have to stay in-network.

## Know Your Health Plan

### Tips for HMO Health Plan Members

1. **Always see your Primary Care Physician (PCP) first.** When you apply for Blue Advantage HMO coverage, you will choose or be assigned a PCP.
   - Your PCP is a partner in keeping you healthy.
   - Your child's pediatrician can be their PCP.
   - Female members can choose an OB/GYN for their PCP.
2. **Stay in-network.** Except for emergencies, if you get care from an out-of-network provider, you will be responsible for the full cost of care – in most cases.
   - Use Provider Finder® to find doctors, specialists, hospitals and pharmacies in your network.
   - Register or log in to Blue Access for Members℠ (BAM℠) to personalize your search based on your health plan and network.
3. **Get a referral for a specialist.** If you need focused care for a medical condition, your PCP will refer you to a specialist.
   - Check Provider Finder to make sure the specialist is in your network.
   - You don't need a referral to see your in-network OB/GYN.

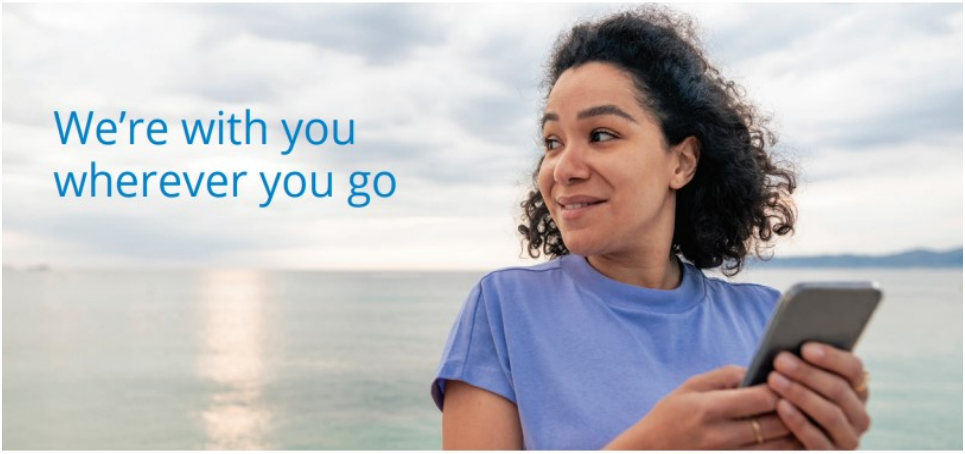
### Tips for PPO Health Plan Members

1. **Stay in-network.** If you visit a doctor or hospital that is not in your network, your share of the health care costs will be higher in most cases. Here are some ways to control your costs:
   - Use Provider Finder to find doctors, specialists, hospitals and pharmacies in your network.
   - Register or log in to BAM, our secure member website, for a personalized search based on your health plan and network.
2. **You can partner with your PCP too.** Your Blue Choice PPO plan doesn't require you to choose a PCP – but having a regular doctor has its benefits.
   - Your PCP knows your health history, medical concerns and the prescription medications you take — so they can help you make more effective decisions about your care.
   - If you need to see a specialist, your PCP can help you find one that's right for your specific needs.
3. **Get Prior Authorization.** Certain tests and services may need to be pre-approved.
   - In-network doctors are responsible for requesting Prior Authorization.
   - Your doctor or you can call the Prior Authorization number on the back of your ID card.

**Know Before You Go**

Before you get care, make sure you know how your plan works, what's covered and where to go. **It can save you time and money.**

# BLUE ACCESS FOR MEMBERS (BAM)




**Download the Blue Cross and Blue Shield of Texas (BCBSTX) App to manage your health wherever you are.**

- Find an in-network doctor, hospital or urgent care facility
- Access your claims, coverage and deductible information
- View or print your member ID card
- Log in securely with your fingerprint or face recognition*
- View your Explanation of Benefits

**Then, Manage Your Preferences**

**In the BCBSTX App:**

- Update your profile with your mobile number.
- Set your notification preferences to text.

**Choose the messages and information you want to get:**

- Claims, prior authorization or referral updates
- New documents to review
- Secure message notifications
- Find out about new benefits and services


Available in Spanish

**Ready to get started?** Text **BCBSTXAPP** to **33633**** to get the app.

Download on the App Store

GET IT ON Google Play


Scan this QR code to visit bcbstx.com.

