ABILENE CHRISTIAN UNIVERSITY

EMPLOYEE BENEFITS GUIDE

2027



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AT ABILENE CHRISTIAN UNIVERSITY,

your benefits matter—not only as part of your compensation, but also as an important way ACU supports you and your family.

Earlier this year, many of you shared your experiences and perspectives through our employee benefits survey and focus groups. We heard you. Your feedback helped us better understand what you value, where you see opportunities for improvement, and what you need from your benefits program. Most importantly, we used what we learned to shape meaningful changes for 2027.

Our commitment extends beyond individual benefits. We remain focused on supporting your total well-being—physical, emotional, and financial—at work, at home, and everywhere in between. We will continue listening to you, evaluating our offerings, and seeking thoughtful ways to make your benefits more valuable and responsive to your needs.

As you consider your 2027 options, please review this guide carefully. It explains the benefits available to you and will help you make confident, informed decisions for yourself and your family. Remember, the elections you make during Annual Open Enrollment will remain in effect throughout the year unless you experience a qualifying life event.

Thank you for sharing your voice, for the important work you do, and for being part of ACU's future.

This guide highlights the main features of many of the benefit plans sponsored by Abilene Christian University. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Abilene Christian University reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

GETTING STARTED

WELCOME TO YOUR 2027 EMPLOYEE BENEFITS GUIDE

Use this guide to see what's new and to learn about your benefit plan options.

ANNUAL OPEN ENROLLMENT

When is Annual Open Enrollment?

Annual Open Enrollment takes place each Fall. ACU will share details and instructions as the enrollment period approaches. Elections made during enrollment will be effective January 1, 2027.

What's New for 2027?

Annual Open Enrollment is your once-a-year opportunity to make changes to your benefits. Before you make your decisions, be sure to review the Benefits Guide and visit myACUbenefits.com for important benefits information and resources.

You spoke, and we listened. Based on feedback from our employee benefits survey and focus groups, ACU is making meaningful changes to the medical plans for 2027. While Auxiant will continue to administer the plans, members will now have access to the Cigna provider network—a traditional network designed to make it easier to find participating providers and understand what to expect when receiving care.

Benefits You Can Count On

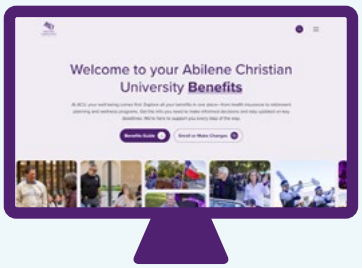
This year, we've focused on maintaining the benefits you value most while making thoughtful improvements based on employee feedback. As we move to the Cigna provider network for 2027, medical premiums will increase moderately to support the new network and expanded access to care. ACU remains committed to offering meaningful benefits while carefully managing costs for employees and their families.

Save up to $100 on Your 2028 Monthly Medical Premiums

Complete your annual physical and biometric screening between August 1, 2026, and July 31, 2027, to earn the wellness credit and decrease your medical premiums for 2028. This incentive applies to both employees and covered spouses.

Have Questions?

Benefits can be confusing, but we've got you covered. When you have questions about your benefit options or need assistance with enrolling, contact your dedicated Sr. Benefit Analyst, Elsa Dunson, at **800-325-1174**, Monday-Friday, 8 a.m.–5 p.m. CT for help.



Explore Your Benefits Anytime, Anywhere

- Visit myACUbenefits.com—your go-to resource for information about your ACU benefits. From health plans to retirement, you'll find easy-to-understand information, helpful tools, important contacts, and the latest updates all in one place.
- Use the site throughout the year to better understand your benefits and make the most of the resources available to you.

ENROLL ONLINE:

Visit myACUbenefits.com and click ***Enroll***.

Follow these steps to make your 2027 benefit elections:

1. **Log in to Workday**
2. **Access Open Enrollment**
   - From your Workday home page, select the Benefits worklet (icon).
   - Under Change, click Open Enrollment.
3. **Make Your Elections**
   - Review each benefit option.
   - Select or update your elections for medical, dental, vision, life insurance, and any other benefits.
   - Add or remove dependents if needed.
4. **Review & Confirm**
   - Carefully check your elections and costs.
   - Make sure your dependents' information is correct.
5. **Submit Your Elections**
   - Click Submit at the end of the process.
   - Print or save your confirmation page for your records.

DO I HAVE TO DO ANYTHING?

If you don't enroll, your current benefits will NOT carry over and will end December 31, 2026.

You must enroll if you want to:

- Contribute to ACU's 403(b) Retirement Plan
- Contribute to a Health Savings Account (HSA)
- Contribute to a Flexible Spending Account (FSA)
- Make changes to your coverage
- Change your beneficiaries

WHAT DO I NEED TO THINK ABOUT?

- Which family members do I want to cover?
- Which medical plan option works best for me and my family?
- Does my family need dental or vision coverage?
- What type of coverage do we need to provide some financial protection in case of serious illness, injury or death?
- Do I want to participate in the HSA or FSA (depends on medical plan enrollment) to help pay for health care expenses by letting me contribute pre-tax money?

HOW TO ENROLL



To Add a Dependent

If you are electing to cover dependents, you must verify their eligibility during Annual Open Enrollment. Your newly added dependents will not be added to your coverage until the dependent eligibility verification process is complete.
If you are not able to provide the required documentation within 30 days of enrollment, please contact your dedicated Sr. Benefit Analyst, Elsa Dunson, at **800-325-1174**, Monday-Friday, 8 a.m.–5 p.m. CT to discuss your options.

ELIGIBILITY

When it comes to choosing your benefits, it's important to understand what you are eligible for so you can make an informed decision about coverage. You are required to work an average number of hours each week to qualify for benefits.

Employee Type	Health & Prescription	Other Benefits	Eligibility Start
Full-Time	✓	✓	Date of hire
Reduced Full-Time	✓	✓	Date of hire
Half-Time	✗	✓	Date of hire
Part-Time	✗	✗	Not eligible

INITIAL ENROLLMENT

When you first join Abilene Christian University, you have 30 days to enroll yourself and your dependents for benefits. If you enroll on time, coverage begins on your date of hire. If you do not enroll within 30 days of becoming eligible, you will have to wait until the next Annual Open Enrollment to enroll for other benefits.

ANNUAL OPEN ENROLLMENT

During Annual Open Enrollment, coverage takes effect on January 1 of the following year.

COVERING YOUR DEPENDENTS

- Your legal spouse
- Your eligible children up to age 26 for medical, dental and vision coverage
- "Children" are defined as your natural children, stepchildren, legally adopted children and children for whom you are the court-appointed legal guardian
- Physically or mentally disabled children of any age who are incapable of self-support
    - Proof of disability may be requested

Child becomes ineligible?

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical, dental or vision plan), you must notify the Human Resources Department at humanresources@acu.edu.



ELIGIBILITY

MAKING CHANGES TO YOUR COVERAGE

Once you make your benefits elections, these choices remain in effect until the next Annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by completing the qualified life event change within the benefits enrollment system. If you do not submit your changes within 31 days, you will have to wait until the next Annual Open Enrollment to make new elections.

QUALIFIED LIFE EVENTS

- Gain/loss of an eligible dependent due to birth, adoption, placement for adoption or death
- Gain/loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce or death of a spouse
- Change in employment status, such as starting or ending employment, for you, your spouse or your children
- End of the maximum period for COBRA coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

PRE-TAX PAYROLL DEDUCTIONS

Medical, dental and vision plans are offered on a pre-tax basis through IRS Section 125. By making your contributions on a pre-tax basis, the premium is withheld from your pay before federal, state (in most cases) and FICA taxes are calculated. This can reduce the amount of taxes you pay per paycheck.

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical, dental or vision plan), you must notify the Human Resources Department at humanresources@acu.edu.





OUR BENEFITS PROGRAM HAS YOU COVERED

Most days, we all count on our simple routines to get us through: getting the kids to school, going to work and finishing dinner in time to enjoy a favorite hobby. But sometimes, things don't always go as planned. Like when your head cold turns into the flu and you have to be away from work. Or your child's game ends with an X-ray. Or even when your spouse learns they need an extensive root canal. That's when Abilene Christian University's benefits are there to help you.

Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. Abilene Christian University's benefits plans allow you to choose the options that work best for your own needs—and your pocketbook. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend.

