2020 Benefits Guide

Southwest General

Partnering with University Hospitals

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Your Wellbeing And Security Matter To Us.

We are proud to offer benefit programs that encourage healthy living and financial security and balance the needs of our employees and the organization. This guide provides the summary information you need to select the benefits that best meet your situation.

We are here to help and ask that you take the time to understand your options, get answers to your questions and make the choices that are right for you and your family.

Visit **www.mysouthwestbenefits.com** for more details about the 2020 benefits plans.

Benefits Eligibility At A Glance

Eligibility criteria:	Full-time Work at least 60 hours bi-weekly	Half-time Work at least 40 hours and not more than 59 hours bi-weekly	Part-time Work at least 8 hours and not more than 39 hours bi-weekly	PRN
Medical *You and Southwest share the cost*	✓	✓		
Dental *You and Southwest share the cost*	✓	✓		
Vison *You and Southwest share the cost*	✓	✓		
Basic Life and Accidental Death & Dismemberment (AD&D) Coverage *Southwest pays 100% of the standard benefit cost*	✓			
Voluntary Life and Accidental Death & Dismemberment (AD&D) Coverage *You pay the cost*	✓	✓		
Disability Insurance *Southwest pays 100% of the cost*	✓			
Short Term Disability Buy-Up Option *You pay the cost*	✓			
Flexible Spending Accounts *You make the deposits*	✓	✓	✓	
Employee Assistance Program (EAP) *Southwest pays the cost*	✓	✓	✓	✓
Southwest Matching Defined Contribution Retirement Plan -403(b) *You and Southwest contribute*	✓	✓	✓	✓

A new hire is eligible for benefits on the first day of the month following their date of hire. Note, benefit elections must be made within 30 days of date of hire. Wisdom Work Program Employees must contact Human Resources regarding their benefit options.

For More Benefits Information

Visit our website at **www.mysouthwestbenefits.com**

2020 Benefits Eligibility

Annually you have the opportunity to choose the benefits that match the needs of you and your family. Your elections are effective from January 1, 2020 through December 31, 2020. Your elections remain in effect for the entire period unless you experience a Qualifying LIfe Event.

If you are a new hire or have a qualified life event, most of your benefits are effective on the first of the month following your date of hire or qualified life event.

EMPLOYEES

Who are regularly scheduled 20+ hours or more per week, you are eligible for Southwest healthcare benefits. Please refer to the chart on the previous page for specific eligibility.

If you and your spouse are both employees of Southwest, each employee may only be covered by one Southwest plan in each benefits category.

DEPENDENTS

Your family's needs matter to us. When you enroll in Southwest benefits, you may also include coverage for eligible dependents including:

- Your legal spouse
- Your children, until the end of the month in which they turn age 26
- Legally adopted children or children for whom you are the legal guardian, until the end of the month in which they turn age 26
- Handicapped children older than age 26, if they rely on you for financial support

If you and your spouse are employees of Southwest and are both eligible for coverage under our plans, only one of you may cover any eligible children as dependents.

Remember, if you experience a Qualified Life Event that impacts your benefits, you must submit the completed Benefit Change Form within 30 days of the Event or you will not be able to change your benefits until the next Annual Enrollment period.

Spousal Surcharge

If your spouse is eligible for medical coverage through his or her employer and you elect to cover him or her under a Southwest medical plan, a $250 monthly spousal surcharge will be added to your monthly medical benefits cost. If you and your spouse are both Southwest employees, each employee may only be covered by one Southwest medical plan and the spousal surcharge will not apply. If a spouse's medical eligibility changes throughout the year, you must notify Human Resources within 30 days of the event.

Qualified Life Events

Life doesn't always follow a predictable path. When certain events occur, you can make changes to your Southwest benefits. These Qualified Life Events include:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Medicare or Medicaid Eligibility

If you need to change your benefits because of one or more of these events:

- Request a Benefits Change Form from Human Resources
- Return the completed form to Human Resources within 30 days of the event
- In some instances, additional documentation will be required.

PLEASE NOTE:

You may change your benefits within 60 days of the determination date of you or your dependents becoming eligible/ineligible for Medicaid or the Children's Health Insurance Program (CHIP). Your change in eligible status must be the reason for the change.

Medical Plans

You can choose from one of three medical plans and have the security of knowing you're covered when you need professional medical care.

All Southwest medical plans offer health care benefits for you and your eligible dependents. Each is structured a little differently so you can select the plan that best meets your needs.

- **The Consumer Driven Health Plan (CDHP)** allows you to minimize your out-of-pocket premium and to open and contribute to a Health Savings Account (HSA) to offset qualified medical expenses. Please review page 5 for more information on this tax-advantaged savings account.
- **The Basic and High Preferred Provider Organization Plans (PPO)** are designed for those who prefer the predictability of set payments for doctors' appointments and other medical services.

The Southwest medical plans are designed with multiple network tiers whereby the medical benefits you receive will be based on where you obtain health care. Choosing Tier 1 facilities and providers will provide you with the lowest out-of-pocket spend. It is important to review this chart prior to receiving treatment.

TIER 1	TIER 2	TIER 3
• Southwest General Health Center • Big Creek Surgery Center • The Surgery Center • Parkside Villa **University Hospital Facilities:** • Ahuja • Cleveland Medical Center • Geauga • Bedford • Conneaut • Geneva • Richmond • Samaritan • Portage • University Hospital North Ridgeville Health Center • University Hospital Westlake Health Center • University Hospital and Southwest physician and ancillary providers • Baylor Genetics (Baylor Miraca Genetics Laboratories LLC) • GeneDX • Invitae Corporation • Orthotic & Prosthetic Specialists and Wig Studio	• Ashtabula County Medical • Barberton Citizens Hospital • Children's Hospital Medical Center of Akron • Cuyahoga Falls General • Grace Hospital • Lake Health • Northern Ohio Regional Cancer Center • St. Vincent Charity Medical Center* • Summa Health System • UH Elyria Medical Center • UH St. John Medical Center • And other SuperMed Facilities not listed and not in Tier 3.	• All CCHS Facilities, Ancillaries and employed physicians • MetroHealth Medical Center • University Hospital Parma Medical Center **The following diagnostic facilities:** • Cleveland Urology Associates** • Southwest Urology** ***Office visits paid at Tier 1; all other services and facility fees paid at Tier 3*

**Bariatric surgery performed by Dr. Craig Eyman at St. Vincent Charity Medical Center (all services) will be paid at Tier 1.*

This Guide is intended as a summary of your medical coverage. Please refer to your Summary Plan Description for the full scope of coverage via www.mysouthwestbenefits.com, or at www.mutualhealthservices.com. In-network services are based on negotiated charges; out-of-network services are based on Reasonable & Customary (R&C) charges.