# HEATH REIMBURSEMENT ARRANGEMENT (HRA)

***Administered by Higginbotham***

A Health Reimbursement Arrangement (HRA) is an employer-funded health care account from which you can be reimbursed – tax free – for qualified medical expenses.

Fort Worth Museum of Science and History currently offers employees covered under the medical plan reimbursement of a portion of the medical deductible for a hospital admission.

## HOW THE PLAN WORKS

When you elect medical coverage Fort Worth Museum of Science and History will automatically establish an HRA in your name.

- The first time you or one of your dependents are admitted to the hospital, after making the payment, turn in an itemized receipt a your paid receipt to Higginbotham, and you will be reimbursed **$500** of your deductible. You must submit an HRA claim form along with the receipt.
- The Health Reimbursement Arrangement will not reimburse any out-of-network expenses.
- Claim forms are located in the back of the Section 12 handbook as well as in Benefits in Hand.

## ELIGIBLE MEDICAL EXPENSES

You can use your HRA to pay for:

- Qualified medical expenses for you and your covered dependents
- Any combination of deductible, coinsurance or copay expenses

## SUBMITTING A CLAIM

You can submit documentation for reimbursement under the HRA the following ways:

**Email** - flexclaims@higginbotham.net

**Online** - https://flexservices.higginbotham.net

**Fax** - (866) 419-3516

**Questions?** Call (866) 419-3519

You must have the proper documentation in order to receive your reimbursement. Credit card receipts, canceled checks and balance due statements are not sufficient to receive reimbursement. You must attach a copy of the Explanation of Benefits (EOB) from www.bcbstx.com to the claim form in order to receive reimbursement. Get a claim form by logging into Benefits in Hand and going to the *Document Library*.

# HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is more than a way to help you and your family cover current medical costs – it is also a tax-exempt tool to supplement your retirement savings and to cover future health costs.

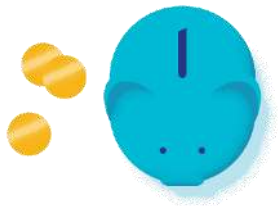
An HSA is a type of personal savings account that is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for current or future qualified medical expenses. There is no "use it or lose 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 HSA Plan
- 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 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.



## MAXIMUM CONTRIBUTIONS

Contributions to your HSA may not exceed the annual maximum amount established by the Internal Revenue Service. The annual contribution maximum is based on the coverage option you elect.

- **Employee Only** $4,150
- **Employee + Dependent** $8,300

Employees age 55 and older are allowed to make an additional annual "catch-up" contribution of up to $1,000.

## OPENING THE HSA

If you meet the eligibility requirements, you may open an HSA at a 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. Complete information regarding HSA is available through Human Resources.

## QUALIFIED MEDICAL EXPENSES (QME)

QME's are designated by the IRS and include medical, dental, vision, and prescription expenses. QMEs are subject to change by the IRS at any time. It is the employee's responsibility to verify that expenses incurred are designated by the IRS a QME, please visit the IRS website for more information.

### IMPORTANT HSA INFORMATION

- Always ask your health care provider to file claims with your medical provider so network discounts can be applied. You can pay the provider with your HSA debit card based on the balance due after discount.
- 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.

# HEALTHCARE OPTIONS

When you need medical attention, you should go to your primary care doctor whenever you can. Your doctor knows you best and has quick access to your medical records. However, there are times when you might need to go to a facility other than your doctor's office. This list shows examples of various care providers and the services they generally provide. The cost of medical care can vary widely. Your cost depends on where and how you receive care. Knowing the facts can help you manage your health and your health care dollars.

| HEALTH CARE PROVIDER | | SYMPTOMS | AVERAGE COST | AVERAGE WAIT |
|---|---|---|---|---|
| **NON-EMERGENCY CARE** | | | | |
|  **VIRTUAL VISITS** | 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<br>• Cough/cold/flu<br>• Rash<br>• Stomachache | **$** | **2-5 minutes** |
|  **DOCTOR'S OFFICE** | Generally, the best place for routine, preventive care; established relationship; able to treat based on medical history **Office hours vary** | • Infections<br>• Sore and strep throat<br>• Vaccinations<br>• Minor injuries, sprains and strains | **$** | **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<br>• Minor injuries<br>• Pregnancy tests<br>• 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<br>• Minor broken bones<br>• Small cuts that may require stitches<br>• Minor burns and infections | **$$** | **15-30 minutes** |
| **EMERGENCY CARE** | | | | |
|  **HOSPITAL ER** | Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility **24 hours a day, 7 days a week** | • Chest pain<br>• Difficulty breathing<br>• Severe bleeding<br>• Blurred or sudden loss of vision<br>• Major broken bones | **$$$$** | **4+ hours** |
|  **FREESTANDING ER** | Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week** | • Most major injuries except trauma<br>• Severe pain | **$$$$$$** | **Minimal** |

