SMU

2026
EMPLOYEE BENEFITS GUIDE

WHAT'S INSIDE

At SMU,

A comprehensive and competitive benefits package is one of the many ways SMU invests in its employees and their families — underscoring our commitment to being a top employer in Dallas–Fort Worth and a model within higher education.

These benefits are designed to support health, financial security, and overall well-being at work, at home, and in every stage of life. From preventive care and wellness programs to retirement savings and family resources, this guide highlights the many tools available to help you and your loved ones make informed choices with confidence.

We encourage you to review this guide in full before making your benefit elections, and reach out to SMU Human Resources if you have any questions.

Thank you for all that you do.

Sheri Starkey

Vice President and
Chief Human Resources Officer

This guide provides a summary of plan highlights. This is not a binding contract. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this guide. Please consult the Summary Plan Description for information on covered charges, limitations and exclusions.

GETTING STARTED

Welcome to your 2026 Benefits Guide

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

Open Enrollment

Open Enrollment is your once-a-year opportunity to make changes to your benefits. Before you make your decisions, review the benefits guide in the Open Enrollment event in my.SMU.edu and other important details about the changes ahead.

When is Open Enrollment?

The Open Enrollment period is October 17–31, 2025. Elections made during enrollment will be effective January 1, 2026.

What's Changing in 2026?

Medical plan premiums will increase by about 5% across all plans and coverage levels. Most employees will see less than a $10 per month change per paycheck. The largest increase is about $11 per month for family coverage under the PPO plan.

Dental and vision plan premiums remain the same for 2026.

Questions?

Navigating your benefits is easier with support and the SMU Benefits team is here to help. When you have questions about your benefit options or need assistance with enrolling, contact the SMU Benefits Department at **214-768-3311**, email benefitsu@smu.edu or visit smu.edu/hr.

HOW TO ENROLL

BENEFITS AT A GLANCE

Core Benefits

- **Medical and Prescription Drug Plans:** Administered by BCBSTX
- **Dental Plan:** Administered by BCBSTX
- **Vision Plan:** Administered by VSP
- **Health Savings Account (HSA):** Available with HDHPs
- **Flexible Spending Accounts (FSAs):** Health Care and Dependent Care

Income Protection and Insurance

- **Basic and Supplemental Life/AD&D Insurance**
- **Short- and Long-Term Disability**
- **Critical Illness, Accident and Hospital Indemnity Insurance**

Retirement and Financial Wellness

- **403(b) Retirement Plan** – with contributions from SMU
- **Emeriti Health Account**
- **Legal and Identity Protection**

Additional Benefits

- **Fertility Coverage, Diabetes and Hypertension Programs**
- **Tuition Benefits and Tuition Exchange**
- **Paid Time Off, Holidays and Leave**
- **Employee Assistance and Wellness Programs**
- **Caregiving and Education Support**

ENROLLING IN BENEFITS AT MY.SMU.EDU

Before You Enroll

- Review the options in this Benefits Guide and at smu.edu/hr
- Have dependent information available, including names, dates of birth, and Social Security numbers
- Ensure you know your SMU Employee ID and login credentials

Making Your Elections

- New hires must complete enrollment within 31 days of their hire date.
- If you experience a qualifying life event, you must make changes within 31 days of the event.
- During Open Enrollment, you must make new elections each year for FSAs and HSAs; prior elections do not automatically carry forward.

Important Reminders

- Changes to your benefits during the year are only permitted if you experience a qualifying life event.
- Review your paycheck deductions after enrollment to ensure accuracy.
- To correct dependent information, email the SMU Benefits Department at benefitsu@smu.edu.
- You will receive an email in November once your elections are finalized, with instructions to view your confirmation statement in my.SMU.edu.
- Your benefit summary will also be available in my.SMU.edu immediately after you submit your elections.

ELIGIBILITY

Employee Eligibility

If you regularly work 20 hours or more per week as a benefit eligible employee, you are eligible to enroll in SMU's benefits plans during your first 31 days of employment, within 31 days of a qualified "Life Event," or during the annual Open Enrollment.

Dependent Eligibility

Eligible dependents include your legal spouse and dependent children. "Children" are defined as your biological children, stepchildren, legally adopted children, and children for whom you are the legal guardian. Children who are physically or mentally disabled and incapable of self-support may continue coverage beyond the normal age limits with proof of disability.

Qualifying Life Events — When you can make changes to your benefits.

Outside of Open Enrollment, you can only change benefits if you have a **Qualifying Life Event**, such as:

- Marriage or divorce
- Birth or adoption of a child
- Death of a covered dependent
- Gaining or losing other health coverage
- Spouse/child starts or ends a job with benefits

If you experience a Qualifying Life Event and want to update your benefits, you must report it within 31 days of the event. Visit my.SMU.edu and submit the change request through the Open Enrollment portal. Then, email the Department of Human Resources at benefitsu@smu.edu with your SMU ID, the type of Life Event, and the date the event occurred (for example, the date of marriage, birth, or coverage loss). Once received, the Benefits team will review your request and email you detailed instructions on how to complete your benefits changes and upload any required documentation.

Coverage by Plan

- **Medical and Dental:** Children through age 25. Coverage ends the day before the child's 26th birthday.
- **Vision:** Children through age 24. Coverage ends on the last day of the month of the child's 25th birthday.
- **Supplemental Health Plans:** Spouse and dependent children through age 25. Coverage ends the day before the child's 26th birthday.
- **Supplemental Life Insurance:** Unmarried children through age 24, as well as unmarried natural or adopted grandchildren through age 24 if financially dependent on you. Coverage ends the day before the child's 26th birthday.
- **Accidental Death & Dismemberment (AD&D):** Unmarried children through age 24, as well as unmarried natural or adopted grandchildren through age 24 if financially dependent on you. Coverage ends the day before the child's 26th birthday.

Medicaid/CHIP?

You have 60 days to report changes if:

- Coverage ends due to ineligibility
- You become eligible for Medicaid/CHIP premium help

Important Note About Newborns

Newborns are NOT automatically added to your coverage.

You must actively enroll them within 31 days of birth — or they will not be covered.

Covering dependents who are not eligible is a violation of both the Internal Revenue Code and University policy.

If your child becomes ineligible for coverage you must notify the Department of Human Resources at benefitsu@smu.edu.

BENEFITS COST

SMU pays a significant portion of the overall cost of your medical and dental benefits. The amount you pay will depend on the choices you make. The table below illustrates the bi-weekly and monthly cost of coverage for full-pay-year employees.

Full-Pay-Year Employees

	Bi-Weekly Faculty/Staff Rate	Monthly Faculty/Staff Rate	Monthly SMU Rate
$2,000 Deductible PPO			
Employee Only	$55.54	$120.34	$901.78
Employee + Spouse	$119.39	$258.67	$1,989.98
Employee + Child(ren)	$111.45	$241.47	$1,904.97
Employee + Family	$173.22	$375.31	$2,895.47
$3,400 Deductible HDHP			
Employee Only	$18.71	$40.53	$918.05
Employee + Spouse	$38.36	$83.11	$2,025.78
Employee + Child(ren)	$34.10	$73.89	$1,939.14
Employee + Family	$55.36	$119.94	$2,947.55
$5,000 Deductible HDHP			
Employee Only	$8.90	$19.29	$874.02
Employee + Spouse	$19.58	$42.43	$1,922.86
Employee + Child(ren)	$17.80	$38.56	$1,748.09
Employee + Family	$28.47	$61.69	$2,796.95
Dental Plan			
Employee Only	$3.46	$7.49	$46.00
Employee + One	$20.26	$43.89	$60.65
Employee + Family	$29.83	$64.62	$79.79
Vision Plan			
Employee Only	$2.90	$6.28	$0
Employee + One	$5.80	$12.56	$0
Employee + Family	$9.34	$20.22	$0

On average, SMU employees pay 25% of the overall medical and pharmacy costs while SMU pays approximately 75%. The employee and SMU contributions listed in the tables above and on pages 8–9 are just one part of the total overall medical and pharmacy cost. Other variables that contribute to the overall medical and pharmacy cost include copays (depending on plan election) and coinsurance, both of which are payment toward the annual deductible and out-of-pocket maximum.

BENEFITS COST

SMU pays a significant portion of the overall cost of your medical and dental benefits. The amount you pay will depend on the choices you make. The table below illustrates the monthly and bi-weekly cost of coverage for partial-pay-year employees.