The Consumer Driven Health Plan (CDHP) Paired With Health Savings Account (HSA)

This plan is designed to meet your health care needs today, throughout your career and into retirement. The CDHP has a higher annual deductible, but features a Health Savings Account (HSA), which is a tax-advantaged savings account that allows you to set aside pre-tax contributions to pay for eligible health care expenses now and in the future.

An HSA has the unique potential to offer triple tax savings through:

- Federal & State Tax-deductible contributions to the HSA
- Tax-free interest or investment earnings
- Tax-free distributions when used for qualified healthcare expenses

YOUR HEALTH SAVINGS ACCOUNT

- Allows you to make contributions with pre-tax dollars through payroll deduction
- Is tax-advantaged. You do not pay federal or state taxes on Southwest's contributions or the money you contribute to the account
- Can be used for the CDHP's annual deductible, coinsurance and other qualified medical expenses
- Can also be used for eligible dental and vision expenses
- Is flexible. Contributions can be changed during the year by contacting Human Resources
- Does not include a "lose it or use it" feature – the balance rolls over year after year
- Includes investment options when your balance reaches $2,000
- Is your account – your HSA goes with you if you leave Southwest for any reason
- Is regulated by the IRS – in 2020, the maximum limit, including Southwest's contributions to your account is $3,550 single/$7,100 family

If you are age 55 or older, you can contribute up to an additional $1,000 into your HSA each year per IRS catch-up provisions.

WHO CAN ESTABLISH AND CONTRIBUTE TO A HEALTH SAVINGS ACCOUNT?

- Must be 18 years of age or older
- Must be covered under a qualified high-deductible health plan (HDHP)
- May not be covered under any health plan that is not a qualified HDHP
- Must not be enrolled in Medicare (the healthcare component of the Social Security program)
- May not be claimed as a dependent on another individual's tax return

You can deposit additional funds to the account, up to current IRS limits.

	Southwest's contributions in 2020*	You can contribute up to**
Individual	$750	$2,800
Family	$1,500	$5,600

FIFTH THIRD BANK

Southwest has partnered with Fifth Third Bank to open and maintain your HSA.

The account works exactly like your personal checking account with debit card access, online capabilities, ATM and mobile access.

Contact Fifth Third Bank Consumer Directed Health Account Support Center at 888-350-5353 or www.53hsa.com and reference Southwest Employer Code FTB-149563 for more information.

Your account must be open before deposits or withdrawals can be made.

For More Information

Visit our website at **www.mysouthwestbenefits.com**

*Southwest will deposit contributions into your HSA on a biweekly pay cycle basis. In order to receive Southwest contributions, you will need to contribute a minimum of $.01 per pay cycle up to no more than the IRS maximum, and activate your account at Fifth Third Bank. Shortly after completing the enrollment process, you will receive email instructions from Fifth Third Bank on how to open your account. For further information, please refer to the HSA section on **www.mysouthwestbenefits.com.**

The Consumer Driven High Deductible Plan (CDHP)

- Covers 100% of preventive care services provided in-network (according to age and gender)
- Will have the best value when you choose in-network healthcare providers
- Allows you to visit any provider
- Requires that you pay medical and prescription costs out-of-pocket until the deductible is met
- Allows you to open and contribute to a tax-advantaged Health Savings Account to pay for medical expenses now and in the future

Consumer Driven Health Plan (CDHP)	TIER 1	TIER 2	TIER 3
	Southwest and UHHS Facilities *(Excluding Elyria, Parma and MetroHealth)*	**SuperMed Plus Network, including Elyria** *(Excluding Parma, CCHS and MetroHealth)*	**Non-Network Providers** *(Including CCHS, CCHS Affiliates, Parma and MetroHealth)*
	YOU PAY	**YOU PAY**	**YOU PAY**
Annual Deductible *(Individual Deductible and Aggregate Family Deductible[1])*	$2,000/$4,000[1]	$2,500/$5,000	$3,000/$6,000
Coinsurance	20%	30%	40%
Annual Out-of-Pocket Maximum *(Individual/Family)*[2]	$4,000/$8,000	$6,550/$13,100	$22,500/$45,000
Lifetime Maximum	Unlimited		
Preventive Care	$0	$0	Deductible then 40% Coinsurance[3]
Primary Care Office Visit	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3]
Specialist Office Visit	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3]
Teladoc Virtual Visit	Deductible then 20% Coinsurance	N/A	N/A
Diagnostic[4]	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3,5]
Inpatient Hospital and Surgical Services	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3]
Outpatient Hospital and Surgical Services	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3]
Emergency Room and Urgent Care	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3]
Hospice Care	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3]
Durable Medical Equipment	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3]
Major Medical Drug Coverage	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance[3]
Prescription Drug Benefits	Subject to Medical Plan Deductible – Refer to page 9 for prescription coverage detail.		

[1] You must satisfy the full family deductible (Aggregate Family Deductible) amount before medical or Rx benefits are paid for any family member covered under the plan.

[2] Annual Out-of-Pocket Maximum includes your deductible and coinsurances; plan pays at 100% after this maximum has been met.

[3] You will be responsible for paying any amount in excess of R&C (Reasonable and Customary allowed amount for Tier 3) in addition to the Deductible and Coinsurance.

[4] Prior authorization is required for all CT, PET and MRI scans.

[5] CT/PET Scans, MRI not covered under Tier 3.

The Basic PPO Plan

- Covers 100% of preventive care services provided in-network (according to age and gender)
- Offers the predictability of copayments for many services
- Allows deductibles, coinsurance and copayments to accumulate toward the out-of-pocket maximum
- Will have the best value when you choose Tier 1 in-network healthcare providers
- Allows you to visit any provider