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

## *Administered by Higginbotham*

***Plan Year runs January 1st through December 31st***

One way to plan ahead and save money over the course of a year is to participate in our Flexible Spending Account (FSA) programs. FSAs allow you to pay for certain health, dental, vision and dependent care expenses with pretax dollars that reduce your taxable income and save you money. Our FSAs are administered by **Higginbotham**.

When you enroll, you must decide how much money to set aside from your paycheck for each account. Be sure to estimate your expenses conservatively as the IRS requires that you use the money in your account during the plan year and applicable grace period (the "use it or lose it" rule).

You may participate in the FSA programs even if you waive Fort Worth Museum of Science and History medical benefits.

### HEALTH CARE SPENDING ACCOUNT

The Health Care Spending Account allows employees to shelter up to **$3,200** of their annual income from taxes with the purpose of paying for out-of-pocket medical, vision, dental expenses such as copayments, coinsurance, and deductibles etc. Over-the-counter medications can be included.

You and your dependents do not need to be enrolled on your employer sponsored plans in order to be eligible to use these funds. Once you select an annual election amount, this amount is irrevocable and cannot be changed until the next open enrollment period. The only exception to this rule is if you experience a family status change.

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

**IMPORTANT:** If you elect to participate in the HDHP medical plan, you can enroll in the Limited Purpose FSA where only eligible dental and vision expenses are allowed for reimbursement.

### DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account helps pay for dependent/elder care expenses associated with caring for elder or child dependents in order for you or your spouse to work or attend school full-time. The dependent child must be under age 13 and claimed as a dependent on your federal income tax return, or a disabled dependent of any age incapable of caring for him or herself, and who spends at least eight hours a day in your home. You can contribute up to **$5,000** annually to the Dependent Care Spending Account.

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

| Health Care FSA | Limited Health Care FSA | Dependent Care FSA |
|---|---|---|
| • Set aside pretax dollars from each paycheck<br>• Contribute up to $3,200 annually<br>• Pay for eligible health care expenses such as office visit copays, deductible, prescription drugs, braces, dental and eye care expenses<br>• Is available only if you **do not** have a health savings account<br>• Is compatible with either medical plan | • Set aside pretax dollars from each paycheck<br>• Contribute up to $3,200 annually<br>• Pay for eligible dental and vision expenses<br>• Is available only if you **have** a health savings account<br>• Is compatible with either of the HDHP medical plans | • Set aside pretax dollars from each paycheck<br>• Contribute up to $5,000 annually<br>• Use for child or dependent elder care expenses<br>• Allows you and your spouse to work or attend school full time<br>• Can not be used to pay for dependent health care expenses |

# FLEXIBLE SPENDING ACCOUNTS

***Administered by Higginbotham***

## HOW THE HEALTH CARE FSA WORKS:

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 for the amount and you will not need to submit a request for reimbursement. 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.

**App:** download the Higginbotham Flex mobile app

**Email:** flexclaims@higginbotham.net

**Online:** https://flexservices.higginbotham.net

**Fax:** (866) 419-3516

## 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 be mailed a Receipt Notification. 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 can not be used for dependent care expenses.

## ROLLOVER RULE

Your FSA offers a "rollover" option which allows the participant to roll over up to **$640** at the end of each plan year. This amount is added to your new plan year election amount and you have all year to use this rollover money.

## GRACE PERIOD

You may continue to incur expenses through December 31, 2024, and must submit all claims by January 31, 2025 in order to qualify for reimbursement.

## 2025 FSA ENROLLMENT

Your 2025 Flexible Spending Account open enrollment will occur annually during the month of 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

## FSA STORE FOR ELIGBLE PRODUCTS

One-stop shopping for all your over-the-counter needs. The thousand of products that are available at FSAStore are all FSA eligible or eligible with a prescription and can be purchased with your FSA debit card or any major credit card.