Benefits Provided at No Cost to You	Benefits You Pay For
• ACU HSA Contribution	• Medical and Prescription Drugs
• Basic Life & Basic AD&D Insurance	• Dental Plan
• Long-Term Disability	• Vision Plan
• Employee Assistance Program	• Optional Life and AD&D Insurance
• Identity Theft Protection	• Short-Term Disability
• Adoption Assistance Plan	• Flexible Spending Accounts
• 403(b) Match	• 403(b) Plan
• Parental Leave	• Voluntary Worksite Benefits

MEDICAL BENEFITS

CONSIDER YOUR COVERAGE

ACU's medical plan options provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

Preferred Provider Organization (PPO Plan)

The PPO plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. However, if you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower. If you choose to receive care from an out-of-network provider, those expenses will not count toward your in-network deductible. **Once you reach your in-network deductible, the plan pays 70% of your in-network health care expenses.** If you choose to incur expenses out-of-network, the plan pays 50% of expenses once your deductible is met. Your deductible, copays and coinsurance accumulate toward your out-of-pocket maximum. Once you reach your out-of-pocket maximum, the plan pays 100% of your health care expenses.

High Deductible Health Plan (HDHP/HSA Plan)

The High Deductible Health Plan (HDHP) works much like the PPO plan in that you can choose to receive care from in-network or out-of-network providers when you need medical care—and it covers the same types of services—but you pay less out of your paycheck for coverage. However, the HDHP has higher deductibles and no office visit copays. **Once your deductible is met, the plan pays 100% of your in-network health care expenses.**

NO MATTER WHICH OPTION YOU CHOOSE, BOTH PLANS:

- Are administered by Auxiant
- Provide preventive care at 100%
- Offer prescription drug coverage
- Provide access to virtual care, mental health services and additional care resources

PROVIDER NETWORK – *NEW FOR 2027!*

- Both ACU medical plans use the Cigna provider network, replacing HealthSmart and Prime.
- To find in-network doctors, specialists, hospitals, and other health care providers, visit the Cigna Provider Directory.
- Before scheduling an appointment or receiving care, confirm that your provider participates in the Cigna network.
- For help finding an in-network provider, contact Auxiant at **800-475-2232**.

Medical Biweekly Premiums

Enrolled	HDHP (Full Wellness Discount Applied)	PPO (Full Wellness Discount Applied)
Employee Only	$60.00	$112.50
Employee + Spouse	$232.00	$307.50
Employee + Child(ren)	$152.50	$220.00
Employee + Family	$337.50	$412.50

All employees will have the same base premium in 2027. If you and/or your enrolled spouse, if applicable, did not complete the prior year's wellness requirements, you will each experience a $25/pay period premium increase to the base rates listed above.

MEDICAL PLAN COMPARISON

	HDHP		PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	Annual Deductible		**Annual Deductible**	
Individual	$3,500	$3,500	$1,500	$1,500
Family	$7,000	$7,000	$3,000	$3,000
	Annual Out-of-Pocket Maximum		**Annual Out-of-Pocket Maximum**	
Individual	$3,500	$7,000	$3,500	$7,000
Family	$7,000	$14,000	$7,000	$14,000
	You Pay		**You Pay**	
Coinsurance (% of expenses you pay after deductible is met)	0%	30%	30%	50%
Preventive Care	0%, no deductible	30% after deductible	0%, no deductible	50% after deductible
Primary Care Physician	0% after deductible	30% after deductible	$30 copay	50% after deductible
Specialist	0% after deductible	30% after deductible	$60 copay	50% after deductible
Diagnostics, X-Ray and Lab Services	0% after deductible	30% after deductible	30% after deductible	50% after deductible
Urgent Care	0% after deductible	30% after deductible	$100 copay	
Emergency Room	0% after deductible	30% after deductible	$200 copay, then 30% coinsurance	
Inpatient Hospital Care	0% after deductible	30% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	30% after deductible	30% after deductible	50% after deductible

* New hires will receive a prorated Company HSA deposit based on the pay period of hire. The total maximum contribution for 2027, including the Company deposit, is $4,500 for single coverage and $9,000 for family coverage.

NEW FOR 2027: Separate In-Network and Out-of-Network Deductibles

Both medical plans have separate deductibles for in-network and out-of-network care. Expenses applied toward your in-network deductible do not count toward your out-of-network deductible, and expenses applied toward out-of-network deductible do not count toward your in-network deductible. Each deductible must be met separately before the applicable post-deductible benefits begin.

Medical Benefits Terms to Know

Benefits can be confusing; here's a quick reference to help you navigate commonly used terms:

- **Copay:** A flat dollar amount you pay the provider when you receive a service.
- **Deductible:** The amount you pay for services before the plan begins paying some of the cost. The deductible may not apply to all services, including preventive care.
- **Coinsurance:** The portion of covered expenses you and the plan share after you meet the deductible (listed as a percentage).
- **Out-of-Pocket Maximum (OOP Max):** The maximum amount you pay out of your pocket for covered expenses in a year. Once you reach the out-of-pocket maximum, the medical plan pays for all covered services for the rest of the year.
- **Embedded Deductible or OOP Max:** A single family member does not need to meet the family Deductible or OOP Max before the benefit begins to pay for health care services.

PRESCRIPTIONS

If you enroll in one of the ACU medical plans, you will automatically receive prescription drug coverage through True Rx. When you need prescriptions, you can purchase them through a local retail pharmacy or, for maintenance medications, through the mail order program.

We encourage you to speak to your physician about the drug that's best for you and to request less expensive prescription drugs (generic drugs). Your pharmacist will be able to recommend alternatives that create the same desired effect but may be more cost efficient than a name brand drug.

PRESCRIPTION DRUG PLAN HIGHLIGHTS (FOR NON-SHARX PRESCRIPTIONS)

	HDHP		PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Retail Prescriptions (up to 30–90 day supply)				
Tier 1*	100% coverage after deductible	70% coverage after deductible	$5 Copay	50% coverage after deductible
Tier 2*	100% coverage after deductible	70% coverage after deductible	$50 Copay	50% coverage after deductible
Tier 3*	100% coverage after deductible	70% coverage after deductible	$75 Copay	50% coverage after deductible
Specialty*	100% coverage after deductible	Not covered	$100 Copay	Not covered
Mail Order Prescriptions (up to 90-day supply; excludes specialty tier)				
All Tiers	100% coverage after deductible	Not covered	2.5x Copay	Not covered

These exclude SHARx prescriptions.
* Assumes medication is not filled through SHARx; see next page or more information.

RETAIL PRESCRIPTION PROGRAM

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. For more information about a particular pharmacy or pharmacy claim, contact:

- True Rx: 866-921-4047 | truerx.myrxplan.com/login

MAIL ORDER PROGRAM

True Rx partners with WB Rx Express for employees outside California and Postal Prescription Services (PPS) for those in California. Mail order is a convenient, cost-effective way to get 90-day maintenance medications delivered right to your door. For questions on this program, you can contact:

- WB Rx Express: **833-391-0126** | wbrxexpress.com
- PPS: **800-552-6694** | ppsrx.com (California only)

HIGH-COST PRESCRIPTION SAVINGS PROGRAM

Certain medications—usually those costing more than $350 for a 30-day supply—must be filled through a designated pharmacy. To help reduce costs and provide support, True Rx partners with SHARx, a free pharmacy advocacy program.

If you're on an ACU medical plan and take an eligible medication, SHARx will contact you with a welcome email or call. You'll be assigned a personal advocate to help you enroll, complete a HIPAA form and get started.

Participation in SHARx is required for coverage of high-cost medications. While enrollment is in progress, you may qualify for a short supply from your local pharmacy. Some manufacturers may ask for income information to access free medication programs. This information is kept private and only shared with the manufacturer. For more information, you can contact:

- SHARx: **314-451-3555** | sharxplan.com

MARK CUBAN COST PLUS DRUGS

True Rx has partnered with Cost Plus Drug Company to offer an easy way to get affordable prescriptions. Medications ordered through Cost Plus are in-network and count toward your deductible and out-of-pocket max. Your copay will apply based on your plan.

- Order directly at costplusdrugs.com or access it through the True Rx member portal: truerx.myrxplan.com
- For help, contact the True Rx Patient Care team.

MEET AUXIANT:
YOUR HEALTH PLAN ADMINISTRATOR

Auxiant is the administrator of ACU's medical plans, which means they're the team behind the scenes making sure your health benefits run smoothly. From processing claims to helping you understand your medical coverage, Auxiant is your go-to resource for navigating the ACU health plan.