Partial-Pay-Year Employees

	9 Months Faculty/Staff Rate		10 Months Faculty/Staff Rate		11 Months Faculty/Staff Rate	
	Bi-Weekly	Monthly	Bi-Weekly	Monthly	Bi-Weekly	Monthly
$2,000 Deductible PPO						
Employee Only	$72.20	$160.46	$65.65	$144.41	$60.17	$131.28
Employee + Spouse	$155.20	$344.90	$141.10	$310.41	$129.34	$282.19
Employee + Child(ren)	$144.88	$321.97	$131.71	$289.77	$120.74	$263.42
Employee + Family	$225.19	$500.41	$204.71	$450.37	$187.65	$409.42
$3,400 Deductible HDHP						
Employee Only	$24.32	$54.05	$22.11	$48.64	$20.27	$44.22
Employee + Spouse	$49.87	$110.81	$45.34	$99.73	$41.55	$90.67
Employee + Child(ren)	$44.33	$98.53	$40.30	$88.67	$36.95	$80.61
Employee + Family	$71.96	$159.92	$65.42	$143.93	$59.97	$130.85
$5,000 Deductible HDHP						
Employee Only	$11.57	$25.72	$10.52	$23.14	$9.65	$21.04
Employee + Spouse	$25.46	$56.57	$23.14	$50.92	$21.22	$46.28
Employee + Child(ren)	$23.14	$51.41	$21.03	$46.27	$19.28	$42.07
Employee + Family	$37.02	$82.26	$33.65	$74.03	$30.85	$67.30
Dental Plan						
Employee Only	$4.50	$9.99	$4.09	$8.99	$3.75	$8.18
Employee + One	$26.34	$58.52	$23.94	$52.67	$21.95	$47.88
Employee + Family	$38.78	$86.16	$35.25	$77.55	$32.31	$70.50
Vision Plan						
Employee Only	$3.77	$8.38	$3.43	$7.54	$3.14	$6.86
Employee + One	$7.54	$16.75	$6.86	$15.08	$6.28	$13.71
Employee + Family	$12.14	$26.96	$11.03	$24.27	$10.11	$22.06

MEDICAL COVERAGE

All Plans Cover

- **100% of preventive care** (physicals, screenings, immunizations)
- **Virtual visits** with MDLIVE
- **Fertility treatments** (up to $15,000 for medical and $15,000 for Rx)

Get the Most Current List of In-network Providers

Find online at the Doctor and Hospital Finder at bcbstx.com (select Blue Choice PPO plan option when prompted).

bcbstx.com

$2,000 PPO Plan

- **Copays:** $25 for primary care, $30 for urgent care, $75 for specialists (not subject to deductible)
- **Deductible:** $2,000 individual / $6,000 family
- **After Deductible:** You pay 20%, plan pays 80%
- **Rx Coverage:** Coinsurance (30–50%) after $100 brand-name drug deductible
- **Best for:** Employees who prefer predictable copays and lower upfront costs for office visits, with higher premiums in exchange for more cost certainty at the point of care

$3,400 High Deductible Health Plan (HDHP)

- **You pay full cost** for most services (including Rx) until you meet the deductible.
- **Deductible:** $3,400 individual / $6,800 family
- **After Deductible:** Plan pays 100%, except:
  - $25 copay (PCP)
  - $75 copay (Specialist)
  - $300 ER copay (if not admitted)
  - Rx coinsurance applies
- **HSA Eligible:** Yes
- **Best for:** Employees seeking lower premiums and the opportunity to contribute to an HSA, and who are comfortable paying more out-of-pocket until the deductible is met

$5,000 High Deductible Health Plan (HDHP)

- **You pay 100%** until deductible is met
- **Deductible and Out-of-Pocket Max are the same:** $5,000 individual / $10,000 family
- **After Deductible:** Plan pays everything (no copays or coinsurance).
- **HSA Eligible:** Yes
- **Best for:** Employees who rarely need care and want the lowest premiums and are prepared to pay the full deductible before the plan pays 100% of covered services

2026 Medical Plan Comparison

	$2,000 PPO		$3,400 HDHP		$5,000 HDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible						
Individual	$2,000	$4,000	$3,400	$4,000	$5,000	$7,500
Family	$6,000	$8,000	$6,800	$8,000	$10,000	$15,000
Annual Out-of-Pocket Maximum (includes deductible, copays and coinsurance)						
Individual	$5,000	$10,000	$5,000	$10,000	$5,000	$10,000
Family	$10,000	$20,000	$10,000	$20,000	$10,000	$20,000
Office Visit						
Primary Care Physician	$25 copay not subject to deductible	40%*	$25 copay after deductible	40%*	$0 after deductible	40%*
Specialist	$75 copay not subject to deductible		$75 copay after deductible		$0 after deductible	
Routine Preventive Care**	$0		$0		$0	
Emergency Care						
Urgent Care Center	$30 copay not subject to deductible	40%*	$30 copay after deductible	40%*	$0 after deductible	40%*
Hospital Emergency Room						
Emergency Care	Deductible + $300 copay + 20% Copay waived if admitted to hospital		Deductible + $300 copay Copay waived if admitted to hospital		0%*	
Non-Emergency Care	Deductible + $300 copay + 20% Copay waived if admitted to hospital	Deductible + $300 copay + 40% Copay waived if admitted to hospital	Deductible + $300 copay + 0% Copay waived if admitted to hospital	Deductible + $300 copay + 40% Copay waived if admitted to hospital	Deductible + $300 copay + 40%	

*After deductible has been satisfied ** Routine physicals, medical screenings, immunizations, preventive mammograms, colonoscopies and prostate exams

Fertility treatment coverage provides medically necessary services for fertility treatments including artificial insemination (AI) and in-vitro fertilization (IVF) and includes a lifetime maximum medical benefit up to $15,000, and lifetime maximum prescription drug benefit up to $15,000. For more information, contact BCBS at (877)-768-2005.

Note about the $3,400 and $5,000 plans: With the exception of preventive care services, this plan does not begin paying any benefits until your annual deductible has been satisfied. After you satisfy the annual deductible, you will also have satisfied the out-of-pocket maximum and the Plan pays 100% of your eligible in-network expenses.

IMPORTANT: About Medicare Part D Coverage If you enroll in the $3,400 or $5,000 HDHP with the HSA and you are eligible for Medicare (or will be Medicare-eligible in the next few years), it's important to know that this plan does not provide "creditable coverage" should you enroll in the Medicare Part D prescription plan going forward. This means if you enroll in this plan and later enroll in Medicare Part D, you will incur a 1% late enrollment fee for every month you remain in this plan past your eligibility for Medicare.

2026 Medical Plan Comparison *(continued)*

<table>
<tr><th></th><th colspan="2">$2,000 PPO</th><th colspan="2">$3,400 HDHP</th><th colspan="2">$5,000 HDHP</th></tr>
<tr><th></th><th>In-Network</th><th>Out-of-Network</th><th>In-Network</th><th>Out-of-Network</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td colspan="7">Other Services</td></tr>
<tr><td>Physical Therapy</td><td rowspan="8">20%*</td><td rowspan="9">40%*</td><td rowspan="8">0%*</td><td rowspan="9">40%*</td><td rowspan="9">0%*</td><td rowspan="9">40%*</td></tr>
<tr><td>Chiropractic Services
Up to 35 visits per calendar year</td></tr>
<tr><td>Hearing Aids
One per ear, every 36 months, no dollar limit</td></tr>
<tr><td>Hospital Inpatient Care</td></tr>
<tr><td>Hospital Outpatient Care</td></tr>
<tr><td>Home Health Care
Up to 60 visits per calendar year</td></tr>
<tr><td>Hospice Care
180-day lifetime maximum</td></tr>
<tr><td>Mental Health/Substance Abuse Inpatient Care (Facility)</td></tr>
<tr><td>Mental Health/Substance Abuse Outpatient Care
(Office Visit)</td><td>PCP visit:
$25 copay
Specialist visit:
$75 copay</td><td>PCP visit:
$25 copay
after deductible
Specialist visit:
$75 copay
after deductible</td></tr>
<tr><td colspan="7">Speech Therapy</td></tr>
<tr><td>Outpatient Visit</td><td>20%*</td><td rowspan="2">40%*</td><td>0%*</td><td rowspan="2">40%*</td><td>0%*</td><td rowspan="2">40%*</td></tr>
<tr><td>Doctor Office Visit</td><td>Specialist visit:
$75 copay</td><td>Specialist visit:
$75 copay</td><td>Specialist visit:
0%*</td></tr>
</table>

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Fertility treatment coverage provides medically necessary services for fertility treatments including artificial insemination (AI) and in-vitro fertilization (IVF) and includes a lifetime maximum medical benefit up to $15,000, and lifetime maximum prescription drug benefit up to $15,000. For more information, contact BCBS at (877)-768-2005.

Note about the $3,400 and $5,000 plans: With the exception of preventive care services, this plan does not begin paying any benefits until your annual deductible has been satisfied. After you satisfy the annual deductible, you will also have satisfied the out-of-pocket maximum and the Plan pays 100% of your eligible in-network expenses.

