SUMMARY PLAN DESCRIPTION

HEALTH CARE AND INSURANCE BENEFIT PLANS
FOR EMPLOYEES AND COBRA PARTICIPANTS

PLAN YEAR 2025

Employee Benefits Office | benefits@swri.org | 210.522.2227

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Effective as of 1-1-2025

I INTRODUCTION

This document serves as the Summary Plan Description (SPD) for benefit programs offered by Southwest Research Institute ("SwRI" or "the Institute"). Together with the insurance certificates and other official benefit descriptions for the benefit programs (available through the Employee Benefits website), this SPD contains important information regarding the benefit programs offered by the Institute to eligible employees and COBRA participants.

The information included in the SPD is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan, the Southwest Research Institute Employees' Health Care Expense Benefits Plan, the Southwest Research Institute Long-Term Disability Income Benefits Plan, the Southwest Research Institute Section 125 Plan, the Southwest Research Institute Health Care Reimbursement Plan, or the Southwest Research Institute Employee Assistance Program Plan (collectively, the "Plans").

Please Note: Neither this SPD, nor any of the benefit programs described herein, is to be considered an employment contract or a limit on the Institute's right to terminate the employment of any employee. The Institute intends to continue the Plans and the employee benefit programs included in the Plans but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plans or any individual employee benefit program at any time, for any reason, and without prior notice. If the Plans or any individual employee benefit program are terminated, covered persons will not have the right to any other benefits from the Plans or individual employee benefit program, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plans. In addition, if the Plans or any individual employee benefit program is amended, covered persons may be subject to altered coverage and benefits as of the effective date for which the Plans or individual employee benefit program is amended.

This SPD describes the health and welfare benefit plans provided by the Institute to eligible employees and serves as the SPD required for benefits covered by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Every effort has been made to report correct information. To the extent there are any differences between this SPD and the plan booklets or insurance contracts, certificates, and policies that govern the benefit programs, the terms of those plan booklets or insurance contracts, certificates, and policies will prevail.

It is the intention of the Institute that certain benefits provided be excludable from taxable income of participating covered employees under the applicable sections of the Internal Revenue Code of 1986, as amended (the "Code"), including but not limited to sections 79, 105, 106 and 125. Moreover, the applicable benefit programs are intended to qualify as a cafeteria plan under section 125 of the Code and this SPD is intended to satisfy the Department of Treasury Regulation section 1.125-1(c).

Benefits subject to ERISA that are not Code section 125 benefits are described in this SPD for the purpose of satisfying the written instrument requirements of ERISA section 402 and shall not be considered part of the Code section 125 arrangement. Similarly, benefits that are Code section 125 benefits and are not subject to ERISA are described in this SPD solely for the purpose of satisfying the written instrument requirements of Code section 125 and shall not be considered subject to ERISA. Any benefits described in this SPD that are not subject to either Code section 125 or ERISA are included in this SPD solely as an administrative convenience to the Institute and shall not be considered as part of the Code section 125 cafeteria arrangement, or subject to ERISA, as the case may be.

The Institute has the right to amend, modify or terminate any and all benefits described herein at any time. No consent of any participant or beneficiary is required for the Institute to exercise its right to do so.

This SPD and the accompanying insurance certificates and other official benefit descriptions are provided electronically to employees through the Institute's Employee Benefits website. You may request a paper copy of the SPD, insurance certificates, other official benefit descriptions, or any part thereof free of charge by calling the Employee Benefits Office at (210) 522-2227.

The Plan Administrator is the Institute's CFO and Vice President – Finance. The Plan Administrator has full authority to interpret all (including ambiguous) terms of the Plans with respect to eligibility and to conduct all other business regarding the Plans. The plan year extends from January 1 through December 31.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for each of the applicable employee benefit programs. For purposes of ERISA, this SPD serves as a Summary of Material Modification to the previous SPD for each of the applicable employee benefit programs.

This SPD is revised with an effective date of January 1, 2025, and has been published in May 2025. Revisions included in this SPD from the 2024 Summary Plan Description include but are not limited to the following:

- XIII – Life Insurance: Group Life
    - C. Summary of Benefits, Limitations and Exclusions
        - 12. What is taxable imputed income and how is it computed?

            This section has been updated to provide a clearer explanation of imputed income. The new explanation includes how this will appear on an employee's pay advice.

There are no further material changes to the document.

II CONTACT INFORMATION

If you have questions about benefits or coverage under any of the programs described in this SPD, please utilize the following contact information. You can also find additional information by contacting the Employee Benefits Office.

EMPLOYEE BENEFITS OFFICE

210 522 2227 *(Benefits main number)*

benefits@swri.org *(Benefits email address)*

https://benefits.swri.org *(Benefits website)*

Building 64 at 240 Harold Vagtborg Ave, 1st Floor (*Benefits Office Bldg.)*

Southwest Research Institute
Employee Benefits Office – B64
6220 Culebra Road
San Antonio, Texas 78238

BENEFIT PLAN	PHONE NUMBER	WEBSITE
Alliance Work Partners – EAP	800-343-3822	www.awpnow.com
CIGNA	800-754-3207	www.mycigna.com
Delta Dental	800-521-2651	www.deltadentalins.com
MetLife Cancer Plan	800-845-7519	www.bbadmin.com
MetLife Legal Plan	800-821-6400	www.members.legalplans.com
New York Life	888-842-4462	www.mynylgbs.com
TRICARE/ASI Supplemental Program	800-638-2610	www.selmanco.com
UnitedHealthcare Choice EPO	877-370-0859	www.myuhc.com
UnitedHealthcare Texas Premier Choice	866-633-2446	www.myuhc.com
Vision Service Plan (VSP)	800-877-7195	www.vsp.com

III SECTION 125

A Introduction

The Section 125 Plan is a benefit plan that offers two unique tax savings programs. The first program requires employees to use pre-tax dollars using salary reduction to pay their cost of certain eligible benefits. Your enrollment in the benefit program(s) that are part of the Section 125 Plan authorizes the Institute to reduce your current salary by an amount sufficient to cover your portion of required participant contributions. This reduction results in your share of the cost of eligible benefits being paid with tax-free dollars.