Visit FSAStore at www.fsastore.com

# DENTAL COVERAGE—*Sun Life*

*Deductible runs from January 1, 2024 - December 31, 2024*

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

## DHMO PLAN

When you enroll in the DHMO plan, you must choose a primary dentist from the DHMO network directory to manage your care. Each eligible dependent may choose their own primary dentist. All services under the DHMO plan are unlimited with fixed copays and no deductibles. There are also no claims forms to file.

**FIND A NETWORK PROVIDER**
Visit **www.sunlife.com/findadentist** or call **(800) 877-7195**

## DPPO PLAN

Two levels of benefits are available with the DPPO plan: in-network and out-of-network. You may select the dental provider of your choice, but your level of coverage may vary based on the provider you see for services. Using an in-network provider will provide you with the highest level of benefits and the deepest discounts in the plan offers. You could pay more if you use an out-of-network provider.

## VSP DISCOUNT VISION PROGRAM

Enrollment in either plan enrolls you in the discount program. No waiting periods, no deductibles, no claim forms to fill out.

Eye Exams, Glasses - 20% discount
Contact Lenses - 15% discount
Laser VisionCare - discount

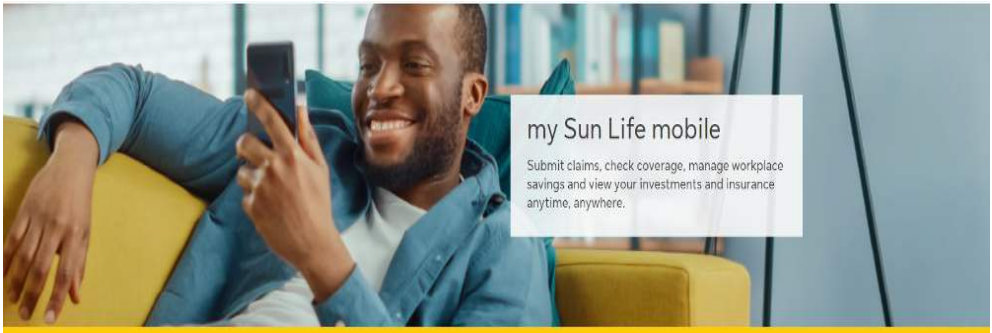
Find providers at **www.vsp.com** or call (800) 877-7195

| Benefit | DHMO PLAN IN-NETWORK ONLY | DPPO PLAN |
|---|---|---|
| **Network** | Heritage Series | Sun Life Dental |
| **Maximum Annual Benefit** *(per person)* | Unlimited | $1,000 |
| **Annual Deductible** Individual | None | $50 |
| **Type I - Preventive Services** | Scheduled copays | 100% |
| **Type II - Basic Services** | Scheduled copays | 80% |
| **Type III - Major** | Scheduled copays | 50% |
| **Type IV - Orthodontia** *(Adult and Child)* | 25% Discount | Not Covered |
| **Waiting Period** | None | Late Entrant Only<br>Preventative/Basic - No Wait<br>Major - 12 Months |
| **Out of Network Reimbursement** | Not Covered | 90th R&C* |

***90th R&C (Reasonable and Customary):** Payment covered services received from an out-of-network dentist is based on the 90th percentile of the usual and customary charge. Sun Life 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.*

| SEMI-MONTHLY DENTAL RATES | DHMO PLAN | DPPO PLAN |
|---|---|---|
| **Employee Only** | **$6.04** | **$20.91** |
| **Employee + Spouse** | **$9.77** | **$40.44** |
| **Employee + Child(ren)** | **$13.20** | **$47.19** |
| **Employee + Family** | **$15.47** | **$66.71** |

# DENTAL COVERAGE—*Mobile App*




## Put Sun Life at your fingertips

See why the my Sun Life mobile app has a 4.5-out-of-5 star rating.[1]

Download it now for iPhone and Android devices.

GET IT ON Google Play

Download on the App Store

*You'll need a valid email/Access ID and password. Register directly from the app.*

## Online Services for Members

With a Sun Life account, you can manage your benefits online, on your schedule.