IMPORTANT: About Medicare Part D Coverage If you enroll in the $3,400 or $5,000 HDHP with the HSA and you are eligible for Medicare (or will be Medicare-eligible in the next few years), it's important to know that this plan does not provide "creditable coverage" should you enroll in the Medicare Part D prescription plan going forward. This means if you enroll in this plan and later enroll in Medicare Part D, you will incur a 1% late enrollment fee for every month you remain in this plan past your eligibility for Medicare.

PRESCRIPTIONS

Prescription drug benefits are included with all SMU medical plans and administered by Prime Therapeutics. You have access to multiple options for filling prescriptions, depending on the type and duration of your medication. Coverage is available through retail pharmacies, a home delivery program for maintenance medications and a specialty pharmacy program for complex or high-cost treatments.

Retail Prescription Program

This program is for short-term or immediate-use prescriptions, such as antibiotics or pain relievers.

- Available at in-network pharmacies across the U.S.
- 30-day supply per fill
- Prescriptions filled at non-participating pharmacies are typically not covered.

Express Scripts Home Delivery Service

Designed for maintenance medications taken regularly, such as for asthma, blood pressure or diabetes.

- Receive up to a 90-day supply mailed to your home
- Lower out-of-pocket costs compared to retail pharmacies
- Avoid frequent pharmacy visits and benefit from automatic refills mailed directly to your home
- Specialty medications cannot be filled through this program

For questions about the Express Scripts Home Delivery Service, call **833-715-0942**.

Accredo Specialty Prescription Program

Specialty drugs treat complex or chronic conditions, including cancer, multiple sclerosis, rheumatoid arthritis and fertility. These medications often require special handling, storage or administration and must be filled through the Accredo Specialty Pharmacy.

Accredo provides:

- Direct delivery of specialty medications to your home
- 24/7 access to pharmacists and care teams
- Ongoing therapy management and education
- Complimentary supplies such as syringes, sharps containers and storage tools
- Coordination between your doctor and pharmacy to help manage care and authorizations

For questions about the Accredo Specialty Pharmacy, call **833-721-1619**.

For a complete list of medications for which a dispensing limit exists, visit bcbstx.com.

Prescription Costs

The $3,400 HDHP covers a portion of the cost of prescription drugs AFTER you meet your annual in-network deductible (for both retail network pharmacies and the home delivery program).

The $5,000 HDHP covers 100% of the cost of prescription drugs AFTER you meet your annual in-network deductible (for both retail network pharmacies and the home delivery program).

	Retail 30-day supply	**Home Delivery** 90-day supply for maintenance medications 30-day supply for specialty medications
$2,000 Deductible PPO You pay the following after satisfying a $100 deductible each year for any brand name medications:		
Generic	30% of cost	30% of cost up to $20 per prescription
Preferred Brand Name		30% of cost up to $98 per prescription
Non-Preferred Brand Name	50% of cost	50% of cost
Specialty Medication	*Specialty medications must be filled through Accredo Specialty Pharmacy*	30% of cost up to $225 max. per prescription
$3,400 Deductible PPO You pay 100% of the cost until you have satisfied the annual plan deductible; then you pay the following amounts:		
Generic	30% of cost	30% of cost up to $20 per prescription
Preferred Brand Name		30% of cost up to $98 per prescription
Non-Preferred Brand Name	50% of cost	50% of cost
Specialty Medication	*Specialty medications must be filled through Accredo Specialty Pharmacy*	30% of cost up to $225 max. per prescription
$5,000 Deductible PPO You pay 100% of the cost until you have satisfied the annual plan deductible; then you pay the following amounts:		
Generic	0% of cost	0% of cost
Preferred Brand Name		
Non-Preferred Brand Name		
Specialty Medication	*Specialty medications must be filled through Accredo Specialty Pharmacy*	

NOTE: Whenever there is a generic drug available, it will be substituted for a brand name drug, unless otherwise directed by your physician as “Brand Necessary” on your prescription.

ADDITIONAL COVERAGE AND RESOURCES

SMU's medical plans go beyond basic coverage to support your total health — physically, mentally and emotionally. These programs and services are included with your medical plan and are available to you and your covered dependents:

Well-being Management Through BCBSTX

This platform provides tools and support to help you stay informed and make confident health decisions, including:

- **24/7 Nurse Line:** Call **800-581-0368** for health advice and round-the-clock access to experienced nurses.
- Online tools for 250+ conditions, treatment options and decision support

For more information about BCBSTX's Well-being Management platform, please visit bcbstx.com and log into your Blue Access for Members (BAM) portal or call BCBSTX at **800-462-3275**.

Women's and Family Health Fertility Coverage

The coverage provides medically necessary services for fertility treatments, including artificial insemination (AI) and in-vitro fertilization (IVF). Coverage includes a lifetime maximum medical benefit up to $15,000, and lifetime maximum prescription drug benefit up to $15,000.

For more information, please contact BCBS at **877-768-2005**.

High Risk Pregnancy Support

If you are expecting and your pregnancy is considered high risk, extra help is available through BCBSTX. The program provides guidance and support tailored to high-risk pregnancies, including health education, treatment plans, and referrals. A maternity specialist may also reach out to help you care for yourself and your baby throughout your pregnancy. This support is available at no additional cost to you when enrolled in an SMU medical plan.

Well onTarget

BlueCross BlueShield's Well onTarget gives you the support you need to make healthy lifestyle choices — and rewards you for your hard work.

- **Health and wellness library:** Articles, podcasts, and videos on health topics important to you
- **Digital self-management programs:** Learn about nutrition, fitness, weight loss, quitting smoking, managing stress, and more
- **Fitness center discounts:** Access to nationwide network of fitness centers and classes (digital and live)
- **Blue points:** Earn points for wellness activities, and redeem them for a variety of retail gift cards
- **Health assessment:** Learn more about your health and receive a personal wellness report
- **Tools and trackers:** Interactive resources to help keep you on track
- **AlwaysOn app:** Sync with devices to track activity and nutrition, complete self-management programs, and more

Well onTarget is available to everyone age 18+ on an SMU medical plan. To access the portal, log into Blue Access for Members at bcbstx.com and click the Wellness tab.

ADDITIONAL COVERAGE AND RESOURCES

Mastectomy Coverage

The medical plans cover surgery after a mastectomy to:

- Reconstruct the breast on which the mastectomy was performed.
- Reconstruct the other breast to produce a symmetrical appearance.

This coverage is required by federal law. Prostheses and physical complications in all stages of the mastectomy, including lymphedemas, are also covered.

Maternity Coverage

Consistent with federal law, SMU's medical plans do not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a Caesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

MDLIVE Virtual Visits

MDLIVE provides you and your covered dependents 24/7/365 access to board-certified physicians for non-emergency medical care through the convenience of phone or video consults.

MDLIVE on App Store

MDLIVE on Google Play

MDLIVE doctors and therapists can help treat many common medical conditions, including:

- General health issues such as allergies, asthma, nausea and sinus infections
- Pediatric care such as cold or flu, ear infections and pinkeye
- Behavioral health issues like anxiety or depression, child behavior or learning issues and marital problems

Costs per virtual visit by plan:

- $2,000 PPO Option = $0 copay for general medical and behavioral health (deductible does not apply)
- $3,400 HDHP Option* = $48 before deductible for general medical, then covered at 100%
- $5,000 HDHP Option* = $48 before deductible for general medical, then covered at 100%

*Costs for behavioral health visit on the HDHP plans will vary depending on provider type (licensed therapists, or board-certified doctors). Once the deductible is met, medical and behavioral visits are covered at 100%.

To register or learn more about MDLIVE Virtual Visits, visit mdlive.com.

Concierge Service/Price Transparency

To help you make informed and cost-effective healthcare decisions, SMU partners with Alight, a concierge service available at no cost to employees enrolled in an SMU medical plan. Alight acts as your personal health advocate, guiding you through the complexities of care by helping you understand your benefits, find highly rated doctors, compare costs, schedule appointments and identify lower-cost alternatives for prescriptions and procedures. The service also offers assistance with medical billing questions, giving you and your family added support in managing your healthcare needs.

For more information, please contact Alight at **800-513-1667** or visit member.alight.com.

HEALTH SAVINGS ACCOUNTS (HSA)

If you're enrolled in one of SMU's High Deductible Health Plans (HDHPs), you can open a Health Savings Account (HSA) — a smart, tax-advantaged way to save for medical expenses. Your HSA is like a personal health piggy bank. You can use it to pay for things like doctor visits, prescriptions, dental work, glasses and even future medical costs. The money is yours to keep, even if you leave SMU, and it rolls over year after year.

Who is Eligible?