Basic PPO Plan	TIER 1	TIER 2	TIER 3
	Southwest and UHHS Facilities *(Excluding Elyria, Parma and MetroHealth)*	**SuperMed Plus Network, including Elyria** *(Excluding Parma, CCHS and MetroHealth)*	**Non-Network Providers** *(Including CCHS, CCHS Affiliates, Parma and MetroHealth)*
	YOU PAY	**YOU PAY**	**YOU PAY**
Annual Deductible *(Individual/Family)*	$450/$900	$900/$1,800	$3,000/$6,000
Coinsurance	25%	45%	45% R&C[1]
Annual Out-of-Pocket Maximum *(Individual/Family)*	$4,000/$8,000	$6,850/$13,700	$22,500/$45,000
Lifetime Maximum	Unlimited		
Preventive Care	$0	$0	Deductible then 50% Coinsurance
Primary Care Office Visit	$20 Copay	$20 Copay	Deductible then 45% Coinsurance
Specialist Office Visit	$40 Copay	$40 Copay	Deductible then 45% Coinsurance
Teladoc Virtual Visit	$20 Copay	N/A	N/A
Diagnostic[2]	$0	45%	Deductible then 45% Coinsurance
Inpatient Hospital Services	$250 Copay + Deductible then 25% Coinsurance	$250 Copay then 45%	Deductible then 45% Coinsurance
Surgical Services	Deductible then 25% Coinsurance	Deductible then 25% Coinsurance	Deductible then 45% Coinsurance
Outpatient Hospital Services	$0	Deductible then 45% Coinsurance	Deductible then 45% Coinsurance
Outpatient Surgical Services	Deductible then 25% Coinsurance	Deductible then 45% Coinsurance	Deductible then 45% Coinsurance
Urgent Care	$40 Copay	$60 Copay	Deductible then 45% Coinsurance
Emergency Room Care *(Waived if admitted)*	$250 Copay[3]		
Bariatric Surgery	$250 Copay + Deductible then 25% Coinsurance	$250 Copay then 45%	Deductible then 45% Coinsurance
Transplant Services – Performed at Centers for Excellence[4] *(Prior authorization is required)*	$0	$0	Deductible then 50% Coinsurance
Hospice Care	Deductible then 25% Coinsurance	Deductible then 45% Coinsurance	Deductible then 45% Coinsurance
Durable Medical Equipment	Deductible then 25%	Deductible then 45% Coinsurance	Deductible then 45% Coinsurance
Temporomandibular Joint – TMJ	Deductible then 25% Coinsurance	Deductible then 45% Coinsurance	No Coverage
Mental Health and Substance Abuse **Inpatient** **Outpatient**	Deductible then 25% Coinsurance $20 Copay	Deductible then 45% Coinsurance $20 Copay	Deductible then 45% Coinsurance Deductible then 45% Coinsurance

[1] You will be responsible for paying any amount in excess of R&C (Reasonable and Customary allowed amount) in addition to the Deductible and Coinsurance.
[2] Prior authorization is required for all CT, PET and MRI scans; not covered under Tier 3.
[3] Waived if admitted.
[4] Performed at Centers for Excellence. Prior authorization is required.

The High PPO Plan

- Is structured like the Basic PPO Plan but includes different copayments, deductibles and premiums
- Covers 100% of preventive care services provided in-network (according to age and gender)
- Offers the predictability of copayments for many services
- Allows deductibles, coinsurance and copays to accumulate toward the out-of-pocket maximum.
- Will have the best value when you choose Tier 1 in-network healthcare providers
- Allows you to visit any provider

High PPO Plan	TIER 1	TIER 2	TIER 3
	Southwest and UHHS Facilities *(Excluding Elyria, Parma and MetroHealth)*	**SuperMed Plus Network, including Elyria** *(Excluding Parma, CCHS and MetroHealth)*	**Non-Network Providers** *(Including CCHS, CCHS Affiliates, Parma and MetroHealth)*
	YOU PAY	**YOU PAY**	**YOU PAY**
Annual Deductible *(Individual/Family)*	$300/$600	$700/$1,400	$3,000/$6,000
Coinsurance	15%	35%	45% R&C[1]
Annual Out-of-Pocket Maximum *(Individual/Family)*	$3,000/$6,000	$6,250/$12,500	$22,500/$45,000
Lifetime Maximum	Unlimited		
Preventive Care	$0	$0	Deductible then 50% Coinsurance
Primary Care Office Visit	$15 Copay	$15 Copay	Deductible then 45% Coinsurance
Specialist Office Visit	$30 Copay	$30 Copay	Deductible then 45% Coinsurance
Teladoc Virtual Visit	$15 Copay	N/A	N/A
Diagnostic[2]	$0	Deductible then 35% Coinsurance	Deductible then 45% Coinsurance
Inpatient Hospital Services	Deductible then 15% Coinsurance	Deductible then 35% Coinsurance	Deductible then 45% Coinsurance
Surgical Services	Deductible then 15% Coinsurance	Deductible then 15% Coinsurance	Deductible then 45% Coinsurance
Outpatient Hospital Services	$0	Deductible then 35% Coinsurance	Deductible then 45% Coinsurance
Outpatient Surgical Services	Deductible then 15% Coinsurance	Deductible then 35% Coinsurance	Deductible then 45% Coinsurance
Urgent Care	$40 Copay	$50 Copay	Deductible then 45% Coinsurance
Emergency Room Care *(Waived if admitted)*	$250 Copay[3]		
Bariatric Surgery	Deductible then 15% Coinsurance	Deductible then 35% Coinsurance	Deductible then 45% Coinsurance
Transplant Services – Performed at Centers for Excellence[4] *(Prior authorization is required)*	$0	$0	Deductible then 50% Coinsurance
Hospice Care	Deductible then 15% Coinsurance	Deductible then 35% Coinsurance	Deductible then 45% Coinsurance
Durable Medical Equipment	Deductible then 15% Coinsurance	Deductible then 35% Coinsurance	Deductible then 45% Coinsurance
Temporomandibular Joint – TMJ	Deductible then 15% Coinsurance	Deductible then 35% Coinsurance	No Coverage

[1] You will be responsible for paying any amount in excess of R&C (Reasonable and Customary allowed amount) in addition to the Deductible and Coinsurance.
[2] Prior authorization is required for all CT, PET and MRI scans.
[3] Waived if admitted.
[4] Performed at Centers for Excellence. Prior authorization is required.

Prescription Drug Coverage

When you select a Southwest medical plan, you're automatically enrolled in our prescription drug plan. Your prescription coverage is managed by MedImpact, one of the nation's leading pharmacy partners.

You have three ways to get your prescriptions filled.

1. **SOUTHWEST GENERAL PHARMACY**
   Purchase a 31-day or 90-day supply of maintenance drugs through Southwest General Pharmacy. If you utilize Southwest for your prescription needs, you will have a lower deductible and cost share under the PPO plans.

2. **RETAIL** (NON-MAINTENANCE MEDICATIONS)
   Use MedImpact's nationwide network of more than 64,000 participating pharmacies for up to a 31-day supply. Locally, Southwest General Pharmacy, CVS, Walmart and Rite Aid are included in the MedImpact network.

3. **BY MAIL***
   Order a 90-day supply through Prescription Solutions (PPS). Enroll online at www.ppsrx.com or call 800-552-6694 to enroll by phone.

All Southwest health care plans maintenance medications must be filled through the Southwest Community Pharmacy or via mail order with Postal Prescription Solutions. Prescriptions filled through the Southwest Community Pharmacy will have a lower deductible and lower cost sharing under any of the Southwest PPO plans. Note, HSA plan participants will pay the full cost of prescriptions until the deductible is met. Maintenance medications are any medications with two or more fills.

Prescription Drug Plan Benefit Summary	CDHP	Basic PPO / High PPO Plan
Annual Deductible (Retail)	All Rx charges are subject to the medical plan aggregate deductible	**$25** Individual/**$75** Family if purchased through Southwest **$50** Individual/**$150** Family if purchased through Retail or Mail Order **$100** per Person Lifestyle Prescriptions**
Annual Out-of-Pocket Coverage	Covered Rx charges are combined with medical charges and accumulate toward the medical plan annual out-of-pocket maximums. Once the maximum is reached, covered expenses will be paid at 100% for the remainder of the plan year.	