What Auxiant Does

As a third-party administrator (TPA), Auxiant manages the day-to-day operations of your health benefits. They do not provide insurance, but they work on ACU's behalf to:

- Process and pay medical claims
- Track your deductible and out-of-pocket totals
- Provide access to digital ID cards and plan documents
- Help you find in-network providers
- Coordinate with your prescription benefits through True Rx
- Offer mobile and online tools for easy plan management

AuxiantHealth Member Portal

The AuxiantHealth platform gives you 24/7 access to your benefits. You can:

- Check your claims status and Explanation of Benefits (EOBs)
- See your deductible and out-of-pocket progress
- Find in-network doctors and facilities
- View or download your ID cards
- Contact customer support via live chat
- Link to your prescription plan through True Rx

Need Help? Just Ask.

If you have questions about a claim, need help finding a provider, or want to understand your plan coverage, contact Auxiant directly.

800-475-2232 | auxiant.com

GET IT ON Google Play | Download on the App Store

MATERNITY MANAGEMENT PROGRAM THROUGH AUXIANT

Expecting a baby is an exciting time—and the Auxiant Maternity Management Program is here to support you every step of the way. This voluntary program provides expectant mothers with personalized guidance, educational resources, and access to a dedicated maternity nurse to help ensure a healthy pregnancy and delivery. From your first trimester through postpartum care, the program offers support tailored to your unique needs. Participation is confidential and free to eligible health plan members.

To learn more or to enroll, call **800-641-3224** and choose option 3.



NEW FOR 2027

THE CIGNA PROVIDER NETWORK

Beginning January 1, 2027, ACU's medical plans will use the Cigna provider network, replacing HealthSmart/Prime.

Through Cigna, you'll have access to a nationwide network of doctors, specialists, hospitals and other health care providers.

FIND CARE THAT WORKS FOR YOU

Choosing an in-network provider can help you make the most of your medical benefits and reduce your out-of-pocket costs.

With Cigna's online provider directory, you can:

- Search for in-network primary care physicians, specialists, hospitals, and other health care providers.
- Find providers based on location, specialty, and other preferences.
- Check whether your current doctors participate in the Cigna network.
- Explore available health care providers before scheduling an appointment.

Save on Lab Work

Where you get your lab work done can make a difference in what you pay. Choosing an in-network national lab, such as Quest Diagnostics® or Labcorp®, may cost less than using a hospital or doctor's office lab—even if those labs are also in the Cigna Healthcare network.

Before your next test, ask your provider about using an in-network national lab and check your plan's coverage. With locations nationwide, Quest and Labcorp offer convenient access to quality lab services.

Ready to find a provider?

Visit the Cigna Provider Directory to search for doctors and facilities in your area. You can search as a guest without logging in.

Remember: While Cigna provides the medical network, Auxiant continues to administer your medical benefits and process claims.

KNOW WHERE TO GO FOR CARE

Choosing the right place for care can help you receive treatment sooner and manage your out-of-pocket costs. The best option depends on your symptoms and the urgency of your situation.

CARE OPTION	WHEN TO USE IT	ACCESS AND COST
TELADOC	• Colds, flu, allergies and sinus problems • Bronchitis and other respiratory infections • Minor rashes, skin conditions and other routine concerns	24/7 by phone or video **$**
RETAIL OR CONVENIENCE CARE	• Colds, flu and sinus problems • Vaccinations and screenings • Minor sprains, burns, rashes, headaches and sore throats	Often available without an appointment **$**
PRIMARY CARE PROVIDER	• Annual preventive exams • Vaccinations and screenings • Managing chronic conditions • Symptoms that are not an immediate threat to your health	Usually by appointment **$$**
URGENT CARE	• Sprains, strains, minor broken bones or cuts • Mild asthma symptoms • Earaches, severe sore throats, minor infections or rashes	Walk-in or same-day care is often available **$$$**
EMERGENCY ROOM	• Chest pain or difficulty breathing • Sudden changes in vision, speech or movement • Severe bleeding, major burns or serious head, neck or spinal injuries • Large wounds or major broken bones	Immediate care, 24/7 **$$$$**

When in doubt If you believe you are experiencing a medical emergency, call 911 or go to the nearest emergency room.

Find an in-network provider Click here, or contact Auxiant at 800-475-2232 for assistance.

This information is general guidance and is not medical advice. Refer to your plan documents for complete information about covered services and costs.

HEALTH SAVINGS ACCOUNT (HSA)

The HDHP offers a tax-savings feature called the Health Savings Account (HSA). With this account, you can pay for certain out-of-pocket medical expenses throughout the year.

WHAT'S A HEALTH SAVINGS ACCOUNT?

A Health Savings Account (HSA) is a tax-free account that earns interest. You can set up an HSA through HSA Bank, our HSA vendor, and make pre-tax contributions to your account from your paychecks throughout the year. You can use the HSA to pay for eligible health care expenses, such as deductibles, coinsurance and other out-of-pocket dental, vision, and prescription drug expenses not covered by a health plan.

ELIGIBILITY

You can participate in the HSA only if you enroll in the HDHP. You are NOT eligible to contribute if:

- You are enrolled in Medicare, including Part A
- You are covered by another medical plan (such as your spouse's plan) that does not qualify as a high deductible health plan
- You or your spouse participates in a Healthcare Flexible Spending Account (FSA) at ACU or at your spouse's employer

FLEXIBILITY

Unlike most other health care options, HSAs roll over from year to year, and because the HSA account belongs to the employee, you can take your funds with you if you leave ACU. All amounts in the HSA are fully vested and unspent balances remain in your account until spent.

TAXES

Annual contributions reduce your taxable income and qualified medical expenses are never taxed. All of the money set aside in an HSA grows tax-deferred until age 65, when funds can be withdrawn for any non-medical purpose at ordinary tax rates or tax-free.

MANAGE YOUR ACCOUNT ONLINE

Sign up to access your account balances, transaction history and statements, as well as track your expenses:

- HSA Mobile App – Download to check available balances, view transactions and save/store receipts.
- myHealth Portfolio – Track your health care expenses and manage receipts and claims from multiple providers.
- Account Preferences – Designate a beneficiary, add an authorized signer order debit cards and keep information up to date.

Need help? Contact HSA Bank

800-357-6246 | **hsabank.com**

GET IT ON Google Play

Download on the App Store

HSA AT A GLANCE

	2027 IRS Allowed Annual	ACU Contribution*	Your Contribution Limit
Employee Only	$4,500	$500	$4,000
All Other Coverage Levels	$9,000	$1,000	$8,000

* If you are age 55 or older, you are allowed an additional $1,000 annual catch-up contribution.

HSA ACCRUALS FOR NEW HIRES

Hire Month	Employee Only Funding	Employee + Dependent(s) Funding
January	$500.00	$1,000.00
February	$458.33	$916.67
March	$416.67	$833.33
April	$375.00	$750.00
May	$333.33	$666.67
June	$291.67	$583.33
July	$250.00	$500.00
August	$208.33	$416.67
September	$166.67	$333.33
October	$125.00	$250.00
November	$83.33	$166.67
December	$41.67	$83.33

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts allow you to pay for certain health care and dependent care expenses using tax-free money deducted from your paychecks. New Healthcare FSA participants will receive a debit card that allows you to pay for eligible expenses directly with funds in your account—no claim forms needed! If you enroll in an FSA, be sure to save your FSA receipts in case the IRS asks for documents verifying your eligible expenses. The Healthcare FSA is subject to the IRS "use it or lose it" rule, meaning that you must spend all of the FSA funds in your account by the end of the allotted period to incur expenses or you lose those funds.

HEALTHCARE FSA

You can contribute up to $3,500 per year on a before-tax basis. ACU provides a 2½ month grace period. You have until March 15, 2028 to incur expenses for the 2027 plan year.

NOTE: This account is available to all eligible employees who are not enrolled in the ACU HDHP for 2027.

DEPENDENT DAY CARE FSA

You can set aside up to $7,500 per year. The dependent care FSA is subject to the IRS's use it or lose it rule. Any funds left unused at the end of the 2027 plan year will be forfeited. However, if you are married and you and your spouse file separate tax returns, the maximum you can contribute is $3,750 each.