In order to participate in an HSA, you:

- Must be enrolled in the $3,400 or $5,000 HDHP.
- Cannot be covered by any other health plan that is not an HDHP.
- Cannot currently be enrolled in Medicare or Tricare.
- Cannot have received medical benefits through the Department of Veterans Affairs (VA) during the preceding three months.
- Cannot be claimed as a dependent on another person's tax return.

HSA Contribution Limits

For 2026, you can contribute up to a maximum of $4,400 for an individual or up to $8,750 for a family. If you are age 55 or older, you can contribute an additional $1,000 in catch-up contributions. Your contributions are deducted from your paycheck on a pretax basis, reducing your taxable income. The money is placed in an account, where it earns interest after you contribute a certain amount. The money in your HSA is always yours to keep.

HSA Fees: SMU pays the monthly account fee on behalf of active employees contributing to the HSA with HealthEquity. Other fees are the responsibility of the HSA participant.

How to Set Up Your HSA

1. Enroll in the $3,400 or $5,000 HDHP during Open Enrollment:
   – You must be in one of these plans to be eligible for an HSA.
2. Elect your HSA contribution in my.SMU.edu:
   – Decide how much you want to set aside for 2026 (you can change it anytime)
3. Your HSA account will be opened automatically with HealthEquity:
   – Once enrolled, you'll receive a welcome email and HSA debit card.

If you don't complete all steps during enrollment, your HSA may not be fully set up — and contributions won't begin.

4. If you have questions about the HSA or want to take advantage of HealthEquity's online customer service tools, visit my.healthequity.com.

If you would like your out-of-pocket expenses, including the deductible, to be automatically debited from your HSA, contact HealthEquity at **866-346-5800** to sign up for auto-adjudication.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

FSAs let you set aside money from your paycheck before taxes to help cover eligible out-of-pocket expenses — saving you money on things you're already paying for. SMU offers two types of FSAs: one for health care costs and one for dependent care.

Health Care FSA

The Health Care FSA can be used to pay for qualified medical, dental and vision expenses for you and your eligible dependents. This includes things like copays, prescriptions, eyeglasses orthodontics and more. For 2025, the maximum contribution is $3,300. The IRS will announce the 2026 limit later this year, and it is expected to increase slightly. You don't need to be enrolled in an SMU medical plan to participate. However, employees enrolled in the $3,400 or $5,000 HDHP cannot contribute to the SMU Health Care FSA.

Dependent Care FSA

The Dependent Care FSA helps cover expenses like daycare, after-school programs, summer day camps or elder care for a dependent adult — anything that allows you (and your spouse, if applicable) to work. For 2026, you can contribute up to $7,500 per household, or $3,750 if married and file separate tax returns. Note: This account is for care expenses only, not medical expenses for your dependents.

How to Set Up Your FSA

1. Elect your FSA(s) during Open Enrollment in my.SMU.edu.
2. Choose how much to contribute for the year — this amount is fixed unless you have a qualifying life event.
3. Use your FSA debit card or submit claims for reimbursement as you incur eligible expenses.
4. Manage your account online through WEX, SMU's FSA administrator.

Important

In order to participate in an HSA:

- The Health Care FSA includes a carryover feature — you can roll over a limited amount of unused funds into the next plan year (the limit is set annually by the IRS; for 2025, it is $660). Any remaining funds above that amount must be used by March 31, 2027, or they will be forfeited.
- The Dependent Care FSA does not allow rollovers — be sure to use all funds by March 31, 2027, or they will be forfeited.
- If you have an unused 2025 Health Care FSA balance that rolls over into 2026, you will be ineligible to contribute to a Health Savings Account in 2026 if you switch to the $3,400 or $5,000 HDHP in 2026.
- Keep in mind, if you enroll in the $3,400 or $5,000 HDHP, you cannot contribute to the SMU Health Care FSA.
- For more details regarding eligible expenses, visit: wexinc.com/insights/benefits-toolkit/eligible-expenses.

WHY BOTHER WITH AN HSA OR FSA?

Reduce Your Taxable Income and Save!

Let's say you and your family average $2,000 a year in out-of-pocket health care expenses (medical, prescription, dental and vision expenses) that your SMU health plans don't fully cover (copays, deductibles and coinsurance).

- **If you enroll in the $2,000 Deductible PPO**, contribute $2,000 (or more) to the Health Care FSA to reimburse yourself for the $2,000 estimated out-of-pocket expense. You need to be careful about how much you contribute to the FSA since any Health Care FSA funds over $660 remaining in your account at the end of the year are forfeited and do NOT roll over to future years. For 2025, the maximum contribution is $3,300. The IRS will announce the 2026 limit later this year, and it is expected to increase slightly.
- **If you enroll in the $3,400 or $5,000 HDHP**, contribute $2,000 (or more) to the Health Savings Account (HSA) to reimburse yourself for the $2,000 estimated out-of-pocket expense. Any HSA funds remaining in your account at the end of the year will roll over from year-to-year to help pay for future eligible expenses. The maximum annual HSA contribution is $4,400 for an individual and $8,750 for family coverage, plus an additional $1,000 if you are age 55 or older.

	No FSA or HSA Contribution	Health Care FSA Contribution	HSA Contribution
Monthly Income*	$3,917	$3,917	$3,917
Monthly Contribution Pretax Deduction	No Contribution	$167	$167
Monthly Taxable Income Less FSA/HSA Contribution	$3,917	$3,750	$3,750
Monthly Federal Income and Social Security Tax**	$1,279	$1,224	$1,224
Monthly Remaining Income	$2,638	$2,526	$2,526
Monthly Tax Savings	$0	($55)	($55)
Annual Tax Savings	$0	($660)	($660)

* Assumes $47,000 annual salary

** Assumes 25% tax bracket and 7.65% FICA tax (SS and Medicare)

- By using pretax dollars to pay for eligible health care expenses, the Health Care FSA or the HSA allows you to save $55 a month ($660 a year) that you would otherwise pay in taxes!
- HSAs offer three separate tax savings benefits: pre-tax contributions, tax-free interest and investment earnings and tax-free payments for qualified medical expenses. Thus, if used for qualified medical expenses, these dollars are never taxed! FSAs offer two tax savings benefits: pre-tax contributions and tax-free payments for qualified medical expenses. Just remember all HSA dollars roll over to the next year, but FSA dollars generally must be used by the end of the calendar year as any Health Care FSA balance over $660 is forfeited and does NOT roll over to future years.

DENTAL COVERAGE

Your smile matters — so SMU offers dental coverage to help you stay on top of routine care and handle unexpected dental needs. Whether it's preventive visits like cleanings and checkups or more involved services like fillings, crowns or orthodontics, this plan helps make dental care more affordable for you and your family. Coverage is available for individuals, spouses and children, with access to a large network of providers through BlueCross BlueShield of Texas.

If you sign up for the dental plan and the medical plan, you will receive a single ID card that covers medical, prescription, and dental services.

Dental Plan Summary	
Lifetime Preventive Care Deductible	
Per Person	$50
Annual Out-of-Pocket Maximum (includes deductible, copays and coinsurance)	
Per Person	$75
Office Visit	
Per Child	$100
Emergency Care	
Preventive Care Services Exam and Cleanings Twice a Year	The plan pays 100% (after Preventive Care deductible)
Basic Services	The plan pays 80%* up to Annual Benefit Maximum
Major Services Includes Implants	The plan pays 50%* up to Annual Benefit Maximum
Orthodontic Services Children up to age 20	The plan pays 50%* up to a lifetime maximum of $1,800 per child
Office Visit Copay	None
Annual Benefit Maximum	
Per Person	$1,800

*After deductible

Visit smu.edu/hr > Benefits and Wellness > Health and Other Benefits > Health > Dental Plan

VISION COVERAGE

Keeping your eyes healthy is just as important as the rest of your wellness — and SMU's vision plan makes it easy. Through VSP (Vision Service Plan), you'll get access to a wide network of eye doctors and great savings on exams, glasses, contact lenses and even laser vision correction. Whether you wear glasses every day or just need an annual checkup, this plan helps you and your family see clearly without breaking the bank.

Vision Plan Summary			
Service	**Frequency**	**In-Network Benefits**	**Out-of-Network Benefits**
Exam	Once per calendar year	100% after $10 copay	$45
Prescription Eye wear	Choose glasses or contacts – you cannot receive both in the same service period.		
Lenses	Once per calendar year	100% after $15 copay (applies to lenses and frames)	$5.10
Frames OR Contact Lenses	Once every other calendar year	Up to $130 retail Up to $130 allowance	Up to $45 retail Up to $105 allowance

Note: The frequency allowances shown above are based on a calendar-year period.