### What can you do in your Sun Life account?

- Have immediate access to your plan information
- View/print personalized dental ID cards
- View most recent dental visits and procedures
- Find a vision or dental network provider and/or specialist


**Easy registration - create an account today!**
www.sunlife.com/createaccount

# LIFE AND AD&D—*Unum*

Life and Accidental Death and Dismemberment (AD&D) insurance through **Unum** are important to 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).

## 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 are reduced by 35% at age 70 and an additional 15% at age 75. Benefits terminate at retirement.

## VOLUNTARY LIFE AND AD&D

You may purchase additional 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 by apply to Unum and paying the premium within 30 days of termination.

| Coverage For | Coverage Available |
|---|---|
| **Employee** | May be purchased in $10,000 increments to a maximum of 5 X your salary or $500,000 (whichever is less)<br>**New Hire Guarantee Issue**: $50,000. |
| **Spouse** | May be purchased in $5,000 increments to a maximum of $500,000 (Not to exceed 100% of employee amount).<br>**New Hire Guarantee Issue:** $25,000 |
| **Child(ren)** | Birth to 6 months: $100<br>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** |
| **Age Reduction** | 35% at age 70;<br>Additional 15% at age 75 |
| **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. |

**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 guarantee issue amount.

## DESIGNATING A BENEFICIARY

A beneficiary is the person or entity you designate to receive the death benefits of your life insurance policy. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, identify the share for each.

# VOLUNTARY LIFE AND AD&D—*Rates*

| MONTHLY LIFE RATES | | | | |
|---|---|---|---|---|
| AGE | EMPLOYEE Per $10,000 Benefit | | SPOUSE Per $5,000 Benefit | CHILD(REN) Per $2,000 Benefit |
| | Non-Tobacco | Tobacco | | |
| <24 | $0.94 | $1.58 | $0.56 | $0.490 |
| 25-29 | $0.94 | $1.58 | $0.56 | |
| 30-34 | $1.08 | $2.00 | $0.68 | |
| 35-39 | $1.63 | $3.02 | $1.05 | |
| 40-44 | $2.26 | $5.05 | $1.79 | |
| 45-49 | $3.90 | $8.67 | $2.97 | |
| 50-54 | $7.02 | $15.47 | $4.76 | |
| 55-59 | $12.12 | $20.55 | $6.61 | |
| 60-64 | $17.38 | $26.71 | $9.40 | |
| 65-69 | $28.85 | $52.94 | $14.04 | |
| 70-74 | $44.55 | $72.43 | $23.39 | |
| 75-79 | $119.15 | $156.94 | $57.12 | |
| 80+ | $119.15 | $156.94 | $57.12 | |

**Spouses rates based on the employee's age*

**Rates will automatically calculate in Benefits in Hand at the time of enrollment.**

# DISABILITY INSURANCE—*Unum*

Disability insurance through **Unum** 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)

Short-Term Disability (STD) is paycheck protection if you are unable to work due to illness or a non-work related injury or accident. Pregnancy and childbirth are also covered. You receive discounted group rates and contribute through a payroll deduction. Premiums are based on your age and income and are paid on a post-tax basis.

| SHORT TERM DISABILITY | |
|---|---|
| **Benefits Begin** | **Accident** - 15th day<br>**Sickness** - 15th day |
| **Percentage of Earnings You Receive** | 60% of weekly earnings |
| **Maximum Weekly Benefit** | $1,000 |
| **Maximum Benefit Period** | Up to 24 weeks |
| **Maternity** | Treated the same as any other disability |
| **When are you eligible** | First of the month following 30 days of employment |

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

## EMPLOYER-PAID LONG TERM DISABILITY (LTD)

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 Social Security Normal Retirement Age (SSNRA).

| LONG TERM DISABILITY | |
|---|---|
| **Benefits Begin** | 181st day |
| **Percentage of Earnings You Receive** | 60% of monthly earnings |
| **Maximum Monthly Benefit** | $10,000 |
| **Maximum Benefit Period** | Social Security Normal Retirement Age, as long as you meet the definition of disability |
| **Pre-existing Limitation*** | 3 months prior / 12 months insured |
| **Own Occupation** | 24 months |
| **When are you eligible** | 30 days after date of hire |