FSA AT A GLANCE

	Flexible Spending Account (FSA)	Health Savings Account (HSA)
Account Owner	Employer	Employee
ACU Contributions	None	$500 Employee Only / $1,000 Employee + Dependents
Grace Period for Unused Amount	Yes	N/A – no use it or lose it rule
Ability to Invest & Earn Interest	No	Yes
Eligible Expenses	IRS Code 213 incurred expenses during the coverage period. Cannot reimburse premiums.	IRS Code 213 incurred expenses; COBRA, qualified LTC, other health premiums in certain circumstances
Distribution of Unused Amounts	No	Permitted but are taxable + 20% excise tax unless disabled, deceased or over 65
Mid-Year Changes	No, unless qualifying life event	Yes, can change HSA election at any time
Medicare Enrolled Employees	Can contribute to FSA	Cannot contribute to HSA, but can use previously contributed HSA dollars for Medicare premiums and other out-of-pocket expenses
Annual Contribution Limits	$3,500	Individual: $4,500 Family: $9,000

*Once elected, FSA contributions cannot be changed during the plan year, unless you have a qualifying event.

EMPLOYEE ASSISTANCE PROGRAM

You and your covered dependents have access to The Standard's Employee Assistance Program (EAP). This confidential service offers free over-the-phone counseling any time, day or night, to help you with a variety of personal situations. The EAP also provides up to three counseling sessions for both you and your covered dependents, either in person or over the phone. Counselors can help with concerns such as emotional well-being and health, relationships, parenting and addiction.

MENTAL WELL-BEING

You can receive up to three counseling sessions per issue per year. The sessions are a free and confidential service and are available face to face, online with televideo or by phone.

Licensed counselors can help with issues such as:

- Mental health concerns
- Emotional difficulties
- Domestic abuse
- Substance abuse
- Financial worries
- Grief and loss
- Relationship support
- Self-esteem and personal development
- Stress management
- Work–life balance

When you need in-the-moment emotional well-being support, counselors are here to help 24/7. Speak to a professional counselor by calling **888-293-6948** | Register at healthadvocate.com/standard3.

WORK–LIFE ASSISTANCE

Resources for Living also provides a wide variety of work-life support, with some services at no cost. A few of the services include:

- Daily life assistance: Resources for child, elder or pet care and household services
- Legal support: Wills and estate planning, family, civil, criminal and real estate
- Financial services: Budgeting, mortgages, college funding and other issues
- Identity theft services: Fraud resolution and credit restoration coaching

Balancing work and life is important to your health. That's why the company provides programs to help you take time away from work to recharge and revitalize your well-being.

TIME AWAY



HOLIDAYS

We all need to recharge now and then—so Abilene Christian University provides you with the following holidays. If a holiday falls on a weekend, the day of observance may vary.

Abilene Campus

- New Year's Day
- Martin Luther King Day
- Spring Break (Friday)
- Good Friday
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Fall Break
- Thanksgiving (3 days)
- Christmas (Christmas Eve and the week between Christmas and New Year's Day)

Dallas Campus

- New Year's Day
- Martin Luther King Day
- Good Friday
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving (3 days)
- Christmas (Christmas Eve and the week between Christmas and New Year's Day)
- Two Floating Holidays

PAID PARENTAL LEAVE

Eligible employees receive six weeks of paid parental leave for the birth or adoption of a child, available to both mothers and fathers. Leave must be used within 12 months of the child's arrival. Additional time off can be taken using sick, vacation, or unpaid leave. If both parents work at ACU, each is eligible for six weeks. Unused leave cannot be transferred.

SICK LEAVE

Full-time faculty and staff accrue 8 hours of sick leave per month, up to a maximum of 1,040 hours. Sick leave may be used for your own illness, to care for an immediate family member or due to a death in the immediate family (yours or your spouse's). Reduced full-time and half-time employees accrue sick leave on a prorated basis.

SHARED LEAVE BANK

The Shared Leave Bank offers a safety net for employees facing a catastrophic health condition (for themselves or an immediate family member) that prevents them from working. Colleagues can donate sick leave to help cover income during this time. This program is not intended to provide unlimited sick leave. To apply, visit acu.edu/hr.

VACATION

Vacation is earned from day one and may be used as accrued. Accrual is based on years of service, with increases awarded on your annual anniversary date. Employees may roll over up to 80 hours of unused vacation into the next calendar year. Reduced full-time and half-time employees accrue vacation on a prorated basis.

Years of Service	Amount of Vacation
0 to 4	80 hours per year
5 to 9	120 hours per year
10 to 14	140 hours per year
15+	160 hours per year

PERSONAL DAYS

Eligible employees receive two personal days per year, separate from sick leave. Personal days do not roll over to the following year.

ONSITE & TELEMEDICINE

ACU ONSITE CLINIC

ACU has an on-campus medical clinic in Abilene that all ACU employees and dependents have access to. There is no built-in pharmacy with the clinic, but the clinic will call in your prescription to your preferred pharmacy.

If you are experiencing flu or cold symptoms, need your annual flu vaccine or have any other acute symptoms, the fee is $40 per visit. If you are enrolled in the ACU medical plan and visit the clinic for your annual wellness exam, the visit will be covered at 100% by the medical plan.

The ACU clinic does not file visits with any medical insurance. Employees may schedule appointments online by going to acu.edu/medical-and-counseling-care, or by calling **325-674-2625**.

TELEMEDICINE

ACU partners with Teladoc to provide telemedicine to all employees and dependents enrolled on the medical plan. Getting sick is never convenient, but telemedicine provides more convenient, quicker access to a medical professional for common conditions. Teladoc allows members to access a doctor from your home, office or anywhere – 24/7/365.

Teladoc licensed providers can diagnose any non-emergency medical conditions with a short phone visit or secure video visit. They can also prescribe medication and send prescriptions to the pharmacy of your choice. Common examples of telehealth visits are cold and flu, allergies and ear infections. See pricing below.

	PPO	HDHP
General Medicine	$10 consult fee	$10 consult fee
Psychologist*	$60 consult fee	$60 consult fee
Psychiatrist*	$60 consult fee	$60 consult fee
Dermatology	$60 consult fee	$60 consult fee

*Behavioral health fees vary depending on the provider seen.

Any time you need a doctor's care, you've got Teladoc.

- **24/7/365 care:** For colds and flu, allergies, rash and much more!
- **Licensed doctors:** U.S. board-certified average 20 years of experience
- **In minutes:** Connect with a doctor by phone or video
- **Get a diagnosis:** Our doctors recommend treatment and prescribe medication (when medically necessary)

To access Teladoc, visit online or via the Teladoc app.

GET IT ON Google Play | Download on the App Store

800-362-2667 | teladoc.com

HEALTH & WELLNESS

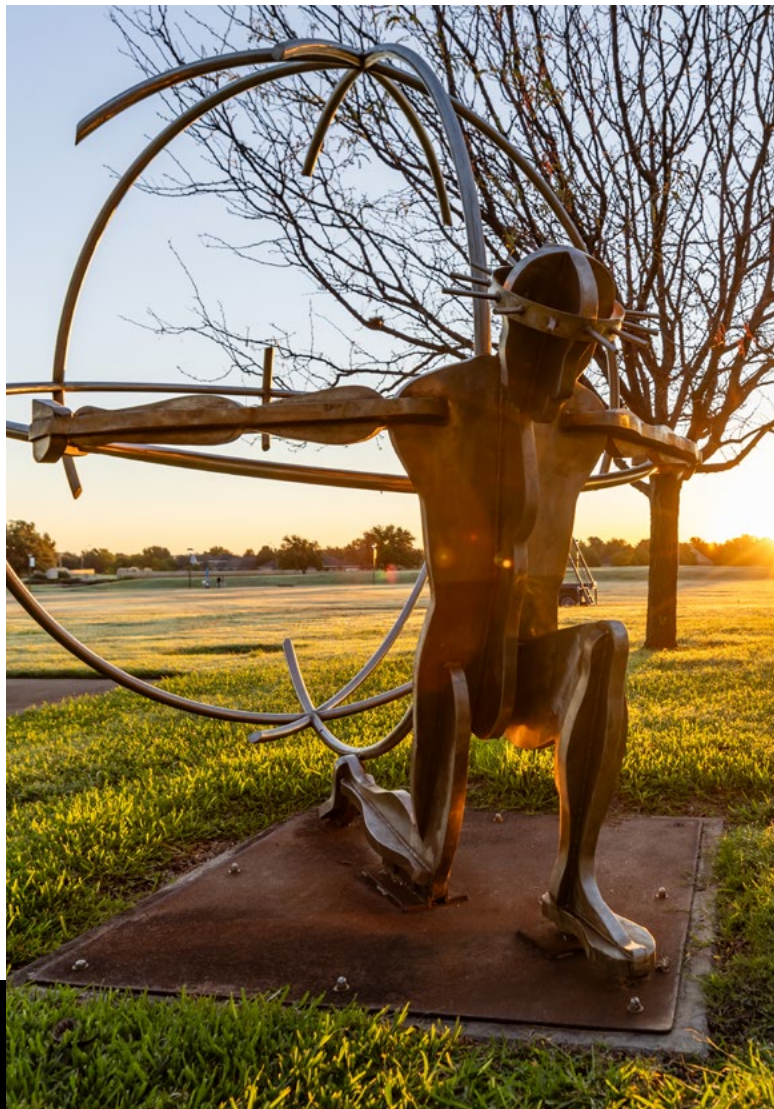
WELLNESS PROGRAM

ACU is committed to your health and well-being. We offer a wellness program to not only provide you with resources to live your healthiest lifestyle, but also to give you an opportunity to decrease your medical premiums.