- VSP Retailers include Costco, Visionworks, Pearl Vision and Texas State Optical.
- VSP also offers discounts for LASIK surgery if you use a participating in-network eye doctor.
- Take advantage of the VSP Essential Medical Eye Care Program which offers a retinal screening.

For all of your vision coverage needs

Need the list of network providers?
Want to print a member reference card?
Just want to learn more vision coverage details?

Visit smu.vspforme.com or contact VSP Member Services at **800-877-7195**.

When you schedule an appointment, ask the office staff to confirm the provider is still in the VSP Network.

LIFE AND AD&D INSURANCE

Basic Group Life Insurance

SMU provides Basic Group Life Insurance for all eligible employees at no cost to you. The Standard administers this policy, which is designed to provide financial protection to your beneficiaries in the event of your death. The Group Life Insurance benefit provides emergency travel assistance services. Key benefits include: emergency medical and personal assistance while traveling more than 100 miles away from home and immediate access to doctors, hospitals, pharmacies and certain other services in a medical-related emergency – 24 hours a day, 365 days a year.

Basic Group Life Insurance		
For...	**Coverage**	**Paid By**
Employee	1.5 times your annual base salary up to a $750,000 maximum	SMU
Post-Doctoral Fellow	$10,000	SMU

Supplemental Group Life Insurance

You may purchase Supplemental Group Life Insurance for yourself, your spouse and your dependent children. You may only elect coverage for your spouse and dependent children if you choose Supplemental coverage for yourself. You pay the cost of Supplemental Group Life Insurance through payroll deductions on a post-tax basis. **Premium rates can be found by visiting the link below.**

Supplemental Group Life Insurance				
For...	**Minimum**	**Incremental Unit**	**Guarantee Issue Amount**	**Maximum**
Employee	1x Annual Base Rate	1x Annual Base Rate	$500,000	5x Annual Base Rate*
Spouse	Lesser of $50,000 or 1x Annual Base Rate			
Child(ren)	$10,000		SMU	

* or $750,000, whichever is less

Note: Amounts of coverage elected above the Guarantee Issue amount are subject to medical underwriting approval. To submit a medical history statement online, visit: myeoi.standard.com/instructions.

Important

There is an age reduction provision that applies to both the Basic Life and Supplemental Life Insurance policies beginning at age 65.

Accidental Death and Dismemberment Insurance

You can purchase Individual or Family Accidental Death and Dismemberment (AD&D) Insurance for yourself, your spouse and your dependent children. This policy is also administered by The Standard. You pay for the cost of AD&D insurance through payroll deductions on a pretax basis.

- You may purchase Individual or Family AD&D insurance in $10,000 increments, up to $500,000 maximum.
- The coverage amount that you elect is referred to as the Principal Sum.
- If you elect Family coverage, your spouse is covered for 60% of your Principal Sum and each child is covered for 20% of your Principal Sum up to the $25,000 maximum per child.

The benefit amount your dependents receive if you die or are injured as a result of an accident, or the amount you receive if your dependents die or become injured as a result of an accident, varies according to the type of loss and the amount of coverage you selected.

Note: You are automatically the beneficiary for any dependent AD&D coverage you elect.

Beneficiary Designation

You MUST designate a beneficiary for your Basic and Supplemental Group Life Insurance and AD&D Insurance when you elect coverage. Your beneficiary is the person (or people, estate, trust, etc.) who will receive your Life and/or AD&D insurance benefits if you die.

- You may change your beneficiary at any time via The Standard's Online Beneficiary Designation System at standard.benselect.com/smu. If you do not name a beneficiary, or if your beneficiary dies before you, benefits will be paid to your estate.

Important: There is an age reduction provision that applies to the Voluntary AD&D Insurance policies beginning at age 75.

DISABILITY

Administered by The Standard

Short-Term Disability

SMU provides you with an opportunity to enroll in Short-Term Disability (STD). This is a 90-day benefit; it replaces a portion of your weekly income if you are unable to work due to a qualified illness or non-work-related injury, such as the birth of a new child. The benefit is employee paid.

If you become disabled from performing the material and substantial duties of your own occupation, this weekly benefit begins to pay after a 14-day elimination period. The benefit pays 60% of your average weekly salary, up to a maximum of $2,500 per week for the duration of disability (not to exceed 90 days).

Long-Term Disability

All full-time benefits-eligible staff and faculty are automatically covered under SMU's Long-Term Disability Plan after three months of employment. The cost of this benefit is paid entirely by SMU.

If you are eligible and you become totally and permanently disabled for 90 days, you will receive monthly income equal to 60% of your basic annual earnings, up to a maximum of $15,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you may be eligible to receive (such as Workers' Compensation).

OPTIONAL SUPPLEMENTAL INSURANCE PLANS

SMU offers three voluntary insurance options through The Standard Insurance Company that provide cash benefits when you experience an accident, serious illness or hospital stay. These plans are designed to complement your medical coverage by helping you pay for out-of-pocket expenses, like deductibles, copays and daily living costs. Each plan pays benefits directly to you, and you decide how to use the funds.

Group Accident Insurance

Life happens — and when it does, this plan helps cover the unexpected costs that follow an injury. If you or a covered family member is hurt in an accident, you'll get cash paid directly to you to help with medical bills, deductibles or anything else you need. It covers a wide range of situations like broken bones, concussions, burns, ER visits and even includes an extra benefit for youth sports injuries. You choose how to use the money — whether it's for treatment, transportation or just keeping life on track while you recover.

Monthly Premiums

Coverage for...	Basic	Premier
You	$10.68	$15.66
You and your spouse	$17.62	$25.22
You and your children	$19.79	$29.24
You, your spouse and your children	$31.29	$46.06

Hospital Indemnity Insurance

A serious diagnosis can come with serious expenses. If you're diagnosed with a covered condition like cancer, heart attack or hospital stay can lead to unexpected costs — this plan helps lighten the load. If you or a family member is admitted to the hospital, you'll receive a cash payment directly, which you can use for anything from medical bills to household expenses. The plan pays a lump sum for admission and daily amounts while you're hospitalized. Coverage is available for your spouse and children, and if you're in the hospital for more than 30 days, your premiums are waived. It's a helpful add-on to your regular health plan.

Monthly Premiums

Coverage for...	Monthly Premium
You	$17.85
You and your spouse	$30.36
You and your children	$25.71
You, your spouse and your children	$45.44

Monthly Premiums

Coverage for...	Benefit Amount
Hospital Admission[1]	$1,000 Maximum 1 per calendar year
Daily Hospital Confinement[1]	$250 per day Maximum 15 days per stay
Daily Critical Care Unit Confinement[2]	

[1] Defined as a stay for at least 20 consecutive hours in a hospital setting.

[2] Payable in addition to the Hospital Admission and Daily Hospital Confinement benefit you may be eligible to receive.

Critical Illness Insurance

A serious diagnosis can come with serious expenses. If you're diagnosed with a covered condition like cancer, heart attack or stroke, this plan gives you a lump-sum cash benefit to use however you need — whether that's for medical costs, groceries, childcare or travel. Most major illnesses pay 100% of your benefit, while early-stage diagnoses pay 25%. Your children are automatically covered at 50% and protected against 21 childhood illnesses.

Bonus: Each covered person gets $50 every year for completing a preventive health screening.

Benefit Options

Coverage for...	Basic
You	Flat amount of $10,000, $20,000 or $30,000
You spouse	Flat amount of $5,000, $10,000 or $15,000, as long as it's not more than 50% of your coverage amount
Your children	Automatically covered at 50% of your coverage amount

Employee Monthly Attained Age Premiums

	18–29 years	30–39 years	40–49 years	50–59 years	60–69 years	70–79 years
$10,000	$3.10	$4.80	$10.20	$21.40	$39.80	$97.00
$20,000	$6.20	$9.60	$20.40	$42.80	$79.60	$194.00
$30,000	$9.30	$14.40	$30.60	$64.20	$119.40	$291.00

Spouse Monthly Attained Age Premiums

	18–29 years	30–39 years	40–49 years	50–59 years	60–69 years	70–79 years
$10,000	1.55	$2.40	$5.10	$10.70	$19.90	$48.50
$20,000	$1.55	$2.40	$5.10	$10.70	$19.90	$48.50
$30,000	$4.65	$7.20	$15.30	$32.10	$59.70	$145.50

TELEMEDICINE

Diabetes Management Program

Through our benefit, you could qualify for help with your diabetes at no cost to you. The Diabetes Management program gives you personalized tools and support to track your blood sugar levels and develop healthier lifestyle habits.

What is the program?

The program supports people diagnosed with type 1 or type 2 diabetes and helps make living with diabetes easier. The program team works with you to provide personalized plans so you can live your healthiest life possible.

What resources do you receive?