Prescription Drug Coverage: All Southwest Plans	Retail *(31-day supply)*	Southwest Retail *(31-day supply)*	Southwest Community Pharmacy Maintenance Prescriptions *(90-day supply)*	Mail Order Maintenance Prescriptions *(90-day supply)*
	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Generic	20% Minimum $5.00 Maximum $50.00	10% Minimum $5.00 Maximum $50.00	10% Minimum $5.00 Maximum $50.00	20% Minimum $10.00 Maximum $125.00
Formulary	30% Minimum $30.00 Maximum $75.00	20% Minimum $30.00 Maximum $75.00	20% Minimum $30.00 Maximum $75.00	30% Minimum $75.00 Maximum $188.00
Non-Formulary	50% Minimum $70.00 Maximum $200.00	50% Minimum $70.00 Maximum $200.00	40% Minimum $140.00 Maximum $400.00	50% Minimum $175.00 Maximum $500.00
Specialty	You pay 20%	You pay 20%	You pay 20%	You pay 20%

Note: When a member requests a brand name drug with a generic available, the member will be charged the difference in the cost between the brand and the generic drug plus the brand copay.

Step Therapy: A step therapy program uses an automated process to determine whether you qualify for coverage based on information we have on file, such as medical history, drug history, age and gender. This program requires that you try another drug before the target drug can be covered by your plan, unless special circumstances exist. If your doctor believes that special circumstances exist, he or she may request a coverage review. For a listing of drugs in the step therapy program, contact MedImpact.

* Prescription mail-order service is managed by Postal Prescription Solutions. Enroll online at www.ppsrx.com or call 800-552-6694 to enroll by phone.
** Smoking cessation prescriptions are included in your normal deductible. Participants of Southwest General Wellness may be eligible to receive additional smoking cessation benefits. Lifestyle prescriptions include medications for sexual dysfunction, etc.

For More Benefits Information

Contact 1-844-513-6007 or go to the member link at http://mp.medimpact.com/PHI.

Medical Mutual of Ohio (MMO)

You need information and resources to make informed decisions when managing your health and healthcare. Register on MutualHealthServices.com to view information on your benefits and access resources to help you and your family navigate the healthcare landscape.

MEDICAL MUTUAL SERVICES

- Precertification of inpatient and outpatient services is managed by MMO. To reach MMO, call 800-338-4114.*
- Improve your health by learning how to manage your diabetes with an individualized treatment plan from **Medical Mutual's Diabetes Management Program**. A trained health coach works with you to supplement the care you get from your doctor. You will receive reminders and help with coordinating the services you need. Call 800-861-4826 and select option 2 to check eligibility and enroll.
- **Medical Information Helpline.** Have a question about your health, medications or treatment plan, access the Medical Mutual's 24/7 **Nurseline** by calling 888-912-0636 or visit MedMutual.com/member to chat with a nurse.
- If you have a serious injury or illness, **MMO Case Management Program** is here to help. Through this program one of our nurse case managers will work with you one-on-one to create a care plan just for you. If you have questions or want to enroll in the program, please call 1-800-258-3175.
- **Teladoc** Virtual Visit available through MHS. Teladoc provides 24/7 access to U.S. board certified doctors by phone or video for many non-emergency illnesses, including flu, allergies, sinus infections and more. Visit Teladoc.com or download the Teladoc mobile app to register for this service.

See your benefit plan document for details pertaining to specific vendor offerings and program requirements. All MMO programs and services are strictly confidential and are HIPAA compliant. MMO program offerings are based on the most recent data files provided by claims and wellness vendors.

*Please reference your Medical Summary Plan Description available on the Southwest's benefits website www.mysouthwestbenefits.com or contact Mutual Health Services at 800-367-3762 for further assistance.

Dental Coverage

Your dental health is a good indicator of your overall health. Identifying issues early can simplify treatment, control costs and keep teeth and gums healthy. Southwest offers two dental plans through Cigna so that you and your family have the coverage that best matches your needs.

CIGNA TOTAL DPPO

With the Cigna Total Dental PPO you:

- ***NEW BENEFIT*** Cigna DPPO Advantage Tier provides you deeper discounts and a higher plan maximum of $2,500. To find a provider in this enhanced tier look for the Cigna DPPO Advantage designation on www.mycigna.com.
- Access the largest network of dentists who have contracted with Cigna for discounted rates
- Do not need to select a primary dentist
- Will have the best value when you choose in-network dentists and specialists
- Can visit any dentist or specialist – in- or out-of-network

To find a network dentist access the online Provider Directory at www.mycigna.com, or call 800-244-6224.

Cigna Total DPPO	CIGNA DPPO ADVANTAGE	CIGNA DPPO	OUT-OF-NETWORK
	YOU PAY	**YOU PAY**	**YOU PAY**
Annual Deductible *(Individual/Family)*	$50/$150	$50/$150	$50/$150
Annual Maximum per individual	$2,500	$1,500	$1,500
Diagnostic and Preventive including cleanings, fluoride treatments, sealants and X-rays	$0 with no deductible	$0 with no deductible	0% of R&C charges, no deductible
Basic Services including fillings, periodontics, scaling and root planning, oral surgery	20% after deductible	20% after deductible	20% of R&C charges after deductible
Major Services including crowns, bridges, full and partial dentures	50% after deductible	50% after deductible	50% of R&C charges after deductible
Orthodontia *(Coverage for employee and all dependents)*	50% $1,000 lifetime maximum	50% $1,000 lifetime maximum	50% $1,000 lifetime maximum
TMJ ($1,000 Lifetime Maximum)	50% after deductible	50% after deductible	50% after deductible
Implants	50% after deductible	50% after deductible	50% after deductible

Reimbursement For Services

Provided by an in-network dentist:
Provider reimbursement to the dentist will be according to a contracted fee schedule.

Provided by an out-of-network dentist:
Reimbursement will be according to the Reasonable & Customary allowance, but the dentist may bill you for the balance up to their usual fee.

CIGNA DENTAL CARE DHMO

This dental coverage uses a designated network of providers and to participate in this plan, you must use one of the dentists included in the network. The dentist you select from the Cigna Dental Care network will manage and provide your general dental care.

Each covered participant in your family may choose their own "general" dentist. The "general" dentist will coordiante and manage your overall dental care.

This plan:

- Requires each member select a "general" dentist that participates in the Cigna DHMO network
- Has no deductibles
- Does not include dollar maximums
- Does not have a waiting period
- Requires no claim forms
- Allows access to orthodontia without referrals
- Includes fixed fees clearly outlined on your Patient Charge Schedule (PCS) so you will know your costs in advance
- Does not put an age limit on sealants
- Includes fixed copayments so you will know your costs before a procedure begins
- Allows your enrolled dependents to choose their own dentist from the network
- No coverage outside of DHMO network

The Patient Charge Schedule can be obtained at **www.mysouthwestbenefits.com**

Access the Provider Directory online at www.cigna.com or call 800.244.6224 to find a dentist included in the plan.