Salary reduction reduces your taxable income and federal income taxes. It may also reduce your social security taxes if your taxable income for the calendar year is less than the social security wage base. As a result, any Social Security benefits you receive at retirement or during a disability may be reduced slightly since you participated in the Section 125 Plan. It may also reduce state and local taxes where applicable. Using salary reduction to pay the cost of eligible benefits does not affect your Southwest Research Institute benefits. Salary reductions under the Section 125 Plan will not reduce your maximum contribution limit to the Institute's retirement program. Your Section 125 Plan elections are not taken into account when computing your maximum allowable retirement contribution limit.

The second program of the Section 125 Plan allows employees to deposit pre-tax dollars into a Health Care Reimbursement Account and/or Dependent Care Reimbursement Account. Employee contributions to the Health Care Reimbursement Account are reimbursed to the employee for health care expenses not covered by the medical, dental, and vision care plans, including deductibles, co-insurance, co-payments, and other non-reimbursable health care expenses. Employee contributions to the Dependent Care Reimbursement Account are reimbursed to the employee for eligible dependent care expenses. Further information on the Dependent Care Reimbursement Account and Health Care Reimbursement Account are discussed in Sections XXII and XXIII.

The Dependent Care Reimbursement Account program is included in the Southwest Research Institute Section 125 Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Section 125 Plan in any way. The actual Southwest Research Institute Section 125 Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Section 125 Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Section 125 Plan documents, the Southwest Research Institute Section 125 Plan documents are controlling.

1 When does my participation in the Section 125 Plan end?

Your participation in the Section 125 Plan will terminate on the earliest of the following events:

- You cease to be in a class of employees eligible to participate in a benefit program which can be purchased via salary reduction or cease to qualify as an employee.
- You fail to make the required premium payments when due.
- You die.
- The Section 125 Plan is discontinued.

2 Can the Section 125 Plan be changed or terminated?

Yes. The Institute reserves the right to amend the Section 125 Plan at any time for any purpose including but not limited to any amendment that reduces, eliminates, or modifies any benefit plan offered under the Section 125 Plan. Such amendment may be made with respect to benefits provided for any active, terminated, or retired employee, his/her beneficiaries, and dependents who may be entitled to benefits under the Section 125 Plan.

The Institute further reserves the right to terminate the Section 125 Plan in whole or in part with respect to any or all benefits provided for any active, terminated, or retired employee including his/her beneficiaries and dependents.

B Eligibility and Participation

1 Who is eligible to participate in the Section 125 Plan?

You are eligible to participate in the Section 125 Plan if you are a full-time regular employee or a part-time regular employee regularly assigned to work at least twenty (20) hours per week. New full-time regular employees or part-time regular employees who are regularly assigned to work at least twenty (20) hours per week are required to participate as of their employment date and will automatically be covered by certain benefits under the Section 125 Plan.

2 What is the enrollment procedure to pay eligible premiums with before-tax dollars?

Eligible new employees will automatically be covered for employee dental, basic life insurance, and basic accidental death & dismemberment insurance immediately upon employment. Other voluntary benefit programs available to and selected by employees are effective at your hire date and after submission to the Employee Benefits Office of an enrollment form that must be completed during the first week of employment. If you have satisfied the Section 125 Plan requirements for eligibility, you will automatically be a participant in the Section 125 Plan.

3 How do I make a change in benefit election?

You may change the benefits you select under the Section 125 Plan for the next calendar year by making the appropriate change on your Open Enrollment Form before the end of the Open Enrollment period.

You cannot change your benefits during the year unless you have a change in family status or other qualifying event. You may change your benefits, including elections for contributions to the reimbursement accounts, due to family status changes or other qualifying events.

Events that qualify as family status changes or other qualifying events include the following:

Those related to the employee:

- Marriage or divorce of employee
- Submission of a Declaration of Domestic Partnership
- Employee being called to active military service, or vice versa, for a period in excess of 30 days
- Moving out of the service area of a health care plan in connection with a change in the employee's worksite

- Switching from regular status to leave of absence status, or vice versa
- Switching from regular status to temporary status or vice versa by the employee
- Qualification for or loss of Medicare or Medicaid coverage by the employee
- Termination of an employee's domestic partnership

Those related to the employee's dependents:

- Birth or adoption of a dependent child under age 26
- Death of employee's spouse, domestic partner, or dependent child under age 26
- The ineligibility of a dependent child due to attainment of age 26
- The ineligibility of a dependent child under age 26 due to enlistment in active military service
- Commencement or termination of employment of employee's spouse, domestic partner, or dependent child under age 26
- Addition or termination of health care benefits by employee's spouse or dependent child under age 26 through an Open Enrollment or due to a change in employment status of the employee's spouse, domestic partner, or dependent child
- Addition or termination of health care benefits by the employer of the employee's spouse, domestic partner, or dependent child under age 26
- A significant change in health care cost or coverage of the health care plan through the employer of the employee's spouse, domestic partner, or dependent child under age 26
- Qualification for or loss of Medicare or Medicaid coverage by the employee's spouse, domestic partner, or dependent child under age 26
- Marriage or divorce of a dependent child under the age of 26
- Addition or termination of enrollment of health care benefits offered by the educational institution of the employee's spouse, domestic partner, or dependent child under the age of 26

If one of these events occurs, and you desire to change an election, you must initiate an electronic Benefit Change Form. This change must be initiated within 31 days from the change in family status or qualifying event (or within 60 days in the event of qualification for or loss of Medicaid coverage). The Benefit Change Form can be obtained by accessing Employee Self Service through the ITC Portal on the i2net. You must submit documentation to the Employee Benefits Office to evidence the qualifying event.