The program gives you a connected meter and Unlimited strips and lancets. If members of the program team see that your glucose levels go out of range, they'll reach out to you within 5 minutes to get you the support you need.* You also have the option to work with a certified health coach for more guidance. If you prefer to receive support in Spanish, this option is available to you.

How can you get started?

Getting registered for the Diabetes Management program is easy and only takes a few minutes.

- **800-835-2362**
- teladochealth.com/register/smuhealth
- Download the **Teledoc Health** app

You will start the process by answering a few simple questions about your health to see if you qualify for the program. If you do qualify, you will be mailed a Welcome Kit with instructions on how to get started.

Hypertension Management Program

The Hypertension Management program is available at no cost to you. Through daily tracking and support, the program helps you discover lifestyle changes that can reduce your blood pressure.

What is the program?

The program helps make living with high blood pressure easier. Members of the program team work with you to provide personalized plans so you can live your healthiest life possible.

What resources do you receive?

The program provides you with a connected blood pressure monitor. This gives you access to personalized information to help you manage your condition better. You also have the option to work with a coach for more guidance. If you prefer to receive support in Spanish, this option is available to you.

How can you get started?

Getting registered for the Diabetes Management program is easy and only takes a few minutes.

- **800-835-2362**
- teladochealth.com/register/smuhealth
- Download the **Teledoc Health** app

You will start the process by answering a few simple questions about your health to see if you qualify for the program. If you do qualify, you will be mailed a Welcome Kit with instructions on how to get started.

EMPLOYEE ASSISTANCE AND SUPPORT PROGRAMS

The EAP offers counseling and referrals for help with situations such as work stress, family issues, legal issues, financial problems, alcohol or drug dependency or abuse and mental health services.

- All faculty and staff, as well as their dependents, are eligible for up to five (5) face-to-face counseling visits six (6) lifestyle coaching sessions and three (3) financial coaching sessions per year through the EAP – at no cost.
- If further counseling is needed, an outside resource will be recommended by Magellan based on the issue you need assistance with and your ability to pay.
- The cost of additional counseling visits may be covered under your medical plan.
- Digital emotional wellness tools include self-guided programs for mental health, grief and loss, conflict management and more.
- Define and achieve your goals with the support of Lifestyle Coaching which helps with personal improvement, healthy eating, weight loss and more.
- Get expert help for financial wellness, legal services and identity theft resolution.

The Employee Assistance Program (EAP) is a confidential service available to you and your immediate family members 24 hours a day. To reach the EAP, call Magellan Services toll-free at **877-704-5696** or visit magellanascend.com.

DIGITAL MENTAL HEALTH

Looking to learn new skills to break old patterns that may be holding you back? All employees and family members on an SMU medical plan can take advantage of the digital mental health programs from Learn to Live to help get their mental health on track so they can feel better and enjoy life more. An online assessment helps pinpoint the right programs for you, such as:

- Stress, anxiety and worry
- Depression
- Insomnia
- Social Anxiety
- Substance Abuse

The information, tools, and techniques used within each program will help you identify the thoughts and behaviors that are contributing to your struggles, and then teach you how to change your behavior patterns so you can overcome them. The programs are based on over 10 years of clinical studies and apply the proven principles of cognitive behavioral therapy.

Log in to Blue Access for Members on bcbstx.com, then click Wellness and Digital Mental Health to get started.

GROUP LEGAL AND IDENTITY PROTECTION

LegalGUARD Plan

The LegalGUARD Plan is administered by LegalEASE and underwritten by Nationwide. The plan provides access to quality legal services and protection from the high cost of legal fees.

Finding the right type of attorney when a need arises can be one of the more stressful tasks when dealing with a legal matter. LegalEASE uses experience and relationships with their network attorneys to connect you with the right type of attorney, in the right location.

- LegalGUARD – **$17.90 per month**
- Covers employee, spouse and unmarried dependent children until age 19 (or age 25 if full-time student).
- Covers attorney fees, up to plan limits, for numerous legal needs, including:
  - **Home:** Purchase, sale, refinancing, tenant dispute
  - **Family:** Divorce, adoption, name change
  - **Consumer:** Warranty, cell phone contract, bank fees, small claims court
  - **Estate Planning:** Will, living will, power of attorney
  - **Financial:** Debt, bankruptcy, foreclosure, tax audit
  - **Criminal:** Serious traffic matter, misdemeanor offense

Allstate Identity Protection (AIP)

The AIP is administered by Allstate. The plan provides a comprehensive and proactive defense against identity theft, with a focus on identity monitoring. AIP is capable of identifying anomalies indicative of fraudulent behavior up to 90 days sooner than credit monitoring. AIP is also paid via SMU payroll deductions.

- **AIP Individual Plan – $8.45 per month**
- **AIP Family Plan – $12.95 per month**
- Covers family members in members' household as well as anyone financially dependent. If they are "under your roof" or "under your wallet" they are covered.
- Elder Fraud Center – Safeguard senior family members with a resource built for seniors, caretakers and family members
- Full-service identity restoration support
- Social media account takeover monitoring
- Comprehensive identity and financial monitoring including tri-bureau credit monitoring
- Dark web monitoring
- Allstate Digital Footprint shows members where their personal information lives online so they can protect it.
- Allstate Security Pro delivers updates and education on scams and emerging threats relevant to you.
- Robocall blocker intercepts scam and telemarketing calls and texts by requiring them to identify themselves before you pick up.
- Up to $1 million in expense reimbursement for stolen funds and out-of-pocket costs due to identity theft

TUITION BENEFITS PROGRAM

SMU offers tuition benefits to full-time benefits-eligible faculty and staff, their spouse and their dependent children. Individuals participating in the Tuition Benefits Program must meet all standard requirements for admission to the University and be admitted to the University in a credit-bearing, degree-granting program.

Employee as Student

Full-time benefits-eligible faculty and staff members are eligible beginning the first new term following their date of hire and acceptance into an academic program. The plan covers 100% of tuition and waives the general student fee for part-time undergraduate or graduate study for academic credit. The plan will cover up to 18 academic hours each academic year.

Spouse as Student

A spouse will be eligible for Tuition Benefits the first full term following the employee's full-time hire date. The plan covers 63% of tuition for one undergraduate or graduate degree.

Dependent as Student

Dependent children will be eligible beginning the first full term following the first anniversary of the employee's full-time employment. Dependents must meet all standard requirements for undergraduate admission to the University, and be admitted to the University in a credit-bearing, degree-granting program, unless attending SMU credit-bearing courses to obtain credit while enrolled in an undergraduate degree-granting program at another accredited institution of higher eucation. The plan covers 100% of tuition for one undergraduate degree.

Note: Tuition Benefits paid for graduate degrees are considered taxable income. However, employees may qualify for an annual IRS exclusion on the first $5,250 of Tuition Benefits they receive each calendar year. This exclusion does not apply to spouses — all graduate-level Tuition Benefits provided to spouses are taxable to the employee.

For more information employees can reach out to tuitionbenefits@smu.edu.

TUITION EXCHANGE PROGRAM

SMU is a member institution of the Tuition Exchange (TE), a reciprocal tuition award program opportunity for the dependent children of eligible faculty and staff at all TE member colleges and universities. There are currently more than 700 member institutions participating in the program.

Visit tuitionexchange.org for a list of member institutions and resources for prospective applicants and families.

A dependent child will be eligible to apply beginning the first full term following the first anniversary of the employee's full-time employment.

Program Guidelines

Tuition Exchange (TE) Awards are granted to Dependent Children seeking an undergraduate degree and are awarded based on policies set by each member school.

- Tuition awards are renewed each year depending upon continued parental benefit eligibility.
- TE Award is competitive and space is limited. SMU cannot guarantee a dependent will receive a TE award or admission into another institution.
- TE awards are offered based on policies set forth by each member institution and have a maximum tuition award.

To Apply

- **Step 1:** Submit a TE online application on the Tuition Exchange website. Select "Southern Methodist University" as your current school employer. Once you click submit, the completed application goes to the TE Liaison Officer for certification of eligibility.
- **Step 2:** Once eligibility is confirmed, the TE application is certified and sent to the applicant's selected schools for consideration.
- **Step 3:** Student must ALSO apply for admission to the participating school of interest according to the school's published application deadlines and other requirements. There are multiple steps to the TE process. Please ensure you begin your application process early.

For more information employees can reach out to tuitionbenefits@smu.edu.

EDUCATION SUPPORT

Ensuring you're on the right track in the complex education system is challenging — whether you're moving schools or your child needs more support. Lean on the Cariloop team of educators, school administrators and counselors to guide you through it.

