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Employee Benefits Guide

SWBC | PEO

Benefit plans effective October 1, 2021 - September 30, 2022

We are committed to providing a comprehensive benefit program that delivers real value to you and your family. We offer an expansive benefits package full of options that allow employees to protect themselves and their families according to their own personal preferences.

The Benefits Guide is not a guarantee of benefits and is subject to change at any time. This is only a Summary of Benefits. Please refer to your plan document for full plan description including exclusions.

Contact Information

If you have questions regarding any of your benefits, please contact SWBC PEO Benefits Department or the administrator listed below:

Coverage Benefits	Carrier Administrator	Phone Number	Website Email	Group Number
Medical - Health	Humana	800-448-6262	Humana.com	786437
Teladoc	Teladoc	800-835-2362	Teladoc.com	n/a
Good Rx	Good Rx	855-782-3703	Goodrx.com	n/a
Dental	MetLife	800-438-6388	Metlife.com/dental	5365100
Vision	MetLife	800-428-4833	Metlife.com/vision	5365100
H S A	SWBC PEO	877-704-0454	PEO-BENEFITS@swbc.com	n/a
FSA/DFSA/LFSA	Omega Benefit Strategies	508-986-9359	Omegabenefitstrategies.com	n/a
Group Life AD&D	MetLife	800-438-6388	Metlife.com	5365100
Voluntary Life AD&D	MetLife	800-438-6388	MetLife.com	5365100
Short Term Disability	MetLife	800-438-6388	MetLife.com	5365100
Long Term Disability	MetLife	800-438-6388	MetLife.com	5365100
Accident Hospital Critical Illness	MetLife	800-438-6388	MetLife.com	5365100
MetLaw	MetLife	800-438-6388	MetLife	166460
Pet Insurance	AMS	210-477-7797	EGarcia@swbc.com	n/a
529 College Savings	American Funds	210-376-3929	SWBC-PEO529@swbc.com	n/a
LifeLock	Norton	800-607-9174	MY.NORTON.COM	n/a
401(k) Plan	Slavic	800-356-3009	customer@Slavic401k.com	n/a
Enrollment	SWBC PEO	877-704-0454	PEO-BENEFITS@swbc.com	n/a
401(k)	SWBC PEO	830-310-8849	Kyle.Hittle@swbc.com	n/a

Annual Enrollment

Annual Enrollment is the period of time during which you may make changes to benefit elections for you and your eligible dependents. Outside of Annual Enrollment, you may only make changes if you have a qualified change of status event. **New elections are effective October 1, 2021.**

Who is Eligible?

If you are a full-time employee, you are eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. In addition, family members are eligible for medical, dental and vision coverage. Dependent children will be eligible for coverage up to the attained age of 26. Eligible dependents include, legally married spouse, natural, adopted, or step children up to the age of 26.

What is the Effective Date?

As a new hire, you will be eligible for benefits on the **first day of the month** following **30 days** from the date of hire.

How do I make changes?

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period.

Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

IMPORTANT: You must notify SWBC PEO of any changes within 30 days of your Qualifying Event.

Medical Coverage

Humana administers your medical and Rx benefits. If you are uncertain if a physician or medical facility is in network, visit www.humana.com or call Humana customer service at **1-800-448-6262.** You may also register online at www.humana.com to review claims status, benefits, coverage details and more.

You can also access your ID cards and benefits at any time by logging into www.humana.com or on the Humana mobile app.

Please choose the plan that best suits your needs and keep in mind that the option you elect will be in place from **October 1, 2021 - September 30, 2022** unless you have a Qualifying Life Event.

BENEFITS TYPE - CHOICE NETWORK	BASE PLAN TXEQ0004 - PLAN 3	MIDDLE PLAN TXEO0196 - PLAN 7	BUY UP PLAN TXEO0206 - PLAN 31
Health Savings Account (HSA) Eligible Employer Contribution to H S A	Yes $0 / year	No N/A	No N/A
Calendar Year Deductible Individual Family	 $5,000 $10,000	 $3,000 $6,000	 $1,000 $2,000
Coinsurance	**20%**	**0%**	**20%**
Total Annual Out of Pocket Expenses (Includes Copays) Individual Family	 $6,350 $12,700	 $6,500 $13,000	 $2,000 $4,000
Preventive Care	**No Charge**	**No Charge**	**No Charge**
Office Visit Primary Care Physician $0<19 Specialist	 20% after Deductible 20% after Deductible	 $40 Copay $65 Copay	 $30 Copay $45 Copay
Urgent Care	20% after Deductible	$75 Copay	$75 Copay
Emergency Room	20% after Deductible	$350 Copay	$250 Copay
Inpatient / Outpatient Hospitalization	20% after Deductible	0% after Deductible	20% after Deductible
Advanced Imaging (MRI, PET, CAT, etc.)	20% after Deductible	0% after Deductible	20% after Deductible
Prescription Drugs Tier 1/2/3/Mail Order	20% after Deductible	$10/$45/$90/2x	$10/$40/$70/2x
OUT OF NETWORK BENEFITS			
Calendar Year Deductible Individual Family	 $15,000 $30,000	 $9,000 $18,000	 $3,000 $6,000
Coinsurance	**50%**	**70%**	**50%**
Total Annual Out of Pocket Expenses (Includes Copays) Individual Family	 $19,050 $38,100	 $19,500 $39,000	 $6,000 $12,000
Emergency Room - Life threatening procedures only	20% after Deductible	$350 Copay	$250 Copay

PER PAYCHECK DEDUCTION	BASE PLAN	MIDDLE PLAN	BUY UP PLAN
Employee Only	$0.00	$38.11	$41.18
Employee + Spouse	$136.15	$212.37	$241.55
Employee + Child(ren)	$122.54	$194.95	$221.52
Employee + Family	$299.53	$421.48	$482.00

Per Paycheck Deductions are based upon 24 pay periods.
*Employer Contributions only apply to Active Full-Time employees.

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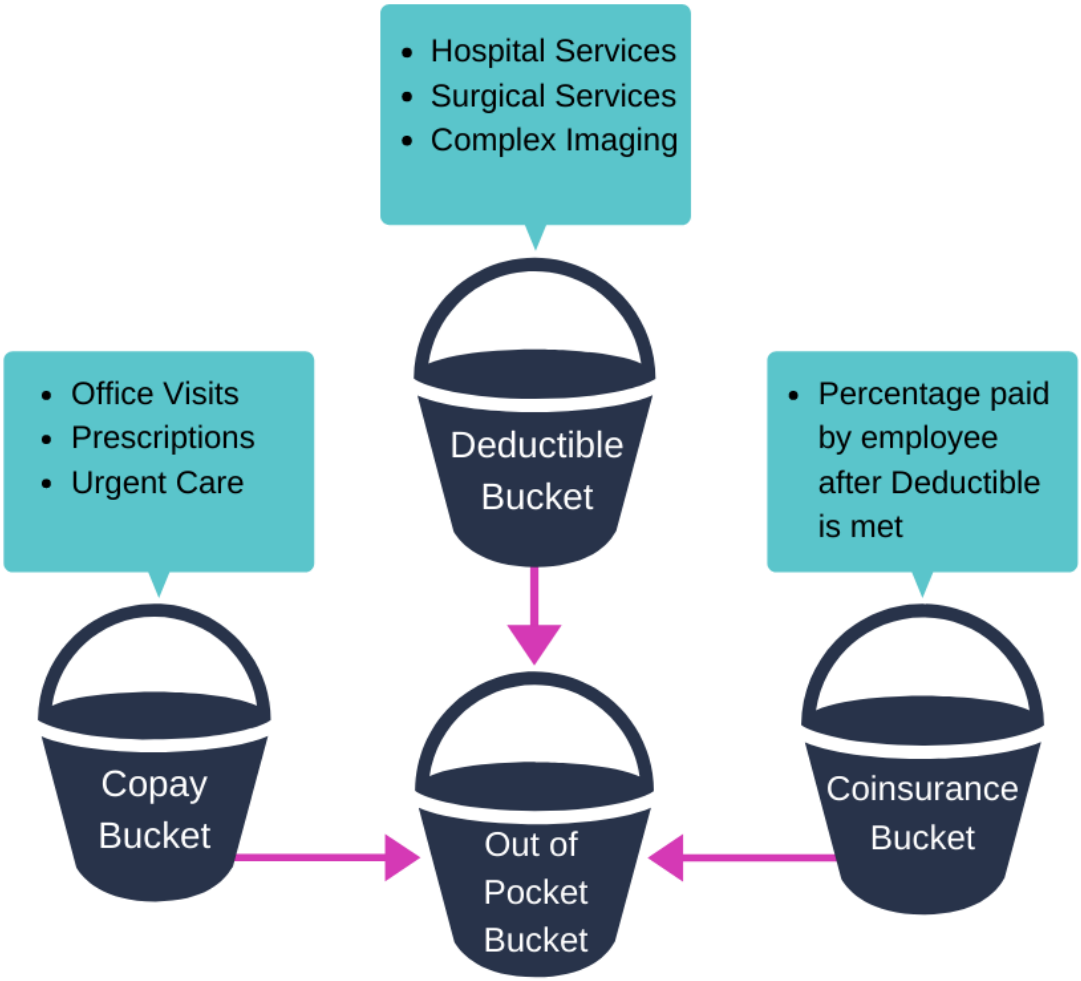
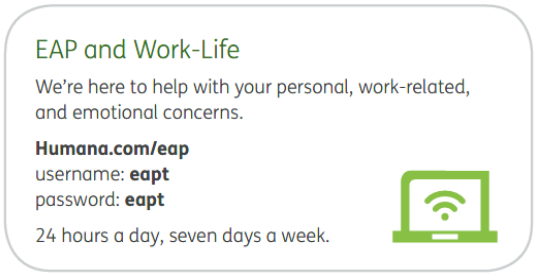
Understanding your Medical Benefits



Please Note: Once you have met your Out of Pocket expenses, your benefits will be paid at 100%

HUMANA OFFERINGS

Humana offers a variety of added value benefits that are at your disposal, most of which are free of charge. They provide something for anyone who might need a lifestyle change, an extra support system or even a friendly ear to help with those stressful moments in life. Take advantage of these resources by logging into your MyHumana account today to get started.



Employee Assistance Program and Work-Life Services

Life made easier at **no cost** to you! Humana offers a robust Employee Assistance Program and Work-Life Services to assist you and your household members manage everyday life issues that can affect you at home and at work. You can call the toll-free number **(866) 440-6556** anytime during the day or night to talk with an experienced counselor who can help you find solutions. This program is confidential and your employer pays all costs when you and members of your household use the services. Find everyday resources for things like: retirement planning, career development, separation/divorce, stress and anxiety management, nutrition, weight loss and much more.

MyHumana Mobile App

Stay connected with Humana and access important health insurance information wherever you are with the MyHumana mobile app. Find a doctor, hospital or urgent care facility or research drug prices. Access to view your coverage and claims information or view/order a new ID card all at your fingertips. **Download the MyHumana mobile app** from your app store and register at **Humana.com** today!

Go365 Wellness and Rewards Program

Say hello to Go365! Your personalized wellness and rewards program. Getting healthier is easier – and lots more fun – with Go365. When it comes to health and wellness, you have your own approach. One that works for you. Go365 makes it easier to get moving along your path with more ways to start, more activities to unlock, and more ways to rack up rewards. **Download the Go365 app today to your smartphone.** Use it to help you stay on track in reaching your health and wellness goals. The app has it all: community or private challenges, activities, ability to connect a compatible device to track your progress, view your rewards history, and much more.

Download the Go365App

Rewards beyond health and fitness! Through the Go365 Wellness and Rewards Program, you can learn how to make more informed health care decisions, create a personalized action plan and complete specific health actions all while being rewarded along the way. Check out **Go365.com** to complete your health assessment and work on your health and wellness goals today!

TELADOC VIRTUAL MEDICINE

You have a physician readily available at any time by using the **TELADOC** services. Any employee and their family members can utilize this service even if they are not all on the same employer's health plan.

HOW DO I GET STARTED?

1. Set up your **TELADOC** account through the mobile app or on your computer. This takes just a few minutes by providing your medical history so that doctors can give you quality medical care. This would also be the time to add any family members in your household to your profile.

2. Now you are ready to talk to a doctor. You will speak with the first available **TELADOC** doctor or schedule an appointment. Within minutes, a doctor will call ready to listen, diagnose and prescribe medication, if medically necessary. After you consult, you can choose to share the results with your primary care physician.

3. If medically necessary, a prescription will be sent to a local pharmacy of your choice. Now you are ready to pick up your prescription. **TELADOC** is a convenient and affordable way to get the care you need NOW!

TALK TO A DOCTOR ANYTIME!

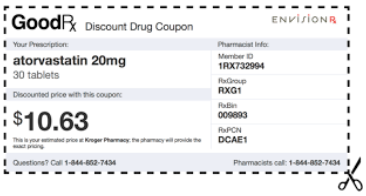
1-800-TELADOC

$0 Co-pay 24/7

I HAVE A PRESCRIPTION NOW WHAT?

Now that you have visited a doctor or had a virtual visit with **TELADOC** now you can use GoodRx to save money at the pharmacy. GoodRx may be able to find you a lower price than your insurance copay. Hundreds of generic medications are available for $4 or even free without insurance.

- Download the GoodRx app to your phone or login on your computer.
- Search for your medication in the GoodRx database.
- Compare the pharmacies' prices that offer your medication in your local area.
- Print the coupon and send it to your pharmacy by text, email or present it in person at the pharmacy.



GoodRx is a free service available to anyone even if you are not enrolled in your group health plan!

FLEXIBLE SPENDING ACCOUNT (FSA)

You have the opportunity to participate in a Flexible Spending Account (FSA) through SWBC PEO. Flexible Spending Accounts provide a way for employees to pay for their out-of-pocket medical and dependent care expenses with pre-tax earnings. Expenses can be paid for at the point of service by utilizing the provided debit card or by filing a claim for reimbursement.

MEDICAL FSA

The Medical FSA allows you to use pre-tax earnings to pay for qualified medical expenses for yourself or a dependent.

* Over-the-counter medications must be to treat a specific medical condition. Vitamins and other wellness products are not eligible. Cosmetic services do not qualify for this plan (medical, dental or otherwise).

MEDICAL FSA	
Expenses Covered	Co-pays, doctor visits, lab and hospital fees, prescriptions, dental, optional expenses and some over-the-counter items *
Annual Minimum	**$150**
Annual Maximum	**$2,750**
Rollover Maximum	Up to **$500** of Medical funds can be rolled over from one plan year to the next. Any funds exceeding the $500 rollover will be forfeited.

DEPENDENT CARE FSA

The Dependent Care FSA uses pre-tax earnings to pay for expenses resulting from care for a qualifying individual to allow you to work.

The need for dependent adult and childcare expenses must be work-related. Employee and spouse must be gainfully employed or a full-time student. A child must be under the age of 13, or a dependent over the age of 26 who is unable to care for himself/herself.

DEPENDENT CARE FSA	
Expenses Covered	**Care for a qualified individual** • Children under the age of 13 (13 and over if the child is mentally or physically unable to care for himself) • Elderly dependents • Disabled spouse
Annual Minimum	**$150**
Annual Maximum	**$5,000** – Married filing jointly/Head of household **$2,500** – Married filing separately

REMEMBER: New election amounts must be made each benefit year. $500 will automatically roll over every year. All unreimbursed claims for the current year, will need to be submitted no later than March 31st of the following year to be considered for reimbursement.

HEALTH SAVINGS ACCOUNT (HSA)

You have the opportunity to open a Health Savings Account (HSA) when enrolled in a High Deductible Health Plan (HDHP). The HSA allows you to use tax-free dollars to pay for medical expenses. This combination gives you ultimate control over how you spend your health care dollars.

When you have a HDHP, you can set aside money in a tax-free bank account to pay for eligible out-of-pocket expenses. Any money left over in your HSA remains **yours**, allowing you to grow your funds over time. Even if you cancel your policy, for any reason, that HSA will remain active, and any money already in it will remain usable. However, you can only actively contribute to an HSA while enrolled in a qualified HDHP.

HOW DO I GET STARTED

Once you enroll in a HDHP, you can go to any banking institution of your choice and open a Health Savings Account (HSA). If your bank does not offer a HSA account you also have many online options available (Optum Bank, HSA Bank, UMB Bank and many more).

ELIGIBLE EXPENSES

- Over-the-counter medicines
- Orthopedic and prosthetic devices
- Doctors
- Dentists and Orthodontists
- Chiropractors
- Optometrists, ophthalmologists, opticians and eyeglasses
- Nursing and personal care facilities
- Medical and dental laboratories
- Medical services and health practitioners
- Ambulance services, equipment and supplies
- Diabetic supplies and insulin
- Flu shots / Vaccinations
- Blood pressure monitors
- Co-payments/deductibles/co-insurance/COBRA
- Healthcare premiums
- Smoking cessation
- Treatment for alcoholism or drug dependency

2022 IRS HSA LIMITS	
Eligibility Requirements	Member must be enrolled in a HDHP in order to actively contribute to an HSA account.
Employee Maximum	**$3,600**
Family Maximum	**$7,200**
Additional Contributions	At age 55, you can contribute an additional $1,000 per year.

IMPORTANT TIP: It is important to keep receipts for tax purposes in the event of an audit.

Dental Coverage

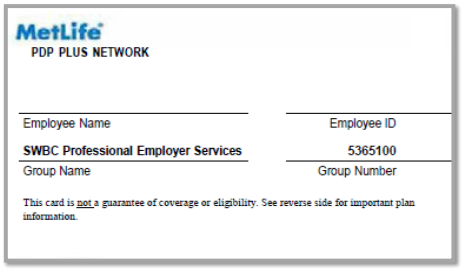
MetLife administers your dental benefits. If you are uncertain if a dentist or facility is in network, visit www.metlife.com/dental and click on "Find a Dentist". Enter your zip code and select **PDP PLUS** network.

MetLife does not send out personalized ID cards.
Providers will verify benefits using the employee's Social Security Number

Please choose the plan that best suits your needs and keep in mind that the option you elect will be in place from **October 1, 2021 - September 30, 2022** unless you have a Qualifying Life Event.

BENEFITS TYPE - PDP Plus Network	BASE PLAN $50 Ded / No Ortho	BUY UP PLAN $25 Ded / Child and Adult Ortho
Calendar Year Deductible Individual Family	 $50 $150	 $25 $75
Annual Maximum (per covered person)	**$1,500**	**$2,250**
Preventive Services Oral Exam, *Routine Cleanings, Bitewing X-Rays, Fluoride Application	0% No Deductible	0% No Deductible
Basic Services Amalgam and Composite Fillings, Sealants	20% After Annual Deductible	20% After Annual Deductible
Major Services Oral Surgery, Crowns, Dentures, Implant Services, Inlays & Onlays, Bridgework, Periodontics, Endodontics	50% After Annual Deductible	50% After Annual Deductible
Orthodontia Adult and Child(ren) No waiting Period	Not Covered	50% $1,500 Lifetime Maximum
PER PAYCHECK DEDUCTION	**BASE PLAN**	**BUY UP PLAN**
Employee Only	$12.71	$16.87
Employee + Spouse	$25.42	$33.75
Employee + Child(ren)	$26.59	$35.29
Employee + Family	$36.85	$48.92

*** Covered once every 6 months**



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Vision Coverage

MetLife administers your vision benefits. If you are uncertain if an optometrist or facility is in network, visit www.metlife.com/vision and click on "Find a Provider". Enter your zip code and select your provider.

MetLife does not send out personalized ID cards.
Providers will verify benefits using the employee's Social Security Number

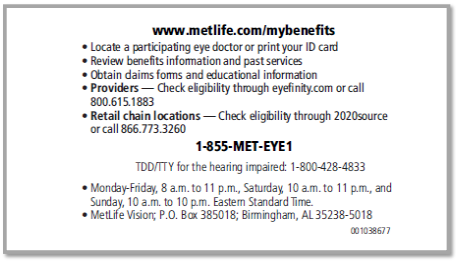
Please choose the plan that best suits your needs and keep in mind that the option you elect will be in place from **October 1, 2021 - September 30, 2022** unless you have a Qualifying Life Event.

BENEFITS TYPE	BASE PLAN In-network	BASE PLAN Out-network	BUY UP PLAN In-network	BUY UP PLAN Out-network
Frequency				
Exam	12 months		12 months	
Lenses / Contact Lenses	12 months		12 months	
Frames	24 months		12 months	
Copayments				
Exam	$10	Reimbursed up to $45	$0	Reimbursed up to $45
Materials	$10		$0	
Lenses		Reimbursed up to -		Reimbursed up to -
Single	$10 copay	$30	$0 copay	$ 30
Bifocal	$10 copay	$50	$0 copay	$ 50
Trifocal	$10 copay	$65	$0 copay	$ 65
Lenticular	$10 copay	$100	$0 copay	$100
Lens Options Specialty Lenses (Polycarbonate, Hi Index, Photo, Chromatic, etc.)	Additional applicable copay		Applied to the allowance for the applicable corrective lens	
Frames	$150 allowance	Reimbursed up to $70	$150 allowance	Reimbursed up to $70
Contacts (in lieu of frames)				
Elective	$150 allowance	Reimbursed up to $105	$150 allowance	Reimbursed up to $105
Medically Necessary	Covered in full after copay	Reimbursed up to $210	Covered in full after copay	Reimbursed up to $210
Lasik *	15% discount off of the regular price or 5% discount off a promotional offer			

PER PAYCHECK DEDUCTION	BASE PLAN	BUY UP PLAN
Employee Only	$3.41	$4.59
Employee + Spouse	$6.06	$7.96
Employee + Child(ren)	$7.31	$9.55
Employee + Family	$8.99	$11.82

*Custom Lasik coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.


MetLife
VISION
Employee Name
Employee ID
SWBC Professional Employer Services
Group Name
5365100
Group Number
This card is not a guarantee of coverage or eligibility. See reverse side for important plan information.


www.metlife.com/mybenefits
- Locate a participating eye doctor or print your ID card
- Review benefits information and past services
- Obtain claims forms and educational information
- **Providers** — Check eligibility through eyefinity.com or call 800.615.1883
- **Retail chain locations** — Check eligibility through 2020source or call 866.773.3260

1-855-MET-EYE1

TDD/TTY for the hearing impaired: 1-800-428-4833

- Monday-Friday, 8 a.m. to 11 p.m., Saturday, 10 a.m. to 11 p.m., and Sunday, 10 a.m. to 10 p.m. Eastern Standard Time.
- MetLife Vision; P.O. Box 385018; Birmingham, AL 35238-5018

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Survivors Benefit Coverage

Discussing what might happen to your family if you were not around to provide for them isn't always the easiest conversation, but it is necessary. Survivor benefits provide financial assistance and can help you plan for the unexpected. If you have life insurance now, you can take comfort in knowing those who depend on you will be provided for.

Please choose the benefit that best suits your needs and keep in mind that the option you elect will be in place from **October 1, 2021 - September 30, 2022. Be sure and add a Beneficiary when enrolling.**

Employer Paid Life with AD&D Benefits

FPO / RCCO / WHR pays 100% towards the cost of a **Life / AD&D policy in the amount of $25,000** for each active, full-time employee, regardless of your enrollment in other benefits. In addition, **SWBC PEO** pays 100% towards the cost of a **Life / AD&D policy in the amount of $2,000** also for each active, full-time employee, regardless of your enrollment in other benefits. Both benefits will be payable to the beneficiary(ies) that you specify during enrollment. **You can update your beneficiary at any time during the year.** If you are terminating employment, you have the option to convert your Basic Life and Voluntary Life to an individual policy.

Voluntary Term Life with AD&D Benefits

In addition to the Employer Paid Life policy provided by your employer, you may also elect additional life insurance coverage with **MetLife** for yourself and your dependents. Statement of Insurability will be required when enrolling for amounts over the guarantee amount or when you are enrolling past your initial enrollment date. Free will preparation available for all employees enrolling in the Voluntary Term Life AD&D coverage.

PLAN FEATURES	EMPLOYEE	SPOUSE	CHILD(REN)
Voluntary Term Life Insurance Coverage Amount	Increments of $5,000 not to exceed 5 times Basic Annual Earnings **Any amount over $100,000 will require Statement of Insurability**	Increments of $5,000 not to exceed 50% of the Employee's benefit with a $75,000 maximum benefit **Any amount over $25,000 will require Statement of Insurability**	Infant child under 6 months old: $1,000 benefit 6 months old through 26 years old: **Up to $10,000 not to exceed 50% of Employee's benefit.**
Minimum Coverage	$10,000	$5,000	$5,000
Maximum Coverage	$500,000	$75,000	$10,000
Accidental Death and Dismemberment (AD&D)	Same as Life Coverage Amount	Same as Life Coverage Amount	Same as Life Coverage Amount
One Time Guarantee Issue **(New Hires Only)**	$100,000	Up to $25,000 based on Employee's Coverage Amount	Up to $10,000 based on Employee's Coverage Amount

RATES

Rate for Each $1,000 of Employee or Spouse Life and AD&D Insurance Coverage. Use Employee age for Spouse rate.

Per Paycheck rates for each $1,000 of Employee / Spouse Voluntary Term Life AD&D Insurance Coverage

Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.045	$0.045	$0.056	$0.071	$0.097	$0.152	$0.215	$0.344	$0.392	$0.702	$1.134	
Child(ren)	$10,000 = $0.50 cents											

Voluntary Term Life Rate Formula

Elected Coverage Amount ÷ $1000 × Life AD&D Rate = Per Paycheck Deduction

Example Calculation of Premium for a 32 year old Employee Only electing $50,000 Coverage Amount:

$50,000 divided by $1,000 = 50 x $0.056 = $2.80 (Premium)

Voluntary Term Life with AD&D Benefits Overview

When you move to the next age bracket, rates will increase at the beginning of the next plan year.

Spouse and Child life coverage are only available if an employee elects Voluntary Term Life AD&D coverage.

Employee is responsibility for enrolling in Portability / Conversion with the carrier within 31 days of coverage cancellation.

Statement of Insurability Requirements

If an employee requests more that $100,000 as a newly eligible employee or $25,000 for a spouse.

If an employee does not enroll as a newly eligible employee or requests an increased amount at annual enrollment of over $5,000.

In the event an employee requests Portability of Conversion of a policy. *(rates may vary).*

Income Protection Coverage

You have the opportunity to participate in a **S**hort **T**erm and **L**ong **T**erm **D**isability Plan administered by MetLife. The STD and LTD Plans provide you with income protection if you become disabled for a covered accident, sickness, injury or pregnancy. If you decline STD and/or LTD coverage when initially offered, you may enroll at a later date. At that time, you will be required to provide a proof of good health by completing a Statement of Insurability and be subject to underwriting approval.

Please choose the benefit that best suits your needs and keep in mind that the option you elect will be in place from **October 1, 2021 - September 30, 2022.**

Voluntary Short Term Disability

Plan Features	Benefits
Benefit Waiting Period Injury Sickness / Illness	 7 days 7 days
Benefit Duration	13 weeks
Benefit Percentage	60%
Weekly Maximum	$2,308
Maternity	Covered same as any other illness
Pre-Existing	6 / 12
Exclusions	Intentionally self-inflicting injuries

Cost

STD Rate Formula
Annual Salary ÷ 52 x .6 / 10 = Weekly Benefit
If your weekly amount is over $2,308 use $2,308
Weekly Benefit x Rate = Per Paycheck Deduction

Age	Rate	Age	Rate
Under 25	$0.3000	45-49	$0.3850
25-29	$0.3155	50-54	$0.4770
30-34	$0.3235	55-59	$0.5850
35-39	$0.2925	60-64	$0.6925
40-44	$0.3155	65+	$0.8310

Voluntary Long Term Disability

Plan Features	Benefits
Duration of Benefits	No benefits will be paid beyond the later of: **(a)** The day before you reach age 65 or **(b)** 24 months of disability following the end of the qualifying event.
Waiting Period	90 Days
Benefit Percentage	60%
Monthly Maximum	$5,000
Own Occupation	24 months
Pre-Existing	3 / 12

Cost

LTD Rate Formula
Annual Salary ÷ 12 = Monthly salary
(If monthly is over $8,333 use $8,333 to continue calculation)
Monthly Salary x Rate / 100 = Per Paycheck deduction

Age	Rate	Age	Rate
Under 35	$0.0805	50-54	$0.4570
35-39	$0.1665	55-59	$0.5585
40-44	$0.2620	60-64	$0.7145
45-49	$0.3555	65+	$0.4955

Hospital Coverage

MetLife administers your Hospital Coverage. You will have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. The coverage can also be converted to an individual policy should you terminate employment with your company.

Contact MetLife Customer Service Representative at 800-438-6388 for additional information. Please note you can visit any provider under this coverage. MetLife does not issue identification card for this coverage.

Please choose the plan that best suits your needs and keep in mind that the option you elect will be in place from **October 1, 2021 - Septmeber 30, 2022.**

BENEFIT TYPE	BASE PLAN	BUY UP PLAN
Hospital Coverage - Accident		
Admission Must occur within 180 days after accident.	$500 per accident (non-ICU) $1,000 per accident (ICU)	$1,000 per accident (non-ICU) $2,000 per accident (ICU)
Confinement Must occur within 180 days after accident.	$100 a day (non-ICU) for up to 31 days $200 a day (ICU) for up to 31 days	$200 a day (non-ICU) for up to 31 days $400 a day (ICU) for up to 31 days
Inpatient Rehabilitation Stay must occur immediately following hospital confinement and occur within 365 day of accident.	$100 a day Up to 15 days per accident Up to 30 day per calendar year	$200 a day Up to 15 days per accident Up to 30 day per calendar year
Hospital Coverage - Sickness		
Admission Payable 1 x per calendar year	$500 (non-ICU) $1,000 (ICU)	$1,000 (non-ICU) $2,000 (ICU)
Confinement Paid per sickness	$100 a day (non-ICU) for up to 31 days $200 a day (ICU) for up to 31 days	$200 a day (non-ICU) for up to 31 days $400 a day (ICU) for up to 31 days
Other Benefits		
Health Screening (Wellness) Benefit provided if the covered member takes one of the covered screening/prevention tests. Payable 1 x per calendar year	$50	$100

PER PAYCHECK DEDUCTION	BASE PLAN	BUY UP PLAN
Employee Only	$6.17	$11.31
Employee + Spouse	$12.16	$22.29
Employee + Child(ren)	$11.17	$20.46
Employee + Family	$19.00	$34.80

This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by your company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this guide is a tool to answer most of your questions, fully details of the plans are contained into the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Accident Coverage

MetLife administers your Accident Coverage. You will have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. The coverage can also be converted to an individual policy should you terminate employment with your company.

Contact MetLife Customer Service Representative at 800-438-6388 for additional information. Please note you can visit any provider under this coverage. MetLife does not issue identification card for this coverage.

Please choose the plan that best suits your needs and keep in mind that the option you elect will be in place from **October 1, 2021 - Septmeber 30, 2022.**

BENEFIT TYPE	BASE PLAN	BUY UP PLAN
Injuries		
Fractures	$50 - $3,000	$100 - $6,000
Dislocations	$50 - $3,000	$100 - $6,000
Second and Third Degree Burns	$50- $5,000	$100 - $10,000
Concussions	$200	$400
Cuts/Lacerations	$25 - $200	$50 - $400
Eye Injuries	$200	$300
Medical Services and Treatment		
Ambulance	$200 - $750	$300 - $1,000
Emergency Care	$25 - $50	$50 - $100
Non-Emergency Care	$25	$50
Physician Follow-Up	$50	$75
Therapy Services (Including Physical Therapy)	$15	$25
Medical Testing Benefits	$100	$200
Medical Appliance	$50 - $500	$100 - $1,000
Inpatient Surgery	$100 - $1,000	$200 - $2,000
Other Benefits		
Accident Death Employee receives 100% Spouse receives 50% Children receive 20%	$25,000 $75,000 (airplanes, trains, buses, trolleys, subways and boats)	$50,000 $150,000 (airplanes, trains, buses, trolleys, subways and boats)
Dismemberment, Loss and Paralysis	$250 - $10,000 per injury	$500 - $50,000 per injury
Lodging Pays for lodging for companion up to 30 nights per calendar year	$100 per night up to 30 nights $3,000 total benefits per calendar year	$200 per night up to 30 nights $6,000 total benefits per calendar year
Health Screening (Wellness) Benefit provided if the covered member takes one of the covered screening/prevention tests. Payable 1 x per calendar year	$50	$50

PER PAYCHECK DEDUCTION	BASE PLAN	BUY UP PLAN
Employee Only	$3.13	$5.42
Employee + Spouse	$5.67	$9.81
Employee + Child(ren)	$6.45	$11.21
Employee + Family	$8.09	$13.78

This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by your company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this guide is a tool to answer most of your questions, fully details of the plans are contained into the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Critical Illness Coverage

MetLife administers your Critical Illness coverage. This benefit is payable when a member is diagnosed with cancer, has a stroke or heart attack, has a major organ transplant, undergoes heart surgery, becomes paralyzed, is severely burned, is in a coma, or loses speech, sight or hearing. The coverage can also be converted to an individual policy should you terminate employment with your company.

Contact MetLife Customer Service Representative at 800-438-6388 for additional information. Please note you can visit any provider under this coverage. MetLife does not issue identification card for this coverage.

Please choose the plan that best suits your needs and keep in mind that the option you elect will be in place from **October 1, 2021 - Septmeber 30, 2022.**

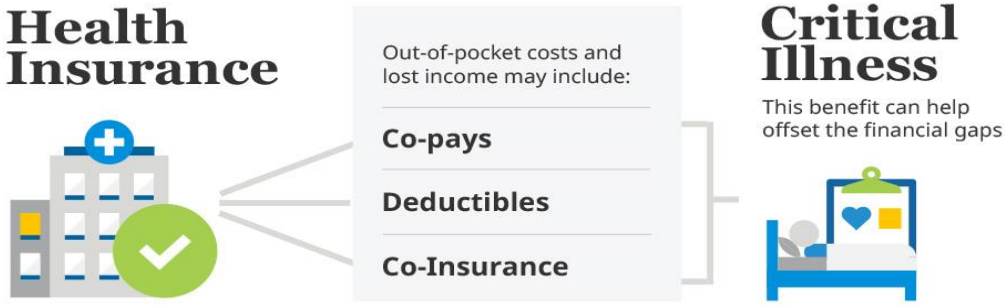
Covered Conditions	Initial Benefit	Reoccurrence Benefit
Full Benefit Cancer	100% of Initial Benefit	50% of Initial Benefit
Partial Benefit Cancer	25% of Initial Benefit	12.5% of Initial Benefit
Heart Attack	100% of Initial Benefit	50% of Initial Benefit
Stroke	100% of Initial Benefit	50% of Initial Benefit
Coronary Artery Bypass Graft	100% of Initial Benefit	50% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease	100% of Initial Benefit	Not applicable
Majored Organ Transplant Benefit	100% of Initial Benefit	Not applicable
Other Conditions - please refer to your certificate	25% of Initial Benefit	Not applicable
Health Screening Benefit Listing		
annual physical exam	echocardiogram	serum cholesterol test to determine LDL and HDL levels
biopsies for cancer	electrocardiogram (EKG)	serum protein electrophoresis
blood test to determine total cholesterol and/or triglycerides	endoscopy	skin cancer biopsy
bone marrow testing	fasting blood glucose test	skin cancer screening
breast MIR, ultrasound and/or sonogram	fasting plasma glucose test	skin exam
cancer antigen 15-3 blood test for breast cancer (CA15-3)	flexible sigmoidoscopy	stress test on bicycle or treadmill
cancer antigen 125 blood test for breast cancer (CA125)	hemoccult stool specimen	successful completion of smoking cessation program
carcinoembryonic antigen blood test for colon cancer (CEA)	hemoglobin A1C	test for sexually transmitted infections (STIs)
carotid Doppler	human papillomavirus (HPV) vaccination	thermography
chest x-rays	lipid panel	two hour post-load plasma glucose test
clinical testicular exam	mammogram	ultrasounds for cancer detection
colonoscopy	oral cancer screen	ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
digital rectal exam (DRE)	pap smears or thin prep pap test	
Doppler screening for cancer and/or peripheral vascular disease	prostate-specific antigen (PSA) test	virtual colonoscopy

MetLife will provide an annual benefit of $50 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year. List of Eligible screening/prevention measures may include any of the ones listed above.

Eligible Individual	Initial Benefit	Requirements
Coverage Options		
Employee	$15,000	Coverage is guaranteed provided you are actively at work.
Spouse/Domestic Partner	50% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.
Dependent Child(ren)	50% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate

PER PAYCHECK DEDUCTION NON TOBACCO USER	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Under 25	$1.95	$3.30	$3.53	$4.88
25 - 29	$2.03	$3.45	$3.60	$5.03
30 - 34	$2.63	$4.35	$4.28	$6.00
35 - 39	$3.68	$5.78	$5.33	$7.43
40 - 44	$5.55	$8.55	$7.20	$10.20
45 - 49	$8.18	$12.38	$9.83	$13.95
50 - 54	$12.00	$17.70	$13.65	$19.28
55 - 59	$17.10	$24.83	$18.75	$26.40
60 - 64	$24.30	$34.88	$25.95	$36.53
65 - 69	$35.93	$51.00	$37.50	$52.65
70+	$50.33	$72.00	$51.98	$73.65

PER PAYCHECK DEDUCTION TOBACCO USER	EMPLOYEE	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
Under 25	$2.48	$4.05	$4.05	$5.70
25 - 29	$2.63	$4.35	$4.28	$6.00
30 - 34	$3.75	$6.00	$5.40	$7.65
35 - 39	$5.48	$8.48	$7.13	$10.13
40 - 44	$8.78	$13.35	$10.43	$15.00
45 - 49	$13.50	$20.18	$15.15	$21.83
50 - 54	$20.40	$29.78	$21.98	$31.43
55 - 59	$29.63	$42.68	$31.28	$44.33
60 - 64	$42.68	$60.90	$44.25	$62.48
65 - 69	$63.60	$90.00	$65.25	$91.58
70+	$89.25	$127.35	$90.90	$128.93



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LEGAL PLAN

MetLaw provides you with telephone and office consultations for an unlimited number of matters with a network attorney of your choice. During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action. **SMART, SIMPLE & AFFORDABLE – coverage for employees, spouses and dependents.**

LEGAL REPRESENTATION

- ESTATE PLANNING
- MONEY MATTERS
- REAL ESTATE
- ELDER LAW
- FAMILY LAW
- TRAFFIC OFFENSES
- DOCUMENT PREPARATION
- IMMIGRATION LAW
- JUVENILE LAW
- CONSUMER PROTECTION
- DEFENSE OF CIVIL LAWSUITS
- PERSONAL PROPERTY PROTECTION

For More Information:

legalplans.com

Access code Legal

Client Service Center

1-800-821-6400

Monday – Friday

8 am to 8 pm EST/EDT

$18.00 per month

ADDITIONAL PLAN FEATURES

Reduced Fees

Network attorneys provide representation of personal injury, probate and estate administration matter at reduced fees.

Family Matters

Available for an additional fee. Separate plan for parent of participant for estate planning documents.

E-Services

Attorney locator, free downloadable legal documents; Life Guide; Links to financial planning, Insurance and work/life matters resources

METLIFE OFFERINGS

MetLife offers a variety of benefits that are at your disposal, most of which are free of charge. Take advantage of these resources by logging into your MetLife MyBenefits account today to get started.

How to Register on MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy access information. MetLife is able to deliver services that empower you to manage your benefits. As a first time user, you will need to register on MyBenefits. To do so, follow the steps outlined below.

Access MyBenefits at www.metlife.com/mybenefits and enter **5365100 - SWBC PEO** and click 'Submit'. On the Home Page, click on 'Register Now' and perform the one-time registration process. Enter your personal information, create a username and password, choose and answer three identity verification questions, agree to the terms of use and complete the registration process. You will see a 'Thank You' confirmation page. You have successfully registered your MyBenefits account!

Will Preparation/Estate Planning Services

If you elect Voluntary Life/AD&D coverage with MetLife, you are automatically eligible to utilize MetLife's online will preparation services provided by SmartLegalForms to create a binding will, living will, or assign a power of attorney. Sign on to an easy-to-use and secure website, available to you and your family members 24/7. Resources are available online to address questions you may have about creating a will or general estate planning. Once you create your binding documents, MetLife will provide you with simple instructions for witnessing/signing them in front of a Notary Republic. To get started visit www.willscenter.com and register as a new user. Follow the simple instructions to create your online document and return at your convenience to complete or update stored documents. In addition, you are also eligible to seek estate-planning services, offered through Hyatt Legal Plans. These services can help you when tasked with settling your spouse/domestic partners' estate. In addition, as a life policyholder, your spouse/domestic partner and the beneficiaries of your estate have access to these services to settle your estate.

Grief Counseling Services

The one predictable thing about life is that it is unpredictable. When times gets hard, we seek comfort, encouragement and hope for our loved ones. Grief comes in many forms and affects us in different ways. That is why grief-counseling services are offered with your life insurance coverage. Whether it is help coping with a loss or a major life change, the professional counselors and services we offer through LifeWorks US Inc. are ready to support you and your family to move forward - at no extra cost.

To speak with a LifeWorks Counselor

Call:
1-888-319-7819

Visit:
metlifegc.lifeworks.com
User Name: **metlifeassist**
Password: **support**

PET INSURANCE

Pet health insurance addresses the potentially high costs of medical care due to illness or injury to dogs and cats by reimbursing you for a portion or all of the veterinary bills incurred. Annual wellness option is available at an additional cost. Rates are based on the age and breed of your animal.

PROGRAM HIGHLIGHTS

- Eligible age for dogs and cats to qualify for full coverage is up to age 14.
- Annual maximum limits vary by state.
- Annual deductibles vary by state.
- Co-payment options reimbursement percentages vary by state.*
- Annual wellness limits of $250, $450 or $650 available at an additional expense.
- Spay/neuter, multi-pet, military, checking account and annual payment discounts are available and can be combined. Available discounts vary by state.
- Available in all 50 states.

CONVENIENT

- Website allows you to get a quote with the right coverage for your pet and purchase the policy online.
- Payment methods available: credit/debit card or checking account.
- Consumers choose their vet.
- Claims are in initiated online and are paid as straightforward percentage of the veterinary bill.

PROGRAM SUMMARY

HEALTH ISSUES COVERED	INCLUDED	OPTIONAL
ACCIDENTS	✓	
CANCER	✓	
BREED-SPECIFIC AND GENETIC CONDITIONS	✓	
CHRONIC AND RECURRING CONDITIONS	✓	
EMERGENCY AND SPECIALIST VET VISITS	✓	
LABORATORY AND DIAGNOSTIC TEST	✓	
SURGERY, HOSPITALIZATION AND NURSING CARE	✓	
ALTERNATIVE THERAPIES SUCH AS ACUPUNCTURE & REHABILITATION	✓	
WELLNESS CARE INLCUDING VACCINATIONS		✓
PRESCRIPTION MEDICATIONS COVERAGE MAY VARY BY STATE		✓
DENTAL CLEANING COVERAGE MAY VARY BY STATE		✓

To obtain a quote, go to:

https://swb.us/peo-pet-insurance

NortonLife Lock

At a time when we are more digitally connected than ever, we are committed to helping protect your identify. In today's world of online shopping, using public Wi-Fi and giving out Social Security numbers as a form of ID, our personal information can be exposed. Unfortunately, free credit monitoring simple alerts you to credit issues. LifeLock not only has proprietary technology to detect range of identify threats, if you do have an identity theft problem, our U.S. - based team of identify Restoration Specialists can help fix it.

LifeLock Identity Theft Protection We look for uses of your personal information, and with proprietary technology alert† you to a wide range of potential threats to your identity.

Norton Device Security protects against existing and emerging threats, including ransomware, viruses, spyware, malware, and other online threats.

Parental Control[1§] helps keep your kids safer online. Help your kids explore the Web more safely by keeping you informed of sites they are visiting, and blocking harmful or inappropriate ones.

Privacy Monitor scans common public people-search websites for your personal information and help you opt-out, giving you peace of mind and greater control over your online privacy.

Monthly Cost

$ 5.49 Employee Only

$10.98 Employee + Family

Member Service

(800) 607-9174

If you ever need assistance or have an identity related question, a LifeLock Identity Protection Agent is available to help you.

MY.NORTON.COM

SET UP YOUR ACCOUNT

1. Verify your identity through this link in the Welcome email: Norton.com/EBsetup
2. Create Your Account Log-in and Password
3. Activate Your Plan Features Access Your Member Dashboard
4. Download Mobile Apps

529 COLLEGE SAVINGS PLAN

SWBC PEO has collaborated with American Funds to offer employees an added benefit, a 529 College Savings Plan. A 529 College Savings Plan is a tax-advantaged savings plan designed to encourage saving for future college expenses for your children, grandchildren, nieces, nephews, friends - even yourself, if you decide to go back to school! Deductions are taken pre-tax from your payroll deductions and put into an investment account that can only be used for eligible education expenses.

Benefits of a 529 College Savings Plan include:

Flexibility:
Use the savings to fund any U.S. public or private college—undergraduate, graduate, professional, or vocational. You can also use funds for expenses such as room and board.

Investing for any beneficiary:
You can name anyone as the beneficiary—family, friends, or yourself! You can change them at any time.

Income Tax breaks:
Although contributions are not deductible, earnings in a 529 plan grow federal tax-free and will not be taxed when the money is taken out to pay for college.

Payroll Deduction:
Take advantage of automatic payroll deductions, low minimum contributions, rollover options, and much more!

Want more information?

Contact **Jamie Wisecarver**
(210)376-3929
Jamie.Wisecarver@swbc.com

Retirement Savings 401(k) Plan

Secure Your Retirement Future Today….

It is up to each one of us to responsibly save and prepare for retirement. To help you accomplish this important goal, one of the most innovative 401(k) plans is now available to you as part of our comprehensive benefits program. This vehicle is essential in building a sound and secure financial future. The Slavic 401(k) plan is not only an excellent financial vehicle; it is one of the most comprehensive programs offered. **Services include:**

- Complete plan and investment administration
- Individual participant investment advice
- Online participant functionality
- Exceptional customer service

Your contributions maximized.

Slavic is dedicated to keeping fees among the lowest in the industry.

Your investment secured.

BKS – one of America's bedrock financial institutions – acts as the custodian for Slavic 401(k) investments.

Your individuality valued.

At Slavic, plan participants are treated as individual investors.

Contact us to get started:

Kyle Hittle
Plan Administrator
(830) 310-8849
Kyle.Hittle@swbc.com

Slavic 401(k)
(800) 356-3009
customers@slavic401.com

SWBC MASTER PLAN - 401(K)

FPO Marketing, LLC - 401(k) Plan highlights

General Details of Your Plan

Effective Date: 1/1/2021

Eligibility Requirements:

- **Deferrals:**
  - **Age:** 0, **Months:** 12, **Hours:** 1000, **Entry:** dual (1/1 and 7/1)

Employee Contribution:

- 1% – 98% (based on all W-2 wages)
- Your contributions are always 100% vested.

Vesting Schedule for Non-Safe Harbor Employer Contributions	Vested Interest
Immediate	100

Safe Harbor Contribution: Your worksite employer will contribute a 401(k) safe harbor matching contribution to your account under the Plan. The Safe Harbor matching contribution will be equal to 100% of your 401(k) elective contributions which do not exceed 3% of your compensation for each payroll period, plus 50% of your 401(k) elective deferrals per pay period up to the next 2% of your eligible compensation for such pay period. The Safe Harbor contribution is always 100% vested.

2021 Annual Limits – You can contribute up to $19,500. For participants over the age of 50, up to $26,000. *Additional limits may apply due to compliance testing

Deferral Options

Pre-tax Traditional – Reduces current taxable income, upon distribution your assets will be taxed accordingly.
Roth 401(k) – After-tax contributions do not affect current taxable income, upon distribution your deferrals and gains on investments are not taxed with a qualified distribution.
Distribution Options – A pension plan may provide for distribution only upon retirement, termination of employment, disability, or death of the participant according to Treasury Regulation §1.401-1(b)(1)(i). Taxes and penalties may apply.
Loan Feature – You can access up to 2 loans at a time from your account, minimum loan $1,000 and maximum loan $50,000.

Investment Portfolio, Changing Allocations and Rollovers:

Investments

Open architecture platform of "true" no-load mutual funds. The funds are traded and cleared through Fidelity, one of the industry's leading financial services firms.

If an investment choice is not selected, your account will default to a Target Date Fund. Target-date funds provide a shifting mix of stocks and bonds that look to become more conservative as you approach retirement.

Fees:

- Annual Admin fee: $16
- Annual Asset fee: see fee disclosure for details

Loan fee:

- $75 initial fee
- $24 annual maintenance fee

Distribution fee:

- $40 standard
- $40 hardship
- $40 QDRO

Service Center Available

(New Enrollments and Changes, Beneficiary updates, loans and distribution questions)

- Toll-free number: (800) 356-3009 Customer service hours: 9a.m. to 8p.m. EST
- customers@slavic401k.com

First-Time Enrollment

- Go to www.slavic401k.com
- Click the Enroll button on the top right hand side.
- Enter your Social Security Number (without dashes).
- Enter your Date of Birth.

New Account Access

- To access your account online for the first time, go to www.slavic401k.com and click on "Log In" in top right-hand corner of the page. Then click on "Sign Up" and provide the information required to verify your account and create your username and password.

BENEFIT NOTICES

NOTICE OF COBRA CONTINUATION RIGHTS

Federal law requires the company to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or COBRA coverage) in certain instances when coverage under a group health plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that the company may maintain and that provides medical care. For simplicity, any such group health plan is referred to in this Notice as the "Plan." You do not have to show that you are insurable to elect continuation coverage; however, you will have to pay the entire premium for your continuation coverage.

This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than what the COBRA statue requires, and this Notice should be construed accordingly.

Both you (the employee) and your spouse should read this summary carefully and keep it with your records!

QUALIFYING EVENTS

If you are the employee and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the two "qualifying events":

1. Termination of employment (for reasons other than gross misconduct).
2. Reduction in the hours of your employment.

If you are the spouse of an employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your spouse.
2. Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the company.
3. Divorce or legal separation from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 30 days after the later divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your spouse becomes entitled to Medicare benefits.

In the case of a dependent child of an employee covered by the Plan, the dependent child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

1. The death of the employee-parent.
2. The termination of the employee-parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment with the company.
3. Parent's divorce or legal separation.
4. The employee-parent becomes entitled to Medicare benefits.
5. The dependent ceases to be a "dependent child" under the Plan.

YOUR IMPORTANT NOTICE OBLIGATIONS

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child's losing dependent status under the Plan, then you (the employee) or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child's losing dependent status. You or your spouse or dependent must provide this notice no later than 30 days after the date coverage terminates under the plan. If you or your spouse or dependent child fails to provide this notice to the Plan Administrator during this 30-day notice period, any spouse or dependent child who loses coverage will NOT be offered to elect continuation coverage. Furthermore, if you or your spouse or dependent child fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses after the date coverage terminate upon the divorce, legal separation, or a child's losing dependent status, then you, your spouse, and your dependent children will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is timely provided with the notice of a divorce, legal separation, or a child's losing dependent status that caused a loss of coverage, then the Plan Administrator will notify the effected family member of the right to elect continuation coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected family member's current mailing address - See the YOU MUST NOTIFY US paragraph below).The Plan Administrator will also notify you (the employee), your spouse and dependent children of the right to elect continuation coverage after it receives notice of the following events that results in a loss of coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, or death, or the employee's becoming entitled for Medicare.

BENEFIT NOTICES

ELECTION PROCEDURES

You (the employee) and/or your spouse and dependent children must elect continuation coverage within 60-days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. A COBRA election mailed to the Plan Administrator is considered to be mailed on the date of mailing.

You (the employee) and/or your spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered employee does not (or is not deemed to) elect it. You (the employee) and/or your spouse and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

TYPE OF COVERAGE

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, an employee, spouse or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage is modified for similarly-situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If more than one group health plan is offered (or a choice of separate benefit packages under a single plan is offered), you (or your spouse or dependent children) may elect COBRA coverage under one or more of those plans (or separate benefit packages) in which you have coverage. For example, if you are covered under three separate Employer plans (e.g., a medical plan, a dental plan, and a vision plan), you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. But if the company maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

A health flexible spending arrangement (health FSA) under which you are reimbursed for medical expenses is offered, you (or your spouse or dependent children) may elect to continue the health FSA coverage under COBRA, but only if there is a positive account balance (i.e., year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted by that date). COBRA coverage under the health FSA will continue only for the remainder of the Plan year in which the qualifying event occurred. If there is a negative account balance (i.e., year-to date-contributions are less than year-to-date claims), then no qualified beneficiary may elect COBRA coverage under the health FSA.

COBRA PREMIUMS THAT YOU MUST PAY

The premium payments for the "initial premium months" must be paid for you (the employee) and for any spouse or dependent children by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made. Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until the month's premium is paid within the 45-day period after the election of continuation coverage is made. All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment that is mailed is considered to be made on the date it is sent. If you don't make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month, with no possibility of reinstatement.

All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment that is mailed is considered to be made on the date it is sent. If you don't make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month, with no possibility of reinstatement.

MAXIMUM COVERAGE PERIODS

The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

36 Months. If you (the spouse or dependent child) lose group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lose your status as a dependent child under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

18 Months. If you (the employee, spouse or dependent child) lose group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage is 18 months for the date of termination or reduction in hours. There are three exceptions:

1. If an employee or family member is disabled at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under Social Security Act must be provided to the Plan Administrator within both the 18-month coverage period and 60 days after the date of the determination.
2. If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.
3. If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and the dependent child) is three years from the date the employee became entitled to Medicare.

Shorter Maximum for Health FSAs. The maximum COBRA period for a health flexible spending arrangement (health FSA) maintained by the company (if there is a positive account balance as of the date of the qualifying event, as explained above) ends on the last day of the Plan year in which the qualifying event occurred. If there is a negative balance as of the date of the qualifying event, no COBRA coverage will be offered.

CHILDREN BORN TO OR PLACED FOR ADOPTION WITH THE COVERED EMPLOYEE DURING COBRA PERIOD

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary, provided that, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

OPEN ENROLLMENT RIGHTS AND HIPAA SPECIAL ENROLLMENT RIGHTS

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children born to or Placed for Adoption With the Covered Employee During COBRA Period," dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries and their coverage will end and at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

ALTERNATE RECIPIENTS UNDER QMCSOS

A child of yours (the employee's) who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during your (the employee's) period of employment with the company is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependent.

BENEFIT NOTICES

TERMINATION OF COBRA COVERAGE BEFORE THE END OF MAXIMUM COVERAGE PERIOD

Continuation coverage of the employee, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. The company no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the employee, spouse or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
4. After electing COBRA coverage, you (the employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the employee, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than the 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

YOU MUST NOTIFY US ABOUT ADDRESS CHANGES, MARITAL STATUS CHANGES, DEPENDENT STATUS CHANGES AND DISABILITY STATUS CHANGES

If you or your spouse's address changes, you must promptly notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important COBRA notices and other information). Also, if your marital status changes or if a dependent cease to be a dependent eligible for coverage under the Plan terms, you or your spouse or your dependent must promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA right for your spouse and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

Plan Administrator
SWBC PEO
ATTN: Human Resources
30815 US HWY 281 NORTH
BULVERDE, TX 78163

For More Information
If you, your spouse or dependent children have any questions about this notice or COBRA, please contact the Plan Administrator if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

BENEFIT NOTICES

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An ex ample of this would include case management.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
- Health Care Operations means such business-related activities as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protectedhealth information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.
- We have the obligation to provide and you have the right to obtain a paper copy of this notice from us at least every three years. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of September 1, 2012 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For more information about HIPAA or to file a complaint: 30815 US
HWY 281 NORTH
BULVERDE, TX 78163
(830) 980-1200
Privacy Officer The U.S. Department of Health & Human Services, Office for Civil Rights 200
Independence Ave, S.W.
Washington, DC 20201
(202) 619-0257
Toll Free: (877) 696-6775

GENERAL NOTICE

General Notice of Special Enrollment Rights and Pre-existing Condition Exclusion Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Your group health plan is required to provide you this notice explaining your group health plan's procedures for your special enrollment rights and imposing pre-existing condition exclusions.

- Your Special Enrollment Rights – If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31days after the marriage, birth, adoption, or placement for adoption.
- Pre-existing Condition Exclusions – Under HIPAA, a "pre-existing condition" is a condition for which medical advice, diagnosis, care, or treatment was recommended and received within the six-month period ending on the enrollment date in a health plan (the look-back period). Taking prescription medications during the look-back period constitutes receiving treatment.

Your plan may deny benefits for a pre-existing condition during a 12-month waiting period beginning on your enrollment date. (If you do not enroll in a timely manner, the maximum waiting period is 12 months from the date coverage begins.) A pre-existing condition exclusion does not apply to a pregnancy or to a newborn child or adopted child under age 18 who becomes covered within 31 days of birth or adoption. A genetic condition without advice, care, or treatment is not a pre-existing condition.

The existence of a pre-existing condition will be determined using information obtained relating to an individual's health status before his or her enrollment date. An individual's enrollment date remains the same even if the individual changes benefit package options, as permitted by plan rules.

The pre-existing condition waiting period is reduced by any creditable coverage (prior coverage under various plans including, but not limited to, group health plans, individual health policies, Medicare, and Medicaid). You may obtain a certificate of creditable coverage from a prior plan sponsor or health insurance issuer. Should you disagree with the length of creditable coverage determined, you have the right to appeal that determination and provide additional evidence of creditable coverage.

NEWBORN AND MOTHERS' HEALTH PROTECTION ACT

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

PRIMARY CARE DESIGNATION AND OB/GYN NOTICE

The company generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please visit the carrier website. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit the carrier website.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

If WHCRA applies to you and if you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses (e.g., breast implant); and
- Treatment for physical complications of the mastectomy, including lymphedema.

Whether WHCRA or a State law that affords you the same coverage as WHCRA applies to your coverage will depend on your situation. Generally, WHCRA applies if you are in a self-insured plan. Your State law will determine whether WHCRA will apply to coverage under an insured group plan, or to individual health insurance coverage.

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help individuals who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact the Texas Medicaid or CHIP office to find out if premium assistance is available.

Website: https://www.gethipptexas.com
Phone: (800) 440-0493

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, you can contact the Texas Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

WOMEN'S PREVENTIVE HEALTH BENEFITS - CHANGES EFFECTIVE AUGUST 1, 2012

As you may know, the Affordable Care Act (ACA, or Health Care Reform law) includes changes that are being phased in over a number of years. The latest set of changes includes additional benefits for certain Women's Preventive Health Services. When plans renew or are effective on or after August 1, 2012, all of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment); certain religious organizations or religious employers may be exempt from offering contraceptive services

MEDICARE PART D NOTICE

Important Notice From The Company About Your Prescription Drug Coverage and Medicare
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the company 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.

IMPORTANT INFORMATION

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. The company has determined that the prescription drug coverage offered by the carrier 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. Please note that if 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. **If you are enrolled in a High Deductible Plan, your plan will not qualify as a Creditable Coverage 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 November 15th through December 31st. 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 company coverage will not be affected. You can keep this coverage if you elect part D and the company's plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current company's coverage, be aware that you and your dependents may 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 the company 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage contact the person listed below for further information.

NOTE: You will 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 the company changes. You also may request a copy of this notice at any time. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare 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: September 1, 2012

Name of Entity/Sender: SWBC PEO

Contact--Position/Office: Human Resources Department Address: 30815 US HWY 281 North Bulverde, TX 78163

Phone Number: (830) 980-1200

This benefits summary guide prepared by:

SWBC | PEO

This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by your company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this guide is a tool to answer most of your questions, fully details of the plans are contained into the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.