You can increase or decrease your election to the Health Care Reimbursement Account, however, only if the change is consistent with the family status change or qualifying event.

4 What is the annual Open Enrollment period?

The Open Enrollment period allows you to review your benefits and make changes that are appropriate to your needs. Benefit changes are effective January 1 of the next calendar year.

In the case of your contribution elections to the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account, you must make a new election on an electronic benefit change form for each

calendar year. When no election is made for the following calendar year, your election is deemed to be zero for that calendar year.

5 What happens to my elections if I resign from the Institute and am re-employed in the same plan year?

If you resign from the Institute and are re-employed within a 30-day period, none of your previously elected benefits will change, and no new elections can be made. If you resign and rejoin the Institute after a 30-day period in the same plan year, you must make new elections for medical, dental, and other voluntary benefit programs. You must also make new elections to both the Health Care and Dependent Care Reimbursement Accounts for the remainder of the calendar year.

C Summary of Benefits, Limitations and Exclusions

1 What benefit programs are included in the Section 125 Plan for pre-tax payment of employee contributions?

Participation contributions required for the following programs are paid on a pre-tax basis using salary reduction:

- Medical Care plans
- Long-Term Disability program
- Dental Care for Dependents
- Voluntary Accidental Death & Dismemberment program
- Vision Care plans
- Cancer/Specified Disease programs

Pre-tax benefits are not available for domestic partners and if applicable, a domestic partner's child(ren). Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.

2 What benefit plans/programs are not included in the Section 125 Plan for pre-tax payment of employee contributions?

The following benefit plans/programs are not eligible for pre-tax premium payments and employee contributions are paid on an after-tax basis using payroll deduction:

- Group Life program
- Dependent Life program
- Voluntary Life program
- Legal Plan
- Critical Illness program
- Accidental Injury program

Premiums for the following programs are fully paid by the Institute and no employee contributions are required:

- Group Accidental Death & Dismemberment program
- Business Travel Accident program
- Dental Care for Employees
- Employee Assistance program

IV Accidental Death & Dismemberment (AD&D): GROUP AD&D

A Introduction

The Group Accidental Death and Dismemberment (AD&D) program is a fully-insured insurance program which provides an additional death benefit that is in addition to life insurance benefits if the death is a covered accident. The Group AD&D program also provides a schedule of benefit payments when a body part(s) is dismembered due to a covered accident. The Group AD&D program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the Group AD&D program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible injuries, their respective payments and policy exclusions and limitations are contained in the Group Accident Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the Group AD&D program?

You are eligible and required to participate in the Group AD&D program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

Dependents are not eligible to participate in the Group AD&D program.

2 How do I enroll in the Group AD&D program?

To participate in the Group AD&D program, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date.

3 How is the Group AD&D program funded?

The Group AD&D program is fully funded by Institute contributions. Participants in long-term disability, family and medical leave, or leave without pay status will remain enrolled for the period of time described in the Group Policy.

4 Can I cancel my enrollment in the Group AD&D program at any time after electing coverage?

No. Because coverage in the Group AD&D program is required for all regular Institute employees, you may not cancel your coverage.

5 Am I enrolled in the Group AD&D program when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Group AD&D program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain other benefits with pre-tax dollars through salary reduction.

6 Can I continue my enrollment in the Group AD&D program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation in the Group AD&D program for 24 months by paying requirement premiums through after-tax payment.

7 What happens to my coverage in the Group AD&D program when my employment at the Institute ends?

Coverage in the Group AD&D program ends on the last day of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. Participation in the Group AD&D program cannot be continued under the COBRA program. Participation may continue if continuation coverage is elected by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date their coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the Group AD&D program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible injuries, their respective payments and policy exclusions and limitations are contained in the Group Accident Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What benefits are provided under the Group AD&D program?

You will receive the same coverage amount for Group AD&D insurance as your Group Life insurance on a death claim due to a covered accident. This coverage is based on two times your annual base salary rounded to the next highest $1,000. The maximum coverage amount is $1,000,000. Scheduled coverages as described in the insurance certificate apply for a loss of limbs (including paralysis), eyesight, hearing, speech, and other body parts or functions due to a covered.

Regular staff age 60 or above who elect an irrevocable one-time charge in their Group Life Insurance to one times their salary will have Group AD&D coverage of one times their annual base salary.

2 What additional benefits are provided under the Group AD&D program?

In addition to benefits for the loss of life and loss of limbs or body parts due to a covered accident, certain additional benefits as defined in the Group Policy may be available. These additional benefits are available when circumstances defined in the Group Policy occur. These benefits include:

- Bereavement and Trauma Counseling
- Child Day Care
- Home Alteration & Vehicle Modification
- Rehabilitation
- Seatbelt and Airbag Benefit
- Special Education Benefit (Child)
- Spouse Training

3 Who is my beneficiary for the Group AD&D program?

As required by law, payments for death benefits under the Group AD&D program must be made to the last-named beneficiary(ies). It is imperative that regular employees check their beneficiary designations. It is a good idea to review spousal or minor children beneficiary designations with a legal advisor. If you want to revise any beneficiary designations, go to the Update Employee Benefit Elections link accessible at Employee Self-Service through the ITC Portal on the i2net. If you have any questions about how to change your beneficiary(ies), contact the Employee Benefits Office at (210) 522-2227.

Payments for other benefits, such as scheduled amounts to the loss of a limb or other body part, are made to the employee.