- **IEP and 504 support:** Prepare for IEP and 504 processes with an Education Coach who will review documentation, attend meetings and clarify jargon
- **Don't miss enrollment:** Get personalized information on registration, enrollment and necessary school-year preparations
- **Tackle college prep:** Get support through the college admissions process including personalized details for applications, disability accommodations, financial aid and navigating the transition to college
- **Explore trade schools and beyond:** Explore personalized options for alternative paths to traditional education, including enrolling in the military, completing a GED or applying to trade schools
- **Ensure well-being:** Navigate your student's well-being with dedicated support through behavioral challenges, peer relationships and extracurricular activity options

Save your time and energy – let our experts support your care-giving needs. Activate your membership now!

Visit cariloop.com/register and download our mobile App to get started.

CAREGIVING SUPPORT

Feeling stressed about caring for a loved one? Cariloop's Care Coaches guide you through the research, questions and next steps needed to feel confident in their care.

Through a secure online portal, you're paired with a licensed or certified Care Coach who supports all ages — from pediatrics to elder care — and can help with:

- Understanding diagnoses (ADHD, Alzheimer's, Autism, Cancer, Parkinson's, etc.)
- Finding doctors or specialists
- Navigating costs and payment options
- Completing legal caregiving documents (wills, POAs, DNRs, etc.)
- Medicare, Medicaid or VA benefits
- Finding care providers (Skilled Nursing, Rehab, Hospice, Home Health, etc.)
- Managing family dynamics
- Researching daycares, nannies, summer programs and more
- Navigating educational needs (finding tutors, special education needs, IEP's, 504 evaluations, college prep, trade programs/armed forces and more)

Caregiver support is provided by Cariloop to all benefits-eligible SMU employees at no cost.

Connect with your very own Care Coach now by visiting cariloop.com/smu or emailing helpme@cariloop.com any time.

UrbanSitter

Cariloop helps you manage caregiving with expert Care Coaches, tailored resources and easy-to-use digital tools. Through our partnership with UrbanSitter, you can quickly find, book and pay for backup care, childcare, pet care, household help and senior support.

UrbanSitter Access

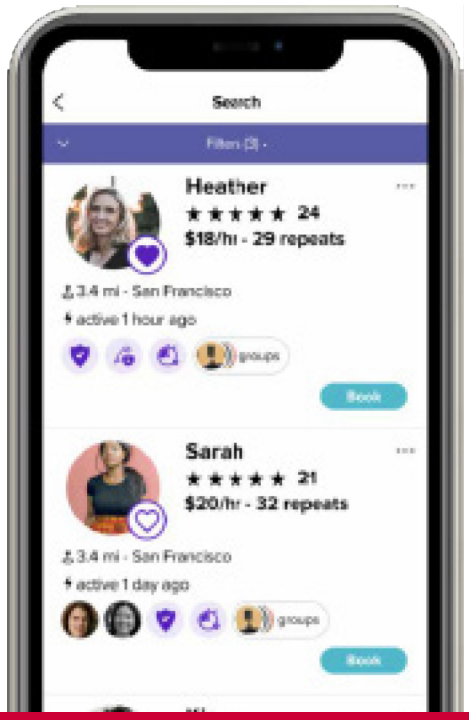
As part of your Cariloop benefit, you also have access to UrbanSitter, a trusted network of background-checked caregivers. UrbanSitter helps you find reliable, short-term care for children, elders, pets and household needs. You can view caregiver profiles, check availability, read parent reviews and book care directly through the platform.

How to Get Started:

1. Log in or register at Cariloop.
2. Go to Find at-home care in your portal.
3. Search providers in your area through UrbanSitter's platform.

Need help? Connect with a Care Coach any time for guidance and explore Cariloop's content library for tips on hiring care providers.

Save time and energy — activate your membership at cariloop.com/register and download our app today.



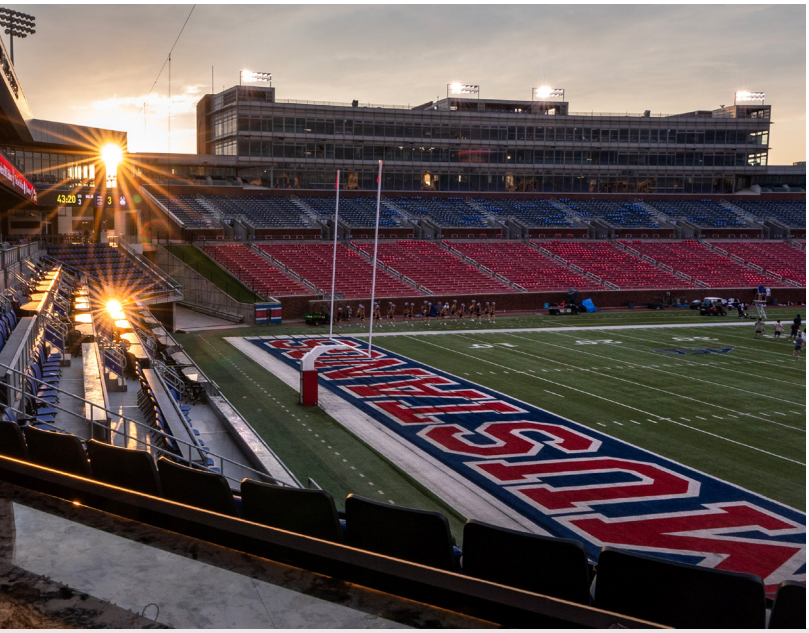
RETIREMENT PLAN

403(b) Retirement Plan

The SMU 403(b) Retirement Plan, administered by Transamerica, is designed to help you save for your retirement years.

- If you are a full-time or part-time (20+ hours/week) benefits-eligible employee, you may enroll in the SMU Retirement Plan as early as age 21.
- If you contribute 5% of your base salary on a pretax basis, you will receive SMU matching contributions. If you contribute less than 5%, you will not be eligible for matching contributions.
- Participation (5% pretax contribution) is required as a condition of employment for full-time employees age 36 or older.

You are not eligible for SMU's matching contribution if you are a temporary employee, post-doctoral fellow or adjunct professor.



Contributions to the Plan

If you contribute 5% of your base salary on a pretax basis, SMU will contribute 8% of your base salary until you reach age 41. SMU begins contributing 10% of your base salary the month following your 41st birthday. You may make additional pretax and/or after-tax (ROTH) unmatched contributions up to IRS limits.

- SMU matching contributions vest after three years and one day of employment.

Beneficiary Designations

It is important that you sign into your Transamerica account and designate your beneficiaries and update your designations as needed.

SMU's On-site Retirement Planning Consultant

SMU's Transamerica Retirement Planning Consultant is Todd Hutson. Todd is available virtually or in-person to discuss your retirement planning needs, investment allocation, automatic contribution increases and any questions you have regarding your account. Visit the HR web-page below for Todd's contact information.

Note: The maximum amount you can contribute to your 403(b) account on a pretax basis is determined by the IRS and changes each year.

Important: It is your responsibility to ensure that applicable IRS maximums are not exceeded.

Emeriti Health Account

To help you save for your health care needs during retirement, SMU offers the Emeriti Health Account. This Health Account offers a tax-advantaged way to invest and accumulate assets to pay for health insurance premiums and other eligible health care expenses in retirement.

The investment fund choices and administrative services for these accounts are administered by OneBridge. The Emeriti Health Account is separate from the SMU 403(b) Retirement Plan.

Here's an overview of the Emeriti Health Account:

Contributions

- You will automatically be enrolled in an Emeriti Health Account and will contribute $101.29 per month via pretax payroll deductions (prorated depending on your pay schedule). SMU will also make a $101.29 monthly contribution on your behalf. Contributions for employees paid bi-weekly or less than 12 months during the calendar year will be prorated accordingly.
- Your contributions and SMU's contributions increase 4% each year.
- When you are enrolled, you choose how to invest your contributions with TIAA.
- SMU will stop contributions to participant's accounts after 25 years (or upon termination of employment or death, if earlier).

Employees enrolled in the program since 2008 will have projected assets of:

- $6,821.87 in five years
- $15,831.74 in ten years
- $27,577.56 in fifteen years

Calculations assume a 2% return on investment.

If you are a full-time employee less than age 40:

- You can enroll in and make unmatched voluntary, after-tax contributions to an Emeriti Health Account.
- Once you reach age 40, you will begin contributing on a pretax basis and SMU will begin making contributions on your behalf.
- Once you leave SMU, you can begin using the funds in your Emeriti Health Account to pay for eligible medical premiums and out-of-pocket expenses for you and your qualified dependents.

You are not eligible to participate in the Emeriti Health Account if you are a:

- Part-time employee (working less than 35 hours/week)
- Post-Doctoral Fellow
- Adjunct professor

How does the vesting provision work?

Your contributions vest immediately. SMU contributions vest after completion of seven years of SMU employment.

LEAVE AND PAID TIME OFF

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.