For More Benefits Information

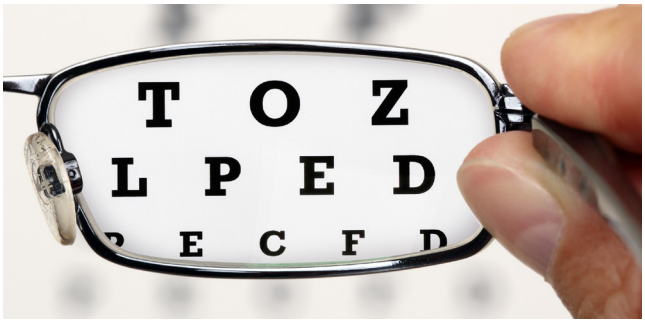
Visit our website at www.mysouthwestbenefits.com, visit www.cigna.com or call 800-244-6224 for assistance.

Vision Coverage

Southwest partners with EyeMed to offer the EyeMed Insights plan for your vision insurance.

EYEMED VISION PLAN

- Utilizes a broad network of providers
- Includes independent providers, as well as top retail chains such as LensCrafters® and Target Optical®
- Offers in-network and out-of-network cost and network discounts and features
- As an EyeMed member you get access to hearing health care discounts through Amplifon 877-203-0675
- In-network online options ContactsDirect.com and Glasses.com



EyeMed Insight Vision Plan	IN-NETWORK	OUT-OF-NETWORK
	YOU PAY	**MAX REIMBURSEMENT**
Exam *(Every 12 months)*	$10 Copay	$50*
Frames *(Every 24 months)*	$0 Copay; $140 allowance; 20% off balance over $140	$50*
Lenses *(Every 12 months)*		
• Single Vision	$0 Copay	$40*
• Bifocal	$0 Copay	$60*
• Trifocal	$0 Copay	$80*
• Lenticular	$0 Copay	$120*
• Progressive Standard	$0 Copay	$60*
• Progressive Premium Tier 1-3	$20-45 Copay	$60*
• Progressive Premium Tier 4	$0 Copay; 20% of Retail less $120 Allowance	$60*
Lens Options		
• UV Treatment & Tint *(solid and gradient)*	$15	N/A
• Standard Plastic Scratch Coating	$0 Copay	$8*
• Standard Polycarbonate – Adults	$40	N/A
• Standard Polycarbonate – Kids under 19	$0 Copay	$20*
• Standard Anti-Reflective Coating	$45	N/A
• Polarized	20% off retail price	N/A
• Photocromatic/Transitions Plastic	$75	N/A
• Premium Anti-Reflective	See your EyeMed website	N/A
• Other Add-ons	20% off Retail Price	N/A
Contact Lenses *(for materials only)*		
• Conventional & Disposable	$0 Copay/$135 allowance/15% off balance over $135	$105*
• Medically Necessary	$0 Copay	$210*
Laser Vision Correction *Call 800-988-4221* **Lasik or PRK from U.S. Laser Network**	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit	40% off eyeglass purchases/ 15% off conventional contact lenses	N/A

*Maximum Reimbursement

**Standard Progressive Lens covered-fund premium progressive as a standard. Refer to Fixed Premium Progressive price list for additional information.

For More Benefits Information

To learn more, including a list of providers, visit www.eyemedvisioncare.com or call 866-804-0982. You can also access the EyeMed Website via **our website at www.mysouthwestbenefits.com.**

2020 Employee Benefit Contributions (per pay)

These rates do not include the Southwest General Wellness Program rate incentives. Please see page 15 for the wellness incentives that can reduce your bi-weekly medical plan premiums.

	MHS CONSUMER DRIVEN HEALTH PLAN (CDHP)	FULL-TIME	HALF-TIME
MEDICAL PLANS	Employee	$108.79	$115.89
	Employee + Child	$138.55	$152.90
	Employee + Spouse*	$230.76	$247.86
	Employee + Children	$166.12	$187.75
	Family*	$250.62	$272.69
	MHS BASIC PPO PLAN	**FULL-TIME**	**HALF-TIME**
	Employee	$131.65	$143.97
	Employee + Child	$162.26	$182.03
	Employee + Spouse*	$256.75	$279.35
	Employee + Children	$189.54	$216.73
	Family*	$278.41	$306.41
	MHS HIGH PPO PLAN	**FULL-TIME**	**HALF-TIME**
	Employee	$210.23	$240.86
	Employee + Child	$321.81	$380.12
	Employee + Spouse*	$434.92	$499.37
	Employee + Children	$412.02	$494.14
	Family*	$525.29	$612.35

	CIGNA TOTAL DPPO PLAN	FULL-TIME	HALF-TIME
DENTAL PLANS	Employee	$9.22	$11.02
	Employee + Child	$17.46	$20.83
	Employee + Spouse	$17.46	$20.83
	Employee + Children	$29.16	$35.45
	Family	$29.16	$35.45
	CIGNA DENTAL CARE DHMO	**FULL-TIME**	**HALF-TIME**
	Employee	$ 6.55	$ 7.68
	Employee + Child	$12.71	$14.89
	Employee + Spouse	$12.71	$14.89
	Employee + Children	$18.41	$22.01
	Family	$18.41	$22.01

	EYEMED INSIGHT VISION PLAN	FULL-TIME	HALF-TIME
VISION PLAN	Employee	$3.50	$3.50
	Employee + Child	$5.07	$5.07
	Employee + Spouse	$5.07	$5.07
	Employee + Children	$9.00	$9.00
	Family	$9.00	$9.00

*A $250 monthly spousal surcharge ($115.38 per pay) will be added to the medical benefit cost when a covered spouse has medical coverage available at his or her place of employment.

Wellness

Southwest General Wellness

You and your spouse want to live your healthiest lives now and in the future. Our voluntary wellness program, Southwest General Wellness, includes tools and resources to help you accomplish your goals.

By meeting the goals below, you and your spouse will earn points which can reduce your monthly medical premiums for the 2020 plan year. And, you'll have a baseline for taking the right steps to improve or maintain your health.

In the 2019 wellness program, employees and covered spouses can earn a total of 22 points. Employee, Employee + Child, and Employee + Children coverage levels will receive an additional 11 points when the employee completes the wellness screening. The additional points will be added after open enrollment in 2019. If you enroll in 2020 benefits for the first time, you will be subject to the Southwest General Wellness Program. All employees are encouraged to participate in the event they happen to enroll in benefits in 2020.