To earn the wellness credit in 2028, you and your covered spouse (if enrolled) must complete the following activities between August 1, 2026 and July 31, 2027:

1. Receive an annual exam with your doctor
2. Receive a biometric screening (either on site or with your doctor)

NOTE: Any new hires hired after April 1, 2027 will automatically receive the wellness credit for 2027.



DENTAL PLAN

ACU's Dental Plan is administered through The Standard and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings and orthodontia for all eligible plan members.

DENTAL PPO PLAN

The Standard's Dental Plan allows you the freedom to visit any dentist, without referrals, for all your dental care. ACU utilizes the Ameritas Dental Network. If you receive care from one of The Standard's preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims. It's always a good idea to ask for a predetermination of benefits for any services expected to exceed $300.

To find an in-network dentist, go to **dentalnetworkpartners.ameritas.com**, enter your zip code or city, then select the Classic PPO.

Plan Features	Dental PPO Plan	
Annual Deductible	$50 / Individual	$150 / Family
Annual Benefit Maximum (per individual) Includes implants	$1,500	
Type I: Preventive Services Exams, routine cleanings, fluoride treatments, sealants, space maintainers, X-rays	100% (no deductible)	
Type II: Basic Services Fillings, denture repairs, extractions	80% after deductible	
Type III: Major Services Crowns, root canals, dentures, veneers, bridges	50% after deductible	
Type IV: Orthodontia Child and adult coverage	50% up to a lifetime maximum of $1,000	
Max Builder Fillings, simple tooth extractions, root canals, gum treatment	$750 / Rollover Threshold	$250 / Rollover Amount
	$1,000 / Rollover Amount Limit	$150 / In-Network Provider Bonus

MAX BUILDER

Earn $250 in rewards by submitting at least one claim during the year and staying under $750 in paid benefits. Get an extra $150 if you use an in-network provider. You can roll over unused benefits and build up to $1,000 in rewards—boosting your annual max to $2,500. If you don't submit a claim during the year, rewards reset—but you can start earning again the next year.

POLICYLINK BENEFIT

The Dental Plan now includes PolicyLink, allowing you to use part of your dental benefits for vision care.

- Combine dental and vision maximums, deductibles and frequencies
- Use up to $150 of your $1,500 dental max toward vision expenses (e.g., contacts, frames, lenses, copays)
- Pay out of pocket, then submit a claim for reimbursement
- No dental expense is required before using this benefit
- See any dentist and use VSP Choice Network for vision care

For questions, contact your dedicated Sr. Benefit Analyst, **Elsa Dunson**, at **800-325-1174**, Monday-Friday, 8 a.m.–5 p.m. CT.

Dental Biweekly Premiums

Enrolled	Dental PPO Plan
Employee Only	$18.71
Employee + Spouse	$38.06
Employee + Child(ren)	$35.82
Employee + Family	$54.78

ACU's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through The Standard.

VISION COVERAGE

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the **VSP Choice Network**, you'll receive a discount on services. To find a network provider, go to vsp.com and select "Find A Provider".

The vision plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Plan Features	IN-NETWORK	OUT-OF-NETWORK Plan Allowance
Eye Exam (Annually)	$20 copay	Up to $45
Materials Copay	$20 copay	
Lenses (Annually)	100% coverage after $20 copay	Single Vision: Up to $30 Lined Bifocal: Up to $50 Lined Trifocal: Up to $65
Frames (Every 24 months)	Up to $150 allowance	Up to $70
Contact lenses in lieu of glasses (Annually)	Contact Lens Fitting: Up to $60 Elective: $150 allowance Therapeutic (medically necessary): 100% covered	Contact Lens Fitting: Up to $60 Elective: Up to $120 Therapeutic (medically necessary): 100% covered after copay

Vision Biweekly Premiums

Enrolled	Vision Plan
Employee Only	$3.60
Employee + 1	$5.22
Employee & 2 or More	$9.35

ELIGIBILITY VERIFICATION

You will not need a vision ID card to receive vision services. When you visit a provider, give your SSN and The Standard name and the provider will verify your eligibility.



VISION PLAN

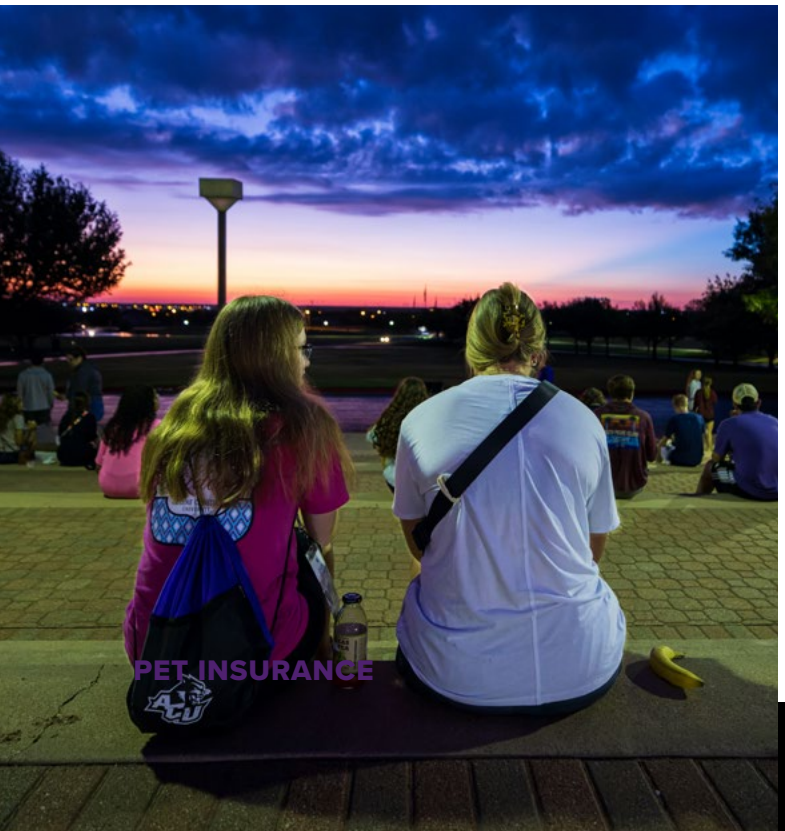
OTHER BENEFITS

IDENTITY THEFT ASSISTANCE

To further enhance our commitment to protect you and your family, ACU provides Identity Theft coverage to all benefits-eligible employees at no cost to you. We also give you the option to purchase this coverage for your dependents. This service will offer income protection, reimbursement for allowable expenses related to the recovery of your identity, and a customer claims representative to aid you in the process of restoring your identity.

ADOPTION ASSISTANCE PROGRAM

All full-time and reduced full-time employees are eligible for the ACU Adoption Assistance Program. If an eligible employee and his/her eligible spouse both work at ACU, only one employee can utilize the benefit. Each eligible employee is eligible to receive up to $5,000 in adoption assistance benefits for the adoption of an eligible child. The limit is increased to $6,000 for an adoption of an eligible child with special needs (as defined by IRS regulations). The adoption assistance benefit shall be in the form of reimbursements for qualified adoption expenses, such as reasonable and necessary adoption fees, court costs and attorney's fees. The Adoption Assistance benefit has a lifetime maximum limit of three adoptions per family. Please contact Human Resources for more information.