Parental Leave

Employees who have been with SMU for at least one year are eligible for parental leave. The University will provide paid Child Birth and Parental Leave to a benefits-eligible staff employee in connection with the birth and/or care of a child. Female staff who give birth are eligible a total of six (6) weeks (thirty (30) consecutive working days) per calendar year of paid Child Birth Leave to give birth and recover from child birth. Staff members, both male and female, who have already taken and received Child birth Leave or who do not qualify for Child birth Leave, are eligible for up to three (3) consecutive weeks (fifteen (15) consecutive working days) per calendar year of paid Parental Leave to bond with and care for their newborn child. See SMU policy 7.17 for additional information.

Adoption Leave

Employees who have been with SMU for at least one year and adopt a child 24 months of age or younger are eligible to receive up to three weeks (15 consecutive working days) of paid leave.

- Medical and vacation days will continue to accrue while on approved Adoption Leave. To request Adoption Leave, complete and submit the Staff Leave of Absence Form. For more information on Adoption Leave, please see Policy 7.17, Staff Childbirth, Parental and Adoption Leave.

Staff Bereavement Leave

The University provides up to three days of paid bereavement leave for benefits-eligible staff employees in the event of the death of a family member.

- For additional information please visit smu.edu/hr and refer to section 7.18 of the SMU Policy Manual.

Note: The schedule of holidays is issued each Spring for the following University fiscal year (June–May).

Official Holidays

SMU generally observes the following holidays each year:

- New Year's Day
- Martin Luther King Jr. Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving Day
- Christmas Break (number of days varies each year)
- Floating Holiday

Note: Part-time staff are paid if they are scheduled to work on a holiday.

Paid Time Off (PTO)

SMU provides a competitive paid time off program, which includes official holidays and accrued vacation time.

Floating Holiday for Staff

SMU staff also receive one floating holiday per year that must be used by the end of each fiscal year (May 31). New employees hired after the start of the fiscal year (June 1) will not receive a floating holiday until the following fiscal year. Floating holidays must be used and cannot be accrued.

VACATION

If You Were Hired ON or AFTER June 1, 1995		
Job Classification	**Length of Employment**	**Annual Vacation**
GROUP IV		
All employees not included in Group V below	From benefits-eligible service date through 2 years	10 days
	Start of 3rd year through 5 years	12 days
	Start of 6th year through 15 years	15 days
	Start of 16th year and beyond	20 days
GROUP V		
Principal Administrative Officers, Senior Administrative and Professional Staff	From benefits-eligible service date through 10 years	15 days
	Start of 6th year and beyond	20 days

If You Were Hired BEFORE June 1, 1995		
Job Classification	**Length of Employment**	**Annual Vacation**
GROUP I		
Principal Administrative Officers – 50	Start of 11th year and beyond	30 days
GROUP II		
12 and higher	Start of 11th year and beyond	20 days
GROUP III		
All pay grades not included in Group I and II	Start of 16th year and beyond	20 days

Benefits-eligible staff members accrue vacation time according to scheduled hours and job classification, beginning on the first day of employment. Vacation must be accrued before it is taken. After completing 90 Days of continuous employment, employees may begin to take accrued vacation. Supervisors must approve all vacation and may determine periods of time when vacation may not be taken.

The number of vacation hours you have accrued appears on your paycheck and can be viewed online through the my.smu.edu Employee Self Service portal. You may accumulate up to two times the amount of time you are eligible to accrue in a year.

Vacation Payout Upon Leaving SMU

If you have been employed by SMU for at least one year and terminate employment with unused vacation days, you will be paid for unused accrued vacation, provided all time has been reported and approved and you have paid any monies due to SMU.

- Hired on or after June 1, 1995: Unused accrued vacation days paid at termination may not exceed 10 days.
- Hired before June 1, 1995: Unused accrued vacation days paid at termination may not exceed the allowance for one year.

CONTACT INFORMATION

SMU Benefits **214-768-3311** benefitsu@smu.edu smu.edu/hr

Coverage	Administrator	Contact and Website
Medical Plans	BlueCross BlueShield of Texas	**877-768-2005** bcbstx.com
Prescription Drug Plan	Prime Therapeutics	**800-858-0723** myprime.com
Concierge Service/Price Transparency	Alight	**800-513-1667** member.alight.com
Supplemental Health Plan (Accident, Critical Illness, Hospital Indemnity)	The Standard	**800-378-2389** standard.com
Dental Plan	BlueCross BlueShield of Texas	**877-768-2005** bcbstx.com
Vision Plan	VSP	**800-877-7195** smu.vspforme.com
Health Savings Account (HSA)	HealthEquity	**866-346-5800** my.healthequity.com
Flexible Spending Accounts (FSAs)	WEX	**866-451-3399** wexinc.com
Supplemental Life, AD&D, Short-Term Disability and Long-Term Disability	The Standard	**800-378-2389** standard.com
403(b) Retirement Plan	Transamerica	**800-755-5801** smu.trsretire.com
LegalGUARD Plan	LegalEASE	**800-248-9000**
Allstate Identity Protection	Allstate	**800-789-2720**
Employee Assistance Program (EAP)	Magellan Health Services	**877-704-5696** magellanascend.com
Caregiving, Education and UrbanSitter Program	Cariloop	**972-325-5836** helpme@cariloop.com
Emeriti Health Account	OneBridge	**866-363-7484** (866-Emeriti) emeritihealth.org/southern-methodist-university
Tuition Benefits/Tuition Exchange	SMU Human Resources	tuitionbenefits@smu.edu

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 depend on your household income. You may also be eligible for a tax credit that lowers your costs.

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% 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:

SMU Department of Human Resources, PO Box 750232, Dallas, TX 75275-0232. Phone Number: 214-768-3311.

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 irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% 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 ADOPTION

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

Southern Methodist University
Department of Human Resources
P.O. Box 750232, Dallas, TX 75275-0232.

Phone Number: 214-768-3311

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

You have the right to:

- 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
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

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

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 operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

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.

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.*

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. 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
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health 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

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- 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.

01/01/2026

Sheri Starkey
Vice President and Chief Human Resources Officer

SMU
P.O. Box 750232
Dallas, TX 75275

214-768-3311
HR@smu.edu

Important Notice from SMU About Your Prescription Drug Coverage offered by the $2,000 Deductible PPO Plan 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 SMU and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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. **SMU has determined that the prescription drug coverage offered by the $2,000 Deductible PPO Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current SMU coverage will be affected. If you enroll for Medicare Part D coverage, you must drop your SMU medical and prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current SMU coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with SMU and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, 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 (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 SMU 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).

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

Date: October 1, 2025

Name of Entity/Sender: Southern Methodist University

Contact/Office: Department of Human Resources

Address: P.O. Box 750232,
Dallas, TX 75275-0232

Phone Number: 214-768-3311

Important Notice from SMU About Your Prescription Drug Coverage offered by the $3,400 and $5,000 Deductible HDHP Plans 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 SMU 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.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

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. SMU has determined that the prescription drug coverage offered by the $3,400 and $5,000 Deductible HDHP Plans are, 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 SMU HDHP Plans. 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 the SMU HDHP Plans. However, because your coverage is noncreditable, 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.
However, if you decide to drop your current coverage with SMU, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the High Deductible Plans

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

Since the coverage under SMU's High Deductible Plans are 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 will be affected. If you enroll for Medicare

Part D coverage, you must drop your SMU medical and prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current SMU coverage, be aware that you and your dependents will not 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 SMU 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:	October 1, 2025
Name of Entity/Sender:	Southern Methodist University
Contact/Office:	Department of Human Resources
Address:	P.O.Box 750232 Dallas, Texas, 75275-0232
Phone Number:	214-768-3311

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to SMU, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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 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:

Southern Methodist University
Department of Human Resources
P.O. Box 750232, Dallas, TX 75275-0232

Phone Number: 214-768-3311

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 ADDRESS 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

Southern Methodist University
Department of Human Resources
P.O. Box 750232, Dallas, TX 75275-0232.

Phone Number: 214-768-3311.

[1.] https://www.medicare.gov/basics/get-started-with-medicare/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. Therefore, the following deductibles and coinsurance apply: Please see the Plan's summary plan description for details of the Plan's deductible, benefit percentage, and copayment requirements. If you would like more information on WHCRA benefits, visit www.dol.gov/dol/topic/health-plans\womens.htm.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy related 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 877-768-2005 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 BCBSTX at 877-768-2005.

Visit cms.gov/nosurprises for more information about your rights under federal law.

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, 2025. 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:* myalhipp.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)	ldh.la.gov/healthy-louisiana *or* www.ldh.la.gov/lahipp	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:* 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)	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, 2025, 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, Option 4, ext. 61565

SMU

2026 Benefits Guide

October 2025