**LTD benefits will not be paid for a disability in which you received medical treatment, care or consultation, or took prescribed drugs or medications during the 3 months prior to your effective date unless you are covered under this policy for 12 consecutive months before the disability begins.*

| SHORT TERM DISABILITY *rates per $10 benefit* | | | | LONG TERM DISABILITY |
|---|---|---|---|---|
| **Age** | **Monthly Rate** | **Age** | **Monthly Rate** | |
| **<20** | $0.89 | **45-49** | $0.74 | ***Paid by Fort Worth Museum of Science and History*** |
| **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 | |

# EMPLOYEE ASSISTANCE PROGRAM–*Unum*

Keeping your work and personal life in balance can be tricky at times. Stressful situations can effect your health, well being and ability to focus on what's important. That's when you can pick up the phone an speak confidentially to a Master's-level consultant who can help you with:

- Child and Elder Care
- Financial Questions
- Personal or Work Situations
- Depression
- Substance Abuse
- Get advice on conflict resolution
- Get a referral to an Attorney

## UNLIMITED WEBSITE ACCESS TO:

- Read books, life articles and guides
- View videos and online seminars
- View podcasts
- Subscribe to email newsletters
- Find information on parenting, retirement, finances, education more.

## ACCESS YOUR EAP BENEFIT TODAY!

Toll-Free 24-Hour Access

1-800-854-1446 (English)

1-877-858-2147 (Spanish)

1-800-999-3004 (TTY/TDD)

## ONLINE ACCESS

Visit **www.lifebalance.net**

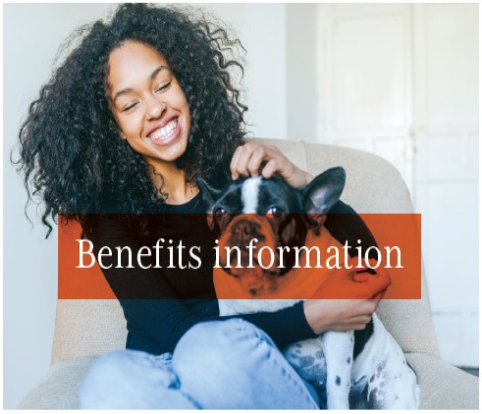
User ID & Password: **lifebalance**

# EMPLOYEE RESPONSE CENTER

## Employee Response Center

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







Call 866-419-3518 to speak with a representative Monday through Friday from 8:00 a.m. to 5:00 p.m. CT. If you leave a voicemail message after 3:00 p.m. CT, your call will be returned the next business day.

Email questions or requests to helpline@higginbotham.net.

Bilingual representatives are also available.

Higginbotham™

# HOW TO ENROLL—*Benefits in Hand*

**Social security numbers and dates of birth are MANDATORY for those enrolling on any plan including spouses and children. Have those available when logging in.**

To begin the enrollment process, log on to the Benefits in Hand portal: **www.benefitsinhand.com**. First time users, follow steps 1-4. Returning users, log in and start at step 5.

1. If this is your first time to log in, 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. Click the ***Start Enrollment*** button to begin the enrollment process.

6. Confirm or update your personal information and click ***Save & Continue***.

7. Add, Edit or Confirm personal home address and click ***Save & Continue***.

8. Verify address. You may either click ***"Use this address"*** to accept the USPS address locator, click "***Back to edit"*** or ***"Keep entered address"***.

9. Edit or add dependents who need to be covered on your benefits. Once all dependents are listed, click ***Save & Continue***.

10. Follow the steps on the screen for each benefit to make your selection. Please notice there is an option to Decline Coverage. If you wish to decline, click the ***Don't want this benefit?*** button and select the reason for declining.

11. Once you have elected or declined all benefits, you will see a summary of your selections. Click the ***Click to Sign*** button.

**Your enrollment will not be complete until you click the *Click to Sign* button.**

Have questions about your benefits or need help enrolling? Call the Employee Response Center at **866-419-3518**. Benefits experts are available to take your call Monday through Friday, 8:00 a.m. – 5:00 p.m. CT.

# REQUIRED 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 with 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.

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).

October 1, 2024
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 describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan - whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by Fort Worth Museum of Science and History, hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It

is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Complaints: If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer.

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

**Conclusion**

PHI use and disclosure by the Plan is regulated by a federal law known as HIPPA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

## 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 are 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 are not 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, 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 go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can 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 are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2024. Contact your State for more information on eligibility.

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

To see if any other States have added a premium assistance program since January 31, 2024, 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 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 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.

"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.

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 final authority. The rights are reserved to change or discontinue the employee benefits plans at any time.

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