ACU partners with SPOT! Pet Insurance to help cover costs when unexpected accidents or illnesses occur, with plan options that reimburse up to 90% of eligible vet bills. Coverage includes access to a 24/7 vet telehealth helpline and discounts through SPOT Perks. This benefit is not payroll deducted—SPOT will bill you directly. Enroll at spotpet.link/acu or call **888-343-2340** using code EB_ACU to receive up to 20% in plan discounts.

LIFE SERVICES TOOLKIT

We know losing a loved one is difficult, and we understand how challenging it can be for beneficiaries to manage their loved one's insurance benefits among other pressures during a difficult time. All employees have access to The Standard's Life Services Toolkit, which offers services to beneficiaries when they need it most.

If you have questions, call **800-378-5742**.

TRAVEL ASSISTANCE

The Standard's Travel Assistance offers members aid before your trip, which includes assistance with cultural information, immunization requirements, visa and passport requirements, foreign exchange rates, assistance with lost or stolen luggage and/or prescriptions, and other travel advisories. The Standard's Travel Assistance also assists with emergency medical transportation benefits for covered individuals traveling 100+ miles from home.

If you would like to learn more about this program, you can call **800-872-1414** for more information.

NEW FOR 2027! – MEDICARE GUIDANCE

ACU partners with Avant Senior Market Solutions to offer free, confidential Medicare guidance to you and your eligible family members. Whether you're approaching Medicare eligibility, planning to retire or reviewing your coverage, a licensed advisor can help you compare your current coverage with Medicare options, understand costs and benefits, and navigate enrollment deadlines. Enrollment assistance and ongoing support are also available. There's no obligation to enroll—the decision is yours.

To schedule a free consultation, contact Luke Siler at **816-307-2115** or LSiler@avantsb.com.

LIFE AND AD&D

ACU offers life insurance coverage to provide financial protection in the event you or your dependents die while you are still working. This coverage is administered through The Standard.

Life insurance pays a benefit if you or a covered family member dies. It is paid to your beneficiary if you die or to you if a dependent dies.

BASIC LIFE & AD&D INSURANCE

ACU automatically provides Basic Life and AD&D Insurance for all eligible employees at no cost. Basic Life and AD&D Insurance is equal to 1 times your annual base earnings up to a maximum benefit of $300,000. It does not include overtime or bonuses. The benefit is paid to your beneficiaries in the event of your death.

Please note, your Life and AD&D Coverage reduces based on age. Please see the following page for details.

IRS RULES ABOUT BASIC LIFE COVERAGE

If your Basic Life coverage is more than $50,000, your income taxes may be affected. IRS regulations require that the value of life insurance benefits over $50,000 be reported as “imputed income,” which is non-cash income that you receive from an employer-provided benefit. The value of any coverage that exceeds $50,000 will be reported to the IRS as imputed income on your W-2 form.

OPTIONAL LIFE AND AD&D INSURANCE

In addition to Basic Life and AD&D Insurance, you may also purchase Optional Life and AD&D Insurance for yourself, your spouse and your dependent children. However, you may only elect coverage for your dependents if you enroll for Optional Life and AD&D coverage for yourself. You pay for the cost of Optional Life and AD&D Insurance on an after-tax basis through payroll deductions. Evidence of Insurability (EOI) is required if you add new coverage or increase current coverage.

Coverage Type	Coverage Available	Guarantee Issue
Employee	Up to $500,000*	$200,000
Spouse	100% of employee election up to $250,000	$50,000
Child(ren) to age 26	Increments of $1,000 up to $10,000	All elected Child amounts are Guarantee Issue

* Employee Basic Life + Voluntary Life total amount cannot exceed 8 times annual earnings.
Reminder: An employee may not be enrolled as both an employee and a spouse.

BENEFICIARY DESIGNATION

You must designate a beneficiary for Basic and Optional Life Insurance benefits when you enroll. Your “beneficiary” is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year.

If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.



EVIDENCE OF INSURABILITY (EOI)

Your voluntary life/AD&D election(s) will be subject to EOI in the following circumstances:

- You or your spouse are currently enrolled in a voluntary life/AD&D amount above the Guarantee Issue amount.
- You or your spouse request a coverage amount above the Guarantee Issue amount.
- If you did not enroll in voluntary life/A&D insurance for a January 1, 2026 effective date OR upon your new hire enrollment election, you will be subject to EOI for any amount above the Guarantee Issue amount.

During Annual Open Enrollment, you can increase your voluntary life/AD&D election for you and/or spouse by one increment (Employee: $10,000; Spouse: $5,000) not to exceed the guarantee issue amount, with no EOI required.

NOTE: If you are a new hire and choose to enroll yourself and/or your spouse in voluntary life, you can enroll in any amount up to the Guarantee Issue without your election being subject to EOI.

BENEFITS REDUCE AT AGE 65

When you or a covered dependent reaches age 65, Basic and Optional Life Insurance benefits are reduced to 65%. They reduce to 50% at age 70. For more information, you can refer to your summary plan description.

VOLUNTARY LIFE AND AD&D PREMIUMS

Supplemental Life Premium Calculation: (Coverage amount x Rate* / 1000) = Monthly Premium**)

* For Rate, see table below. **Divide monthly premium by 2 to get the biweekly premium

Employee/Spouse Age Band	Rate
Under 30	$0.086
30–24	$0.106
35–39	$0.128
40–44	$0.172
45–49	$0.258
50–54	$0.395
55–59	$0.594
60–64	$0.913
65–69	$1.567
70–99	$2.776
Child	$0.226 / $1,000

DISABILITY

ACU offers you two disability plans that work together to keep all or part of your paycheck coming if you cannot work because of illness, injury or pregnancy. Disability benefits are administered through The Standard.

SHORT-TERM DISABILITY

You are responsible for the cost of Short-Term Disability (STD) coverage. If you become disabled, you will be eligible to receive a weekly benefit based on a percentage of your weekly income.

- Your benefits will begin after seven days of injury or seven days of sickness.
- Benefits will be paid for a maximum period of 180 days.
- Your benefit is paid at 60% of your weekly salary to a maximum payment of $1,750/week.
- Late entrants will be subject to a 60-day waiting period for sickness or pregnancy during the first 12 months on the plan.
- You can choose to use your Sick Leave or your STD benefit, but you cannot use both at the same time.

This formula will help you calculate your rate for coverage:

(Annual Salary ÷ 52 = Weekly Salary*) x Benefit % = Your Weekly Benefit

Your Weekly Benefit ÷ 10 = Amount x Your Rate** = Your Monthly Cost***

* NOTE: If your weekly salary exceeds $2,917, use $2,917 as your weekly salary in the calculation.

** Rates will be calculated for you when you complete your enrollment.

***Divide your monthly cost by 2 to get your pay period cost.

LONG-TERM DISABILITY

ACU provides Long-Term Disability (LTD) coverage to all eligible employees at no cost to you. If you continue to be disabled after your STD period has run out, you will be eligible to receive a monthly benefit based on a percentage of your monthly income.

- Your LTD benefits will become payable on a monthly basis once you have been disabled for 180 days (when your STD, if any, ends).
- Your benefit is paid at 60% of your monthly salary to a maximum payment of $15,000/month.
- You are not considered disabled because your right to perform your own occupation is restricted, including a restriction or loss of license.



VOLUNTARY WORKSITE BENEFITS

Medical insurance is designed to cover most medical expenses and pays the medical provider. With voluntary worksite benefits, benefits are paid directly to you, the policyholder, unless otherwise assigned, regardless of any other insurance you may have. The money can be used to help cover medical expenses (copayments, deductibles, etc.), as well as non-medical expenses.

CRITICAL CARE INSURANCE

The Standard's critical illness insurance is a supplemental health insurance plan that is designed to provide a tax-free, lump-sum cash benefit at the first occurrence of major critical illnesses, including cancer (spread beyond initial tissue), heart attack, stroke, advanced Alzheimer's, advanced Parkinson's, loss of hearing or speech, major organ failure, etc.

This benefit provides the pivotal financial support needed at the onset of a major illness, which can be used in any way by the policy owner. This benefit is portable, which allows you to take the policy with you at a locked in, level rate. This coverage is also open to spouses and children of employees. This coverage also includes a $50 per year benefit for receiving a health screening. No Evidence of Insurability (EOI) will be required for critical illness insurance.