4 How are benefits claimed and disbursed in the Group AD&D program?

For benefits relating to your death which results from a covered accident, your beneficiary or the administrator of your estate will need to file a claim with the insurer for the Group AD&D program through the Employee Benefits Office and provide evidence of your death and accident. The Employee Benefits Office is available to provide the necessary forms, to assist with the completion of these forms, and to answer questions.

Benefits greater than $5,000 will be deposited into a free, interest-bearing account, called the NYL GBS Survivor Assurance account, in the name of the beneficiary. If your benefit is less than $5,000, New York Life will send you a check for the total benefit amount.

5 Are there any exclusions under the Group AD&D program?

Yes. Benefits will not be paid for any covered death or covered loss which, directly or indirectly, in whole or in part, is caused by or results from any of the circumstances described in the Group Policy.

6 Can I purchase additional AD&D coverage for myself or my dependents under this program?

No. Coverage under this program is limited to the basic employee benefit. However, additional coverage for the employee and dependents is available under a separate voluntary AD&D program. This program is described in Section VI.

V Accidental Death & Dismemberment (AD&D): BUSINESS TRAVEL ACCIDENT

A Introduction

The Business Travel Accident (BTA) program is an insurance program which provides an additional death benefit that is in addition to life insurance benefits if the death is a covered accident incurred while on business travel. The BTA program also provides a schedule of benefit payments when a body part(s) is dismembered in a covered accident while on business travel. The BTA program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the BTA program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible injuries, their respective payments and policy exclusions and limitations are contained in the Business Travel Accident Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the BTA program?

You are eligible and required to participate in the BTA program if you are employed by the Institute as a regular full-time employee, a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week, or a temporary employee. Temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

Dependents are not eligible to participate in the BTA program.

2 How do I enroll in the BTA program?

No enrollment is required to participate in the BTA program. Coverage will be effective as of your hire date.

3 How is the BTA program funded?

The BTA program is fully funded by Institute contributions.

4 Can I cancel my enrollment in the BTA program at any time after electing coverage?

No. Because coverage in the BTA program is required for all regular and temporary Institute employees, you may not cancel your coverage.

5 Am I enrolled in the BTA program when I enroll in the Section 125 Plan?

No enrollment is required to participate in the BTA program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain other benefits with pre-tax dollars through salary reduction.

6 What happens to my coverage in the BTA program when I terminate my employment at the Institute?

Coverage in the BTA program ends on the last day an individual is classified as a regular or temporary employee. Coverage cannot be continued under the COBRA program.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the BTA program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible injuries, their respective payments and policy exclusions and limitations are contained in the Business Travel Accident Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What benefits are provided under the BTA program?

The BTA program includes $300,000 of additional accidental death and dismemberment insurance protection for all active employees for a covered accident while traveling on Institute business. This additional benefit applies for the duration of a business-related trip whether locally or out of town. Coverage also applies for losses due to a covered accident that occurs while an employee is commuting directly between the Institute grounds and home. Coverage for an accidental death is $300,000 and scheduled coverages as described in the Group Policy also apply for loss of limbs (including paralysis), eyesight, hearing, speech, or other body parts and functions due to a covered accident.

2 What additional benefits are provided under the BTA program?

In addition to benefits for the loss of life and loss of limbs or body parts due to a covered accident, certain additional benefits as defined in the Group Policy may be available. These additional benefits are available when circumstances defined in the Group Policy occur. These benefits include:

- Carjacking Benefit
- Felonious Assault and Violent Crime Benefit
- Seatbelt Benefit

3 Who is my beneficiary in the BTA program?

As required by law, payments for death benefits under the BTA program must be made to the last-named beneficiary(ies). It is imperative that regular employees check their beneficiary designations. It is a good idea to review spousal or minor children beneficiary designations with a legal advisor. If you want to revise any beneficiary designations, go to the Update Employee Benefit Elections accessible at Employee Self-Service through the ITC Portal on the i2net. If you have any questions about how to change your designations, contact the Employee Benefits Office at (210) 522-2227.

Payments for other benefits, such as scheduled amounts due to the loss of a limb or other body part, are made to the employee.

4 How are benefits claimed and disbursed in the BTA program?

For benefits relating to your death, your beneficiary or the administrator of your estate will need to file a claim with the insurer for BTA program benefits through the Employee Benefits Office and provide evidence of your death and accident. The Employee Benefits Office is available to provide the necessary forms, to assist with the completion of these forms, and to answer questions.

Benefits greater than $5,000 will be deposited into a free, interest-bearing account, called the NYL GBS Survivor Assurance account, in the name of the beneficiary. If your benefit is less than $5,000, New York Life will send the beneficiary a check for the total benefit amount.

5 Are there any exclusions under the BTA program?

Yes. Benefits will not be paid for any covered death or covered loss which, directly or indirectly, in whole or in part, is caused by or results from any of the circumstances described in the Group Policy.

6 Is coverage in the BTA program in effect for business travel anywhere in the world?

No. Coverage is in effect in all countries, except for Afghanistan, Egypt, Iraq, Pakistan, Somalia, Sudan, and Syria. Coverage for business travel to these countries is subject to review by the insurer and if provided, a policy amendment may be enacted. You should contact the Employee Benefits Office as soon as it is likely that you will be travelling for business to one of these countries.

7 Does the BTA program include coverage for dependents traveling with me?

Yes. The insured's spouse and unmarried children are covered for loss of life ($25,000 for a spouse and $10,000 for each dependent child) while traveling with an employee during business travel.

VI Accidental Death & Dismemberment (AD&D): VOLUNTARY AD&D

A Introduction

The Voluntary Accidental Death & Dismemberment (VAD&D) program is a fully-insured benefit program that provides an additional benefit when you and your covered dependents die or are dismembered as a result of an accident as defined by the insurance carrier. The VAD&D program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the VADD program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible injuries, their respective payments and policy exclusions and limitations are contained in the Group Accident Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the VAD&D program?