Wellness Screening Tests	Goal	Points Value
Healthy Weight	BMI: ≤27.5 or Waist: Females- ≤ 33" Males- ≤ 35" or 10% Weight loss since 2018 screening	1
Blood Pressure (mm Hg)	<140/85	1
LDL Cholesterol (mg/dL)	<130	1
Hemoglobin A1c (percent)	≤5.8	1
Tobacco/Nicotine	Negative	1
Healthy Actions	Complete up to 6 Health Actions for 1 point each. See program guide for details.	6

The goals above are for both employees and spouses for the 2019/2020 Southwest General Wellness program. Improvement goals and points will automatically be calculated and awarded based on your 2018/2019 wellness program results.

Bi-Weekly Wellness Discounts - 2020		0-3	4-6	7-10	11-14	15-18	19-21	22
CDHP PLAN	Employee	$23.64	$32.84	$42.03	$51.22	$60.42	$69.61	$78.80
	Employee + Child	$23.88	$33.16	$42.44	$51.72	$61.02	$70.30	$79.58
	Employee + Spouse	$47.75	$66.32	$84.88	$103.46	$122.02	$140.60	$159.17
	Employee + Children	$23.41	$32.51	$41.61	$50.71	$59.82	$68.92	$78.02
	Family	$47.75	$66.32	$84.88	$103.46	$122.02	$140.60	$159.17
BASIC PPO PLAN	Employee	$24.24	$33.65	$43.07	$52.50	$61.92	$71.35	$80.76
	Employee + Child	$24.47	$33.98	$43.50	$53.01	$62.53	$72.05	$81.56
	Employee + Spouse	$48.94	$67.97	$86.99	$106.03	$125.05	$144.09	$163.11
	Employee + Children	$23.76	$32.99	$42.23	$51.47	$60.71	$69.95	$79.18
	Family	$48.94	$67.97	$86.99	$106.03	$125.05	$144.09	$163.11
HIGH PPO PLAN	Employee	$25.56	$35.49	$45.42	$55.36	$65.30	$75.23	$85.17
	Employee + Child	$25.80	$35.83	$45.86	$55.88	$65.92	$75.95	$85.98
	Employee + Spouse	$51.59	$71.66	$91.71	$111.78	$131.83	$151.90	$171.96
	Employee + Children	$24.34	$33.80	$43.26	$52.72	$62.19	$71.65	$81.11
	Family	$51.59	$71.66	$91.71	$111.78	$131.83	$151.90	$171.96

If you are unable to meet the standard goal, but still make significant improvement in that area compared to your results from last year, you can still earn point(s) in that area. Go to **https://swgwellness.com** for more information and instructions on how to file an appeal.

Your Privacy is Part of Our Program

Southwest General Wellness is a separate provider committed to your privacy and confidentiality – your detailed health information is kept separate from your employment records. Southwest General Wellness fully complies with the Affordable Care Act and federal departmental regulations and policies.

Flexible Spending Accounts (FSA)

FSAs are a great way to save money for eligible medical, dental, vision and dependent care costs.

Two types of Healthcare FSAs – FSA and Limited FSA – are used for healthcare-related expenses. The account you can elect depends on the medical plan you choose.

The Dependent Care FSA is used for dependent care expenses.

ALL FSAS

- Are tax-advantaged. You do not pay federal taxes on your pre-tax contributions or on reimbursements made from the account.
- Allows you to make contributions with pre-tax dollars through payroll deduction.
- Can be accessed online, through mobile technology or by phone.
- Are regulated by the IRS and subject to yearly contribution limits.
- Election amounts amounts cannot be changed during the year unless you have a Qualified Life Event.
- Elections will be in effect from January 1 through December 31. Use it or lose it, any funds remaining in your account as of March 15 of the following year will be forfeited.
- Is administered by Administrative Services Corporation (TASC), an industry leader in reimbursement accounts.

Your FSA elections will be in effect from January 1 through December 31. Claims for reimbursement must be submitted by April 15 of the following year for expenses incurred through March 15. Please plan your contributions carefully. Any money remaining in your account as of March 15 will be forfeited. This is known as the "use it or lose it" rule and it is governed by Internal Revenue Service regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

Flexible Savings Accounts (FSA) Account Type	Who Can Have an FSA?	Eligible Expenses	Annual Contribution Limits
Healthcare Flexible Spending Account	Anyone covered by a non-high deducible health plan	Most medical, dental and vision care expenses that are not covered under your health plan (such as copayments, deductibles, eyeglasses and doctor prescribed over the counter medications).	$2,750 (Projected)
Limited-purpose Flexible Spending Account	Anyone covered by a high deductible health plan	Limited to qualifying dental and vision expenses (such as copayments, eyeglasses).	
Dependent Care Flexible Spending Account	Any benefit-eligible employee	Dependent care expenses (such as day care, after school programs or elder care programs) so you and your spouse may continue working, look for employment or attend school full-time.	$5,000 ($2,500 if married and filing separate tax returns)

Here is an example of how much you can save when you use the FSAs to pay for your predictable health care and dependent care expenses.

Account Type	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pre-tax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$11,701	$12,355
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses and taxes	$36,299	$35,645
Tax savings with the Health Care and Dependent Care FSA	$654	N/A

* This is an example only. It assumes a 25% federal income tax marginal rate and a 7.7% FICA marginal rate. You will save on state and local taxes which are not reflected in this example.

▶For More Benefits Information

For examples of eligible and ineligible expenses, go to the our website **at www.mysouthwestbenefits.com** or at **www.tasconline.com**. You can also reach TASC by phone at **800-422-4661.**

Life and Accidental Death & Dismemberment Insurance Coverage

If you die or suffer an accidental dismemberment, you want to make sure those that depend on you have some financial security. Life insurance and Accidental Death and Dismemberment benefits will award your beneficiaries payment if these instances occur.

BASIC LIFE AND AD&D INSURANCE

- Is provided to all full-time employees at no cost
- Pays one times annual base earnings, up to a maximum benefit of $25,000
- Can be converted/ported to an individual policy if within 31 days from the day your insurance is terminated. Contact Human Resources within 7 days of your loss of coverage if you wish to convert/port your coverage.

Refer to your Certificate of Coverage for additional information.

Disability Insurance Coverage

If you become disabled and unable to work because of a non-work related illness or injury, Disability Insurance replaces some of your lost income.

DISABILITY INSURANCE

- Is provided to all full-time employees at no cost
- Includes both short- and long-term coverage
- Covers 60% of your base annual earnings for the time you are disabled
- Includes a 30-day waiting period (optional 14 day Buy-Up coverage available)
- Buy-Up STD will require Evidence of Insurability (EOI) if electing outside of the new hire benefit enrollment period
- Follows Southwest's eligibility standards – first day of the month following your hire date or your status change to full-time employment.

Paid Absence Management (PAM)

We recognize the need for employees to take time off from work for varying needs. Southwest's holiday, vacation and paid sick days combine into Paid Absence Management (PAM).

PAM provides full-time and half-time employees with paid time off and the opportunity to manage their time off. Complete PAM details can be found in Policy #812.

If you need to take an FMLA leave, contact Lincoln at **800-210-0268**, or complete a leave request online at **www.mylincolnportal.com**

For a non-FMLA leave, see Policy #821 on Personal Leave of Absence.

Important Beneficiary Information

You must designate your beneficiaries for all applicable plans through Employee Self Service (Basic Life, AD&D, Voluntary Life and Voluntary AD&D). You are the beneficiary for all Dependent Life and AD&D Insurance policies.

Voluntary Benefits

If you want more protection and a greater sense of financial security, Southwest offers optional life and disability plans for you and your dependents.

Voluntary benefits

- Offer the convenience of payroll deduction for premium payments
- May require Evidence of Insurability at the time you enroll

VOLUNTARY EMPLOYEE TERM LIFE

This coverage

- Can be purchased in $10,000 increments to a maximum of $200,000
- May include Evidence of Insurability requirements. If you currently have Voluntary Life, you may increase your coverage in $10,000 increments up to $50,000 without Evidence of Insurability. Any additional election above $50,000 will require completion of a medical questionnaire and be subject to approval by the insurance company.
- Will require Evidence of Insurability at the time of enrollment if you previously declined this coverage

EMPLOYEE MONTHLY CONTRIBUTIONS PER $10,000 OF COVERAGE

Voluntary Employee Term Life Insurance	
AGE	**COST**
0 to 24	$0.50
25 to 29	$0.60
30 to 34	$0.80
35 to 39	$0.90
40 to 44	$1.10
45 to 49	$1.70
50 to 54	$2.90
55 to 59	$5.10
60 to 64	$6.60
65 to 69	$12.70
70 to 74	$20.60
75 to 79	$33.40

VOLUNTARY DEPENDENT TERM LIFE

This coverage is available to those enrolled in Voluntary Employee Term Life.

- Provides $20,000 of coverage for your spouse, up to age 70
- Provides $2,000 of coverage for your children under 6 months
- Provides $10,000 of coverage for your children age 6 months to age 26
- The cost is $4.70 per month regardless of number of dependents covered

Can be converted/ported to an individual policy if your group policy is terminated. Contact Human Resources within 7 days of your loss of coverage.

Voluntary Benefits

VOLUNTARY EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

This coverage

- Costs $0.02 per month per $1,000 of coverage
- Is available in $10,000 increments to a maximum of $300,000

DEPENDENT VOLUNTARY AD&D COVERAGE

This coverage is available to those enrolled in Voluntary Employee AD&D

- Provides $50,000 of coverage for your spouse up to age 70
- Provides $2,000 of coverage for your children under 6 months
- Provides $10,000 of coverage for your children under the age of 26
- The cost is $1.56 per month regardless of number of dependents if enrolled in Voluntary AD&D

ADDITIONAL VOLUNTARY BENEFITS

Your needs may change with time and we are pleased to offer additional benefits to help you meet different situations.

Aflac - *NEW BENEFIT!*

- Voluntary Cancer Care plan

MetLife Voluntary Benefits
(only available during annual enrollment)

- Comprehensive Auto and Home Insurance
- Veterinary Pet Insurance

Unum Voluntary Benefits
(only available during annual enrollment)

- Accident Insurance
- Critical Health Insurance
- Half-time Disability Insurance

LifeWorks of Southwest

- Fitness Incentive Plan

When you enroll in voluntary life insurance, you will designate a beneficiary identifying the person or persons who will receive benefits under the plan in the event of your death.

This beneficiary may or may not be the same as your basic life insurance beneficiary provided by Southwest. The beneficiary on all dependent life insurance plans is the employee.

For More Benefits Information

Visit our website at **www.mysouthwestbenefits.com** for more information about your benefits and to designate your beneficiaries.

Your Wellbeing

EMPLOYEE ASSISTANCE PROGRAM: *HELP IS AVAILABLE 24/7/365*

Ease@Work

When you find yourself in need of some professional support to deal with personal, work, financial or family issues, EASE@ Work, your Employee Assistance Program, can assist.

You and your immediate family (spouse, dependent children, parents and parents-in-law) can use this program for a variety of issues, including:

- Marital matters
- Job related difficulties
- Stress, anxiety and depression
- Parent and child relationships
- Legal and financial counseling
- Substance abuse
- Financial planning
- Eldercare issues

SOUTHWEST MATCHING DEFINED CONTRIBUTION RETIREMENT PLAN [403(B)]

Saving for retirement is important, that is why Southwest offers the Southwest Matching Defined Contribution Retirement Plan [403(b)]. Eligible employees are able to participate in the 403(b) plan immediately upon hire. Because saving is so important, newly hired employees are automatically enrolled in the 403(b) Plan with a deferral rate of 3% after 30 days of employment. Southwest offers both traditional pre-tax and after-tax Roth contributions options. The Southwest 403(b) Plan offers many different investment options for you to choose from. If you do not make an investment election then your contributions will automatically be invested for you into a default investment fund which is based on your target retirement age. You may access your account at any time by going to www.principal.com or by calling 1-800-547-7754.

In addition to your deferrals, Southwest will make an employer matching contribution of 50% on the first 6% of your deferred earnings. An employee will become eligible to receive matching contributions on the date he or she completes one year of eligibility service. The matching contributions occur after the end of the plan year. An Employee must be employed by Southwest on December 31st of each year, unless your termination is due to death, disability or attainment of normal retirement age.

ESC Percentage Chart:	
POINTS (AGE + SERVICE)	**ANNUAL CONTRIBUTION (% OF PLAN PAY)**
Less than 40	1.50%
40-54	2.25%
55-69	3.00%
70 to 84	4.00%
At least 85	5.00%

Southwest will also make an additional contribution to your 403(b) in the form of our Employer Savings Contribution (ESC). Southwest contributes the ESC to your 403(b) plan regardless of whether you contribute to the plan. Employees become eligible for the Employer Savings Contributions (ESC) on the date he or she completes one year of eligibility service. The ESC you receive will be equal to a percentage of your annual compensation. The percentage is determined by a "points" formula, with your points being the total of your age and years of service at the end of the Plan year, per the ESC percentage chart. A year of service for this purpose is a plan year in which you complete 1,000 hours of service.

All money you contribute to the 403(b) plan is yours. To withdraw the company match or ESC, employees need to complete three (3) years of service to be fully vested in those portions of their 403(b) plan. A year of service for this purpose is a plan year in which you complete 1,000 hours of service. Employees will receive 1 year of service for every calendar year in which you work a minimum of 1,000 hours.

Boost your retirement savings by participating in the Southwest 403(b) plan:

- 50% matching contribution up to 6% of your pay
- Pre-tax or Roth or both are available
- Saving is easy through payroll deductions
- Individual Financial Wellness one on one meetings offered at Southwest

To access your retirement account, make changes to your deferrals, or for assistance with roll overs please go to:
www.Principal.com;
or call 1-800-547-7754.
(Southwest 403(b)
Plan Number: 708952)

Health Insurance Marketplace Coverage Options And Your Health Coverage

PART A

General information

When key parts of the health care reform law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November each year for coverage starting as early as the following January 1.

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5%[1] of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

How can I get more information?

For more information about your coverage offered by your employer, please check your Summary Plan Description or contact Southwest General Health Center's intranet site and select the Employee tab, then the Benefits Information tab.

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.

PART B

Information about health coverage offered by your employer

This section contains information about health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums

3. Employer name Southwest General Health System		4. Employer identification Number (EIN)e 34-1455141
5. Employer address 18697 Bagley Road		6. Employer phone number Southwest General Health System
7. City Middleburg Heights	8. State Ohio	9. ZIP Code 44130
10. Who can we contact about employee health coverage at this job? Southwest's intranet or Human Resources		
11. Phone number (if different from above)	12. Email address www.swgeneral.com	

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

[1] This percentage is adjusted by inflation from time-to-time.

[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Important Health Plan Notices

MEDICARE PART D CREDITABLE COVERAGE

Important notice from Southwest General Health System 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 Southwest General Health System 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. Southwest General Health System has determined that the prescription drug coverage offered by the Southwest Employee Benefit 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 15th to December 7th.

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 Southwest coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Southwest coverage, be aware that you and your dependents will 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 Southwest 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**.**

▶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).

Important Health Plan Notices

For more information about this notice or your Current Prescription Drug Coverage

Contact Human Resources for further information at 440-816-8025.

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 Southwest 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 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).**

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment 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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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).

In addition, if you have a new dependent as result of 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, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

Federal law requires that all plan participants be notified at enrollment and annually of their rights under the "Women's Health and Cancer Rights Act." This notice is being furnished to you incompliance with the requirements of the law.

The law requires that all group health plans that provide coverage for a surgically removed breast must also:

- Provide coverage for reconstruction of the surgically removed breast;
- Provide coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Provide coverage for prostheses and any physical complications that may occur in any stage of a mastectomy, including lymphedemas (swelling associated with the removal of the lymph nodes).

Coverage for breast reconstruction and any related services will be subject to any Plan deductibles and covered percentage amounts that apply to other covered medical benefits of the Plan.

The provisions of this law are also detailed in your Summary Plan Description.

Important Health Plan Notices

PATIENT PROTECTION DISCLOSURE

Southwest General Health System Employee Benefit Plan 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 children, you may designate a pediatrician as the primary care provider. You do not need prior authorization 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 information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Mutual Health Services at www.mutualhealthservices.com or 800-367-3762.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, 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 section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996)

Notification of Privacy Practices HIPAA includes provisions that protect privacy of health plan participants. These provisions, which went into effect in April of 2003, govern how covered entities such as health insurance companies and the plan sponsor must handle protected health information. Southwest distributes HIPAA Privacy Notices, in accordance with Federal Regulations. You can obtain a copy of the HIPAA Privacy Notice from Human Resources

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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)**.

To find out if your state participates in a premium assistance program or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration C
www.dol.gov/ebsav
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Health Plan Notices

GINA WARNING FOR WELLNESS PROGRAM MATERIALS REQUESTING MEDICAL INFORMATION

When completing the Health Risk Assessment, do not include any genetic information. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which an individual may be at risk.

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 [choose and enter appropriate information: must pay or aren't required to 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.

Important Health Plan Notices

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Southwest General Health Center, 18697 Bagley Road, Middleburg Hts., Ohio 44130, 440-816-8000.

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. This notice should be sent to: Southwest General Health Center, 18697 Bagley Road, Middleburg Hts., OH 44130, **440-816-8000.**

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.

Important Health Plan Notices

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, Medicaid, 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.

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

Southwest General Health Center
18697 Bagley Road
Middleburg Hts., OH 44130
440-816-8000

NOTICE REGARDING WELLNESS PROGRAMS

Southwest General Wellness is a voluntary wellness program available to all benefit-eligible employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that see to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act (HIPAA), as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for LDL Cholesterol and Hemoglobin A1C. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive incentives.* Although you are not required to complete the HRA or participate in the biometric screening, only employees and spouses who do so will receive incentives.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes.* If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard by calling **888-672-3272** to learn more.

The information from your HRA, and the results from your biometric screening, will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as Southwest's Smoking Cessation Program. You also are encouraged to share your results or concerns with your own doctor.

*Refer to the **Southwest General Wellness** section of this guide for details.

Important Health Plan Notices

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at **440-816-8025.**

Southwest General Health System Benefit Contact Information

Plan	Whom To Call	Plan ID	Phone Number	Website
Medical	Mutual Health Services (Basic PPO Plan, High PPO Plan or Consumer-Driven Health Plan (CDHP))	SWGH001	800-367-3762	www.mutualhealthservices.com
Health Savings (HSA)	Fifth Third Bank	FTP-149563	888-350-5353	www.53hsa.com
Prescription Drugs	MedImpact	RxBin: 003585 RxPCN: ASPROD1 RxGroup: PHI10	844-513-6007	http://mp.medimpact.com/PHI
Vision	EyeMed Insight Network	9859513	866-804-0982	www.eyemedvisioncare.com
Dental	Cigna Dental PPO Cigna Dental DHMO	Group # 3217012 Group # 3217012	800-244-6224	www.cigna.com www.mycigna.com
Disability Insurance	Lincoln	90-LF0006	800-290-0395	www.mylincolnportal.com Company Code: SWGENERAL
Leave of Absence	Lincoln	90-LF0006	800-290-0395	www.mylincolnportal.com Company Code: SWGENERAL
Life Insurance (Basic, Voluntary Employee & Dependent, Will Preparation)	Lincoln	90-LF0006	888-287-8494	www.mylincolnportal.com Company Code: SWGENERAL
AD&D (Basic, Voluntary Employee and Dependent)	Lincoln	90-LF0006	888-287-8494	www.mylincolnportal.com Company Code: SWGENERAL
Employee Assistance Program	EASE@Work	Company Access Code: southwest	800-521-3273	www.easeatwork.com
Flexible Spending Accounts	TASC		800-422-4661	www.tasconline.com
Accident and Critical Illness Insurance	Unum		800-635-5597	www.unum.com
Cancer Care Insurance	Aflac - Erik Geiger	MRW17	440-933-5245	www.aflac.com
College Advantage 529 Plan	Black Rock	23755	866-529-8582	
MetLife Home, Auto & Pet Insurance	MetLife		800-438-6388	www.mybenefits.metlife.com
Long Term Care Insurance	Transamerica (prior to 2001) Monumental Life		800-227-3740 800-338-0257	www.transamerica.com www.monlife.com
Southwest Matching Defined Contribution Retirement Plan (403b)	Principal		800-547-7754	www.principal.com

For More Benefits Information

Visit our website at www.mysouthwestbenefits.com