ACCIDENT INSURANCE

The Standard's Accident Insurance covers a wide range of injuries and accident-related expenses, such as hospitalization, physical therapy, hospital intensive care, transportation, and lodging plus coverage for Accidental Death and/or catastrophic accidents that involve the loss or use of sight, hearing, speech, arms or legs. These benefits are designed to help pay for out-of-pocket costs that may not be covered by traditional health insurance and are open to spouses and children of employees. No Evidence of Insurability (EOI) will be required for accident insurance. **This coverage also includes a $100 per year benefit for receiving a health screening.**

HOSPITAL INDEMNITY INSURANCE

The Standard's Hospital Indemnity Insurance provides benefits for inpatient or ICU stays at any hospital or facility. These benefits are designed to help pay for out-of-pocket costs that may not be covered by traditional health insurance and are open to spouses and children of employees. No Evidence of Insurability (EOI) will be required for hospital indemnity insurance.

If you have additional questions regarding these voluntary plans, please visit the benefits library found on myACU or contact dedicated Sr. Benefit Analyst, Elsa Dunson, at **800-325-1174**, Monday-Friday, 8 a.m.–5 p.m. CT.

*Reference The Standard Health Screenings document in the myACU portal for a list of approved screenings.

Reminder: An employee cannot be enrolled as both an employee and a spouse.

FINANCIAL

Your well-being extends beyond the physical and emotional—it applies to your financial health too. Abilene Christian University offers a variety of benefits designed to help you save and grow your money.

403(B) RETIREMENT PLAN

It is critical to plan for your retirement. A 403(b) plan can be a powerful tool toward achieving security in retirement. The Abilene Christian University 403(b) plan helps eligible employees save and invest for retirement while receiving certain tax advantages.

ELIGIBILITY

Full-time, reduced full-time and half-time employees can make a percentage of base pay contribution into a 403(b) retirement plan. Employees have the option of contributing an amount of 0% to 8% of base pay into their 403(b) with a corresponding match from ACU.

YOUR CONTRIBUTIONS

You may contribute 1% to 75% of your eligible base pay up to the IRS limits. This retirement option gives participants the freedom of allocation changes and a three-year cliff vesting. For information on your retirement plans, please visit tiaa.org/acu. Below is a highlight of the benefit.

Employee Contribution	Employer Matches
0% Optional	0%
1% Optional	1%
2% Optional	2%
3% Optional	3%
4% Optional	4%
5% Optional	5%
6% Optional	6%
7% Optional	7%
8% Optional	8%

Contributing to the Plan

If you are or will be age 50 or older in this calendar year and contribute the maximum allowed to your account, you may also make "catch-up contributions" to your account. The catch-up contribution is intended to help you accelerate your progress toward your retirement goals. Contact your Plan Administrator for more details.

Changing or Stopping Your Contributions

You may change the amount of your contributions at any time. All changes will become effective as soon as administratively feasible and will remain in effect until modified or terminated by you. You may discontinue your contributions at any time. Once you stop making contributions, you may start again at any time. Contact ACU Human Resources for more information.

You can make contributions in three ways:

- **Before-Tax:** Contributions are made on a before-tax basis. Withdrawals and earnings are taxable.
- **Roth:** Contributions are made on an after-tax basis. Withdrawals and earnings are tax-free.
- **After-Tax:** Contributions are made on an after-tax basis. Withdrawals are tax-free, but earnings are taxable.

Company Match

Abilene Christian University matches your retirement savings dollar-for-dollar, up to 8% of your pay. The company match is contributed to your account each pay period, so the money is put to work right away.

You become eligible to receive the company match upon hire and enrollment in the plan.

ACU's matching contributions are subject to a three-year vesting period.

BIWEEKLY PREMIUMS

MEDICAL BIWEEKLY PREMIUMS

Enrolled	HDHP (Full Wellness Discount Applied)	PPO (Full Wellness Discount Applied)
Employee Only	$60.00	$112.50
Employee + Spouse	$232.00	$307.50
Employee + Child(ren)	$152.50	$220.00
Employee + Family	$337.50	$412.50

All employees will have the same base premium in 2027. If you and/or your enrolled spouse, if applicable, did not complete the prior year's wellness requirements, you will each experience a $25/pay period premium increase to the base rates listed above.

DENTAL BIWEEKLY PREMIUMS

Enrolled	Dental PPO Plan
Employee Only	$18.71
Employee + Spouse	$38.06
Employee + Child(ren)	$35.82
Employee + Family	$54.78

VISION BIWEEKLY PREMIUMS

Enrolled	Vision Plan
Employee Only	$3.60
Employee + 1	$5.22
Employee + 2 or More	$9.35



PAYCHECK DEDUCTIONS

The charts on this page contain the biweekly paycheck deductions for benefits beginning January 1, 2027.

Benefit deductions are taken from 24 of the 26 paychecks each year. Retirement plan contributions are withheld from all 26 paychecks.

HOLMES MURPHY BENEFIT ANALYST



ELSA DUNSON
Dedicated Senior Benefit Analyst

ACU has partnered with Holmes Murphy to provide dedicated customer service support and assistance in navigating the health care system. It is important to our organization to know that our employees have a confidential resource to help answer questions when you and your family need it.

If you have questions about your benefits or plan options, your dedicated Senior Benefit Analyst, Elsa Dunson, is ready to answer questions such as:

- ***When am I eligible to enroll in my benefits?***
- ***I've lost my ID card; how do I get a new one?***
- ***How do I make changes to my benefits?***
- ***What is a qualifying life event?***
- ***Where can I find a list of in-network providers?***
- ***What is my deductible and what does "coinsurance" mean?***
- ***What can I use my HSA funds for?***
- ***I received a bill from my doctor – was my claim paid correctly?***
- ***What is an "EOB" and how do I read it?***

As an alternative to contacting Human Resources or waiting on hold to speak to your insurance carrier's customer service, you may contact your experienced Benefits Analyst.

ELSA DUNSON
Senior Benefit Analyst

800-325-1174
edunson@holmesmurphy.com

Available Monday–Friday 8 a.m.–5 p.m. CT

IMPORTANT CONTACTS

Resource	Provider - Network	Phone	Website
Medical – PPO, HDHP/HSA	Auxiant (Group #2076)	800-475-2232	auxiant.com
Prescription	True Rx Retail Network	866-921-4047	truerx.com
Mail Order Rx – Non-CA	WB Rx Express	833-391-0126	wbrxexpress.com
Mail Order Rx – CA only	Postal Prescription Services	800-552-6694	ppsrx.com
High-Cost Medication Savings	SHARx	314-451-3555	app.sharxplan.com/login
Dental	The Standard (Group #762623) Ameritas Classic PPO	800-547-9515	dentalnetworkpartners.ameritas.com
Vision	The Standard (Group #762623) VSP Choice PPO	800-877-7195	vsp.com
Health Savings Account	HSA Bank	800-357-6246	hsabank.com
Flexible Spending Accounts	WEX	866-451-3399	wexinc.com/discovery-benefits
Life and AD&D Insurance, Short-Term Disability, Long-Term Disability	The Standard (Group #762623)	888-937-4783	standard.com/individuals-families/workplace-benefits/life-and-add
Employee Assistance Program	The Standard	888-293-6948	healthadvocate.com/standard3
Pet Insurance	SPOT Pet Insurance	800-905-1595	spotpet.link/acu
403(b) Retirement Plan	TIAA	800-842-2733	tiaa.org/acu
Identity Theft	AIG (Group #7077631)	866-434-3572	aig.com
Senior Benefit Analyst	Elsa Dunson	800-325-1174	edunson@holmesmurphy.com

REQUIRED NOTICES

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 and health coverage offered through your employment.

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 that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 10.22%[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 10.22% 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. 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 HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

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

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit 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 your Human Resources Department. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-26-26.pdf** for 2026.
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% 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.

SPECIAL ENROLLMENT NOTICE

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

LOSS OF OTHER COVERAGE

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

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR AFTER DEDUCTIBLEOPTION

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 request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: Human Resources Department at **humanresources@acu.edu**.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes:

- How health information about you may be used and disclosed
- Your rights with respect to your health information
- How to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information
- You have a right to a copy of this notice (in paper or electronic form) and to discuss it with **Wendy Jones** at **325-674-2359** or jonesw@acu.edu if you have any questions.

Please review it carefully.

YOUR RIGHTS

You have the right to:

- Consent to most uses and disclosures of your health information
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Discuss this notice with someone in our program
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

With your consent, we can use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Fulfill your requests to share information with your consent
- Prevent multiple program enrollments
- Report about court-referred treatment
- Report to prescription drug monitoring programs

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- In these circumstances, we must protect your information and limit how we use and share it.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes.
- We are not required to agree to your request, and we may say "no" if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly upon such request.