You and your eligible dependents (see question 4) are eligible to participate in the VAD&D Program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary and leased employees are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the VAD&D program?

To participate in the VAD&D program, you must complete, sign, and submit an electronic Benefit Enrollment Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premium is required until the following payroll period.

If you have declined coverage and now wish to elect it, or you need to change your current enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

The qualifying events for which enrollment changes can be submitted are included in Section III, *Section 125 Plan*.

3 How is the VAD&D program funded?

The VAD&D program is fully funded by participant contributions. On a periodic basis, the insurer may increase the required premium from participants for each of the coverage levels. Participant contributions are provided by salary reduction on a pre-tax basis.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid following the termination effective date will be reversed.

As long as premiums are paid, participation may continue for the period of time described in the Group Policy. After that period ends, employees may elect to continue coverage by contacting the Employee Benefits Office for an application to continue coverage and the participant's submission of the continuation of coverage application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

Coverage for a participant whose employment classification changes to temporary or who is out on a leave of absence will end and employees may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and submitting the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

4 Who are my eligible dependents in the VAD&D program?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse, whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26 or other children as defined in the Group Policy.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he

or she attains age 26. Coverage for an employee's lawful spouse terminates on the divorce date. The divorce date is the date the divorce decree is signed by the judge or court.

An eligible employee whose spouse or domestic partner is also an Institute employee may enroll one spouse or domestic partner as a dependent of the other, or each spouse or domestic partner may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as dependents of both employees.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the VAD&D program?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the VAD&D program at any time after electing coverage?

Unless you have a qualifying event, coverage in the VAD&D program may only be cancelled during the annual Open Enrollment period, and coverage will terminate as of the end of the current calendar year.

7 Am I enrolled in the VAD&D program when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the VAD&D Program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain benefit programs, including the VAD&D Program, with pre-tax dollars through salary reduction.

8 Can I continue my enrollment in the VAD&D program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in the VAD&D program for 24 months by paying required premiums through after-tax premium payments.

9 What happens to my coverage in the VAD&D program when my employment at the Institute ends?

Coverage in the VAD&D program ends at the end of the pay period during which an employee's employment as a regular full-time or part-time employee ceases. Coverage cannot be continued under COBRA. Coverage may continue by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the VAD&D program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible injuries, their respective payments and policy exclusions and limitations are contained in the Group Accident Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What benefits are provided under the VAD&D program?

The VAD&D program provides protection for injuries caused by accident that occur anywhere on or off the job, on vacation, or at home resulting in an accidental death, dismemberment or paralysis. Eligible active employees may enroll for coverage in $25,000 increments up to $500,000. Employees can select spouse coverage in $25,000 increments up to maximum amount of $500,000; spouse coverage amount may not exceed the employee coverage amount. Employees can also select child coverage in $5,000 increments up to $75,000; child coverage amount may not exceed the employee coverage amount.

Scheduled coverage for loss of limbs (including paralysis), eyesight, hearing, speech, or other body parts or functions is described in the Group Policy.

2 What additional benefits are provided under the VAD&D program?

In addition to benefits for the loss of life and loss of limbs or body parts due to a covered accident, certain additional benefits as defined in the Group Policy may be available. These additional benefits are available when circumstances defined in the Group Policy occur. These benefits include:

- Bereavement and Trauma Counseling Benefit
- Childcare Center Benefit
- Home Alteration and Vehicle Modification Benefit
- Increased Dependent Child Dismemberment Benefit
- Rehabilitation Benefit
- Seatbelt and Airbag Benefit

- Special Education Benefit
- Spouse Retraining Benefit

3 Who is the employee's beneficiary in the VAD&D program?

As required by law, payments for death benefits under the VAD&D program must be made to the last-named beneficiary(ies). Payments for other benefits in the VAD&D program, such as scheduled amounts due to the loss of a limb or other body parts of functions, are made to the employee. It is imperative that regular employees check their beneficiary designations. It is a good idea to review spousal or domestic partner or minor children beneficiary designations with a legal advisor. VAD&D and other beneficiary designations can be reviewed by going to Employee Self-Service through the ITC Portal on the i2net and checking on View Your Benefit Elections Report. If you want to revise any plan designations, go to the Update Employee Benefit Elections accessible at Employee Self-Service through the ITC Portal on the i2net. If you have any questions about how to change your beneficiary(ies), contact the Employee Benefits Office at (210) 522-2227.

4 Who is the beneficiary for my covered dependents in the VAD&D program?

The employee is automatically the beneficiary for covered dependents.

5 How are VAD&D program benefits claimed and disbursed?

For benefits caused by an accident, the beneficiary will need to file a claim with the insurer for VAD&D program benefits through the Employee Benefits Office and provide evidence of the death and/or accident. The Employee Benefits Office is available to provide the necessary forms, to assist with the completion of these forms, and to answer questions.

Benefits greater than $5,000 will be deposited into a free, interest-bearing account, called the NYL GBS Survivor Assurance account, in the name of the beneficiary. If your benefit is less than $5,000, New York Life will send the beneficiary a check for the total benefit amount.

6 Are there any exclusions in the VAD&D program?

Yes. Benefits will not be paid for any covered death or covered loss which, directly or indirectly, in whole or in part, is caused by or results from any of the circumstances described in the Group Policy.

VII ACCIDENTAL INJURY

A Introduction

The Accidental Injury program is a fully-insured benefit program. that provides supplemental income when you and your covered dependents receive medical and other covered services resulting from a covered accident. The Accidental Injury program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the Accidental Injury program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible injuries, their respective payments and policy exclusions and limitations are contained in the Group Accident Indemnity Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the Accidental Injury program?

You and your eligible dependents (see question 4) are eligible to participate in the Accidental Injury program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary and leased employees are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Accidental Injury program?

To participate in the Accidental Injury program, you must complete, sign and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premium is required until the following payroll period.

If you have declined coverage and now wish to elect it or need to change your current enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year. If you are not actively working on the date you elect coverage, enrollment in the Accidental Injury program or a change in coverage for the Accidental Injury program will be effective on the date you resume actively working for the employer.

The qualifying events for which enrollment changes can be submitted are the same as those included in Section III, *Section 125 Plan*.

3 How is the Accidental Injury program funded?

The Accidental Injury program is fully funded by participant contributions. On a periodic basis, the insurer may increase the required premium from participants. Participant contributions are provided by payroll deduction on an after-tax basis.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue after-tax premium payments by converting eligible accumulated leave hours. If no leave hours are available, participants must make arrangements with the Employee Benefits Office for payment of premiums. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid following termination effective date will be reversed.

As long as premiums are paid, participation may continue for the period of time described in the Group Policy. After that period ends, coverage may be continued by contacting the Employee Benefits Office for an application to continue coverage and the participant's submission of the continuation of coverage application directly to the insurer within 31 days of the date coverage ends.

A participant whose employment classification changes to temporary may continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date your coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

4 Who are my eligible dependents in the Accidental Injury Program?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse, whether by ceremony or common law
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is: under the age of 26; or other children defined in the Group Policy as an eligible dependent.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26. Coverage for an employee's lawful spouse or domestic partner terminates on the divorce date or the termination of the domestic partnership. The divorce date is the date the divorce decree is signed by the judge or court. The domestic partnership termination date is the date the notarized termination agreement is signed.

An eligible employee whose spouse or domestic partner is also an Institute employee may enroll one spouse or domestic partner as a dependent of the other, or each spouse or domestic partner may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as dependents of both employees.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the Accidental Injury program?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the Accidental Injury program at any time after electing coverage?

Unless you have a qualifying event, coverage in the Accidental Injury program may only be cancelled during the annual Open Enrollment period, and coverage will terminate as of the end of the current calendar year.

7 Am I enrolled in the Accidental Injury program when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Accidental Injury program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in other benefit programs with pre-tax dollars

through salary reduction. Participant contributions for the Accidental Injury program are paid on an after-tax basis through payroll deduction.

8 Can I continue my enrollment in the Accidental Injury program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in Accidental Injury program for 24 months by paying required premiums through after-tax premium payments.

9 What happens to my coverage in the Accidental Injury program when my employment at the Institute ends?

Coverage in the Accidental Injury program ends as of the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. Coverage may not be continued under the COBRA program. Coverage may be continued by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the last day of coverage. If coverage is continued, required premiums are paid by the participant directly to the insurer.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the Accidental Injury program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible injuries, their respective payments and policy exclusions and limitations are contained in the Group Accident Indemnity Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What benefits are available in the Accidental Injury program?

The Accidental Injury program is a voluntary supplemental income benefit that provides benefit payments for medical services and treatment you receive due to a covered accident. The Accidental Injury program provides eligible employees the opportunity to enroll in a low, medium, and high level of coverage. Program benefits, including benefit payout amounts for each coverage level, are described in the Group Policy.

2 What are the Accidental Injury program's wellness, health screening and preventive care benefits?

Even if you do not experience a covered accident, you may receive one wellness, health screening or preventive care benefit annually. Depending on your elected level of coverage, a benefit of $50 - $100 is available annually per covered person by participating in a type of wellness, health screening or preventive care service described in the Group Policy.

The wellness, health screening and preventive care benefit is not available to employees who reside in the state of New Hampshire.

3 How are claims administered?

To file a claim for benefits in the Accidental Injury program when you have a covered accident or when you have a covered wellness, health screening or preventive care visit, you must complete the applicable claim

form (available on the Employee Benefits website), attach copies of supporting documentation, and send these documents to the insurer's claims department.

4 Are there any coverage exclusions?

Benefits in the Accidental Injury program will not be paid for any covered accident that is caused, directly or indirectly, by any exclusion described in the Group Policy.

VIII Cancer: METLIFE CANCER AND SPECIFIED DISEASE EXPENSE

A Introduction

The MetLife Cancer and Specified Disease Expense program is a fully-insured benefit program administered by Bay Bridge Administrators that provides supplemental income when you or your covered dependents are diagnosed with cancer or another covered disease. The MetLife Cancer and Specified Disease Expense program is underwritten by the Metropolitan Life Insurance Company. The MetLife Cancer and Specified Disease Expense program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Benefits, limitations, exclusions, and other features of the MetLife Cancer and Specified Disease Expense program are described in the insurance certificate which all covered participants receive upon request to Bay Bridge Administrators after enrolling into the MetLife Cancer and Specified Disease Expense program.

B Eligibility and Participation

1 Who is eligible to participate in the MetLife Cancer and Specified Disease Expense program?

You and your eligible dependents (see question 4) are eligible to participate if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the MetLife Cancer and Specified Disease Expense program?

To participate in the MetLife Cancer and Specified Disease Expense program, you must complete, sign and submit an electronic Benefit Enrollment Change Form within the first week of your employment. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premium is required until the following pay period.

If you have declined coverage and now wish to elect it or need to change your current enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year. Enrollment changes submitted within 31 days of a qualifying event will be effective on the date when the electronic Benefit Enrollment Change Form is submitted.

The qualifying events for which enrollment changes can be submitted are included in Section III, *Section 125 Plan*.

3 How is the MetLife Cancer and Specified Disease Expense program funded?

Participants are responsible for the full cost of premiums for themselves and enrolled dependents. On a periodic basis, the cost of the program is reviewed, and premiums are authorized by the insurer.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid following the termination effective date will be reversed.

Coverage for a participant whose employment classification changes to temporary or who is out on a leave of absence will end as of the employee's classification change effective date. In such cases, the employee may elect continue to participate by contacting the insurer to request an application to continue coverage. Such application must be returned directly to the insurer, and the individual(s) continuing coverage must make arrangements for payment of the required premiums for continued coverage with the insurer.

4 Who are my eligible dependents in the MetLife Cancer and Specified Disease Expense program?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural child, adopted child, or stepchild under the age of 25 or to age 26 if fulltime student.

The above-mentioned persons are the only ones who qualify as eligible dependents. Any other dependents you may have (mother, father, or other relatives) are not eligible.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

5 Can I add new dependents acquired by marriage, remarriage, or adoption to the MetLife Cancer and Specified Disease Expense program?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent,

you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the MetLife Cancer and Specified Disease Expense program or change my level of coverage at any time after electing coverage?

Unless you have a qualifying event, a participant has the right to cancel his or her enrollment or change his or her level of coverage only at the end of each calendar year. This is accomplished by declining coverage for the next plan year during Open Enrollment. Cancellations are effective as of the end of the calendar year.

7 Am I enrolled in the MetLife Cancer and Specified Disease Expense program when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the MetLife Cancer and Specified Disease Expense program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain benefit programs, including the MetLife Cancer and Specified Disease Expense program, with pre-tax dollars through salary reduction.

8 Can I continue my enrollment in the MetLife Cancer and Specified Disease Expense program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in the MetLife Cancer and Specified Disease Expense program for 24 months by paying required premiums through after-tax premium payments.

9 What happens to my coverage in the MetLife Cancer and Specified Disease Expense program when my employment at the Institute ends?

Coverage in the MetLife Cancer and Specified Disease Expense program ends as of the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. Coverage may not be continued under the COBRA program. Coverage may continue if the employee contacts the insurer and elects to continue coverage directly with the insurer.

C Summary of Benefits, Limitations and Exclusions

Benefits, limitations and exclusions of the MetLife Cancer and Specified Disease Expense program are described fully in your insurance certificate which you receive upon request to Bay Bridge Administrators after enrolling in the MetLife Cancer and Specified Disease Expense program. A summary of benefits, limitations and exclusions in the MetLife Cancer and Specified Disease Expense program is described below. In the event of any discrepancy between the information described below and your MetLife Cancer and Specified Disease Expense program insurance certificate, the MetLife Cancer and Specified Disease Expense program insurance certificate is controlling.

1 What benefits are available is the MetLife Cancer and Specified Disease Expense program?

Benefits of the MetLife Cancer and Specified Disease Plan depend on the level in which the participant is enrolled and are described in your certificate. There are two levels of benefits: a high option and a low option. Each covered person may receive one cancer screening benefit annually. The cancer screening benefit is described in your insurance certificate.

2 How are claims administered in the MetLife Cancer and Specified Disease Expense program?

To file a claim for benefits in the MetLife Cancer and Specified Disease Expense program when you have a covered critical illness or when you have a covered cancer screening visit, you must complete the applicable claim form (available on the Employee Benefits website), attach copies of supporting documentation, and send these documents to the insurer's claims department.

3 Are there any coverage exclusions in the MetLife Cancer and Specified Disease Expense program?

Benefits in the MetLife Cancer and Specified Disease Expense Program will not be paid for any exclusions described in the insurance certificate. Benefit limitations are also described in the insurance certificate. As described in the insurance certificate, benefits are not payable for any pre-existing conditions. During the first 12 months an individual is covered on the MetLife Cancer and Specified Disease plan, no benefits are payable for any condition for which an individual has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately prior to the individual's benefit effective date. Any cancer or another covered specified disease diagnosed prior to an individual's coverage effective date with MetLife is not eligible for coverage.

IX CRITICAL ILLNESS

A Introduction

The Critical Illness program is a fully-insured benefit program that provides supplemental income when you or your covered dependents are diagnosed with a covered critical illness. The Critical Illness program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the Critical Illness program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible critical illnesses, their respective payments and policy exclusions and limitations are contained in the Group Critical Illness Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the Critical Illness program?

You and your eligible dependents (see question 4) are eligible to participate in the Critical Illness program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Critical Illness program?

To participate in the Critical Illness program, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premium is required until the following payroll period.

If you have declined coverage and now wish to elect it or need to change your current enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Children are covered at no additional premium cost, but you must select the appropriate coverage tier and indicate on the electronic Benefit Change Form that you are electing for your child(ren) to be covered.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year. If you are not actively working on the date you elect coverage, enrollment in the Critical Illness program or a change in coverage in the Critical Illness program will be effective on the date you resume actively working for the employer.

The qualifying events for which enrollment changes can be submitted are the same as those included in Section III, *Section 125 Plan*.

3 How is the Critical Illness program funded?

The Critical Illness program is fully funded by participant contributions. On a periodic basis, the insurer may increase the required premium from participants. Participant contributions are provided by payroll deduction on an after-tax basis.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue after-tax premium payments by converting eligible accumulated leave hours. If no leave hours are available, participants must make arrangements with the Employee Benefits Office for payment of premiums. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid after the termination effective date will be reversed.

As long as premiums are paid, participation may continue for the period of time described in the Group Policy. After that period ends, coverage may be continued by contacting the Employee Benefits Office for an application to continue coverage and the participant's submission of the application directly to the insurer within 31 days of the date coverage ends.

A participant whose employment classification changes to temporary may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

4 Who are my eligible dependents in the Critical Illness program?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild under the age of 26; or other children as defined in the Group Policy as an eligible dependent.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26. Coverage for an employee's lawful spouse or domestic partner terminates on the divorce date or the termination of the domestic partnership. The divorce date is the date the divorce decree is signed by the judge or court. The domestic partnership termination date is the date the notarized termination agreement is signed.

An eligible employee whose spouse or domestic partner is also an Institute employee may enroll one spouse or domestic partner as a dependent of the other, or each spouse or domestic partner may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as dependents of both employees.

5 How do I add new dependents acquired by marriage, remarriage, or adoption in the Critical Illness program?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date. Children are covered at no additional cost, but you must indicate on the electronic Benefit Change Form that you are electing for your child(ren) to be covered.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date. Children are covered at no additional cost, but you must indicate on the electronic Benefit Change Form that you are electing that your child(ren) be covered.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the Critical Illness program at any time after electing coverage?

Unless you have a qualifying event, coverage in the Critical Illness program may only be cancelled during the annual Open Enrollment period, and coverage will terminate as of the end of the current calendar year.

7 Am I enrolled in the Critical Illness program when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Critical Illness program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in other benefit programs with pre-tax dollars through salary reduction. Participant contributions for the Critical Illness program are paid on an after-tax basis through payroll deduction.

8 Can I continue my enrollment in the Critical Illness program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in the Critical Illness program for 24 months by paying required premiums through after-tax premium payments.

9 What happens to my coverage in the Critical Illness program when my employment at the Institute ends?

Coverage in the Critical Illness program ends as of the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. Coverage may not be continued under the COBRA program. Coverage may be continued by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the last day of coverage. If coverage is continued, required premiums are paid by the participant directly to the insurer.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the Critical Illness program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including covered critical illnesses, their respective payments and policy exclusions and limitations are contained in the Group Critical Illness Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What benefits are available in the Critical Illness program?

The Critical Illness program is a voluntary supplemental income benefit. The program provides a benefit payment for a covered critical illness. Benefits in the Critical Illness program depend on the coverage level in which the participant is enrolled. The Critical Illness program pays a lump sum cash benefit in the amount of $10,000, $20,000, or $30,000 in the event a covered employee is first diagnosed with a covered critical illness. Benefits paid can be used for expenses beyond direct medical costs, including:

- Travel, room and board for medical treatment
- Childcare
- Treatment options not covered by traditional insurance
- Everyday household bills that may pile up due to lost wages

A covered spouse or domestic partner is eligible for a lump sum cash benefit of 50% of the employee amount; for example, if the employee elects $20,000 coverage, the spouse or domestic partner will receive $10,000 of

coverage. A covered dependent child is eligible for a payment of 25% of the employee amount; for example, if the employee elects $20,000 coverage, the child will receive $5,000 of coverage.

Covered conditions are the following and are defined in the Group Policy:

- Invasive Cancer
- Heart Attack
- Stroke
- Benign Brain Tumor
- Blindness
- End-Stage Renal (Kidney) Disease
- Major Organ Failure
- Paralysis
- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)*
- Coronary Artery Disease (Surgery) *
- Carcinoma in Situ *
- Aortic & Cerebral Aneurysm*
- Advanced Heart Failure*
- Advanced Stage Alzheimer's Disease*
- Parkinson's Disease*
- Multiple Sclerosis*
- Severe Sepsis*
- Coma*
- Advanced Obesity*
- Crohn's Disease*
- Pulmonary Embolism*

*Coverage for these conditions is 25% of the elected amount.

2 What is the health screening benefit for the Critical Illness Program?

Each covered person may receive one health screening benefit annually. Regardless of the elected level of coverage, a benefit of $100 per covered person is available in the Critical Illness program annually per covered person by participating in a type of health screening service described in the Group Policy.

3 How are claims administered?

To file a claim for benefits in the Critical Illness program when a covered person has a covered critical illness or when a covered person has a covered health screening visit, the applicable claim form (available on the

Employee Benefits website) must be completed, and copies of supporting documentation sent to the insurer's claims department.

4 Are there any coverage exclusions in the Critical Illness program?

Benefits in the Critical Illness program will not be paid for any covered accident that is caused, directly or indirectly, by any exclusion described in the Group Policy.

X Dental: DELTA DENTAL PPO

A Introduction

The Delta Dental PPO plan is a dental program which provides benefits for covered dental services. The Delta Dental PPO plan is included in the Southwest Research Institute Employees' Health Care Expense Benefits Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Health Care Expense Benefits Plan in any way. The actual Southwest Research Institute Employees' Health Care Expense Benefits Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Health Care Expense Benefits Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Health Care Expense Benefits Plan documents, the Southwest Research Institute Employees' Health Care Expense Benefits Plan documents are controlling. Benefits, limitations, exclusions, and other features of the Delta Dental PPO plan are described in the Delta Dental Employee Benefit Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

B Eligibility and Participation

1 Who is eligible to participate in the Delta Dental PPO plan?

You and your eligible dependents (see question 4) are eligible to participate in the Delta Dental PPO plan if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Delta Dental PPO plan?

To participate in the Delta Dental PPO plan, you must complete, sign, and submit an electronic Benefit Enrollment Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium for any elected dependent coverage is required for the first payroll period. If your hire date is in the second week of the pay period, no premium for dependent coverage is required until the follow pay period.

Employee coverage is mandatory. If you have declined coverage for your eligible dependents and now wish to elect it or need to change your current eligible dependent enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within one of the following time periods:

- within 31 days of employment
- within 31 days of a qualifying event
- at the next Open Enrollment period

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

Further information on qualifying events for which enrollment changes can be submitted outside of the Open Enrollment period is included in Section III, *Section 125 Plan*.

3 How is the Delta Dental PPO plan funded?

The Delta Dental PPO plan is funded by Institute and participant contributions. No participant contribution is required for Employee coverage. On an annual basis, Institute senior management reviews and approves participant contributions for dependent coverage. Participant contributions are provided by salary reduction on a pre-tax basis.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid after the termination effective date will be reversed.

As long as premiums are paid, participation may continue until the employee's employment ends or is no longer eligible to participate in the Delta Dental PPO plan. In this case, coverage may be continued