Discuss this notice with someone in our program

- You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Example 2: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, or legislative investigations or proceedings against you without (1) your consent or (2) a court order or subpoena. For more information see: **https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence, only as required by applicable law
- Preventing or reducing a serious threat to anyone's health or safety

For your medical emergencies

We may use or share your health information with health care providers or emergency personnel when needed to provide you with emergency treatment or to respond to a serious and immediate threat to your health or safety, even when you are unable to consent. This is allowed under HIPAA's rules for treatment and emergency disclosures.

Do research

We can use or share your information for health research. Researchers cannot include any patient identifying information in their reports about the research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Legal Proceedings and Lawful Process

We may use or share your health information as permitted or required by law when responding to legal proceedings. This includes disclosures in response to a valid court order, warrant, subpoena, or other lawful process, consistent with HIPAA's rules for judicial and administrative proceedings (45 CFR §164.512(e)) and law enforcement requests (45 CFR §164.512(f)).When responding to legal requests, we disclose only the information required and follow all conditions and limitations imposed by HIPAA.

Communicate within our program and with contractors

We may use and disclose your information within our health plan and with organizations that help us administer our program, including contractors and business associates who perform services for us. These disclosures occur only as permitted by HIPAA for health care operations.

Respond to audits and program oversight

We may use and share your information for health oversight and health care operations. This includes sharing with government agencies that are authorized by law to conduct audits, inspections, and licensure activities, and with accrediting organizations to support accreditation, quality assessment and improvement, and program evaluation of our health plan. We share only the minimum necessary information as required by law.

Disclosure to Law Enforcement

We may disclose information to law enforcement if we believe, in good faith, that it is evidence of a crime that occurred on our premises, or to report certain crimes during a medical emergency that did not occur on our premises. In these situations, we will disclose only what the law allows in these situations.

OUR RESPONSIBILITIES

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

OTHER INSTRUCTIONS FOR NOTICE

January 1, 2027

Wendy Jones
Abilene Christian University
213 Hardin Administration Building
Abilene, TX 79699

325-674-2359 / jonesw@acu.edu

IMPORTANT NOTICE FROM ACU ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Abilene Christian University has determined that the prescription drug coverage offered by Abilene Christian University is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the Abilene Christian University Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. **You can keep your current coverage from Abilene Christian University. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under Abilene Christian University is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage may be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Abilene Christian University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

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

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

Date: 1/1/2027

Name of Entity/Sender:	Abilene Christian University
Contact/Office:	Human Resources
Address:	213 Hardin Administration Building Abilene, TX 79699
Phone Number:	325-674-2359

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

Name of Entity/Sender:	Abilene Christian University
Contact/Office:	Human Resources
Address:	213 Hardin Administration Bldg Abilene, TX 79699
Phone Number:	325-674-2359

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

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

For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF AFTER DEDUCTIBLEDRESS CHANGES

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

PLAN CONTACT INFORMATION

Name of Entity/Sender:	Abilene Christian University
Contact/Office:	Human Resources
Address:	213 Hardin Administration Bldg Abilene, TX 79699
Phone Number:	325-674-2359

https://www.medicare.gov/basics/get-started-withmedicare/sign-up/when-does-medicare-coverage-start.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at Abilene Christian University Human Resources at 325-674-2359.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomyrelated services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 325-674-2359 for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier.

The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage.

Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the **Frequently Asked Questions (FAQs)** about the Newborns' and Mothers' Health Protection Act.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

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

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

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

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

If you believe you've been wrongly billed, you may contact Fairos Member Services at 855-426-1100.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

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

STATE	WEBSITE/E-MAIL	PHONE
Alabama (Medicaid)	myalhipp.com	855-692-5447
Alaska (Medicaid)	*Premium Payment Program:* **myakhipp.com** *Medicaid Eligibility:* health.alaska.gov/dpa *E-mail:* customerservice@myakhipp.com	866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California (Medicaid)	dhcs.ca.gov/hipp *E-mail:* hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	*Medicaid:* healthfirstcolorado.com *CHIP:* https://hcpf.colorado.gov/child-health-plan-plus *HIBI:* mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida (Medicaid)	flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia (Medicaid)	*HIPP:* medicaid.georgia.gov/health-insurance-premium-payment-program-hipp *CHIPRA:* medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	*HIPP:* http://www.in.gov/fssa/dfr/ *All other Medicaid:* in.gov/medicaid	800-403-0864 800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* hhs.iowa.gov/programs/welcome-iowa-medicaid *CHIP:* hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki *HIPP:* hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas (Medicaid)	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky (Medicaid and CHIP)	*KI-HIPP:* chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx *KI-HIPP E-mail:* KIHIPP.PROGRAM@ky.gov *KCHIP:* kynect.ky.gov *Medicaid:* chfs.ky.gov/agencies/dms	855-459-6328 877-524-4718
Louisiana (Medicaid)	*Medicaid:* ldh.la.gov/healthy-louisiana *or email:* healthy@la.gov *LaHIPP:* www.ldh.la.gov/lahipp *or email:* La.HIPP@la.gov	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine (Medicaid)	*Enrollment*: mymaineconnection.gov/benefits *Private health insurance premium:* maine.gov/dhhs/ofi/applications-forms	*Enroll:* 800-442-6003 *Private HIP:* 800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	mass.gov/masshealth/pa *Email:* masspremassistance@accenture.com	800-862-4840 TTY: 711

STATE	WEBSITE/E-MAIL	PHONE
Minnesota (Medicaid)	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri (Medicaid)	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	*HIPP:* dphhs.mt.gov/MontanaHealthcarePrograms/HIPP *HIPP Email:* HHSHIPPProgram@mt.gov	800-694-3084
Nebraska (Medicaid)	ACCESSNebraska.ne.gov	855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	*Medicaid:* dhcfp.nv.gov	800-992-0900
New Hampshire (Medicaid)	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program *Email:* DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218
New Jersey (Medicaid and CHIP)	*Medicaid:* state.nj.gov/humanservices/dmahs/clients/medicaid *CHIP:* njfamilycare.org/index.html	*Medicaid:* 800-356-1561 *CHIP Premium Assist:* 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York (Medicaid)	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina (Medicaid)	medicaid.ncdhhs.gov	919-855-4100
North Dakota (Medicaid)	hhs.nd.gov/healthcare	844-854-4825
Oklahoma (Medicaid and CHIP)	insureoklahoma.org	888-365-3742
Oregon (Medicaid)	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania (Medicaid and CHIP)	*Medicaid:* pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html *CHIP:* dhs.pa.gov/CHIP/Pages/CHIP.aspx	*Medicaid:* 800-692-7462 *CHIP:* 800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	scdhhs.gov	888-549-0820
South Dakota (Medicaid)	dss.sd.gov	888-828-0059
Texas (Medicaid)	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah (Medicaid and CHIP)	*UPP:* medicaid.utah.gov/upp/ *UPP Email:* upp@utah.gov *Adult Expansion:* medicaid.utah.gov/expansion/ *Utah Medicaid Buyout Program:* medicaid.utah.gov/buyout-program/ *CHIP:* chip.utah.gov	*UPP:* 877-222-2542
Vermont (Medicaid)	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia (Medicaid and CHIP)	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington (Medicaid)	hca.wa.gov	800-562-3022
West Virginia (Medicaid and CHIP)	dhhr.wv.gov/bms/ mywvhipp.com/	*Medicaid:* 304-558-1700 *CHIP:* 855-699-8447
Wisconsin (Medicaid and CHIP)	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming (Medicaid)	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

WELLNESS PROGRAM NOTICES

Abilene Christian University's wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary annual physical and a biometric screening. However, employees who choose to participate in the wellness program will receive an incentive of $25 per paycheck each for yourself and your enrolled spouse for completing an annual physical and biometric screening. Although you are not required to participate in the wellness prorgam, only employees and enrolled spouses who do so will receive the incentive for the following plan year.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at 325-674-2359.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Abilene Christian University may use aggregate information it collects to design a program based on identified health risks in the workplace, Abilene Christian University's wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are healthcare providers in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 325-674-2359

ACCOMMODATIONS

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees who are enrolled in one of the Abilene Christian University health plans. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at Human Resources at 325-674-2359 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTES

ABILENE CHRISTIAN UNIVERSITY

2027 Benefits Guide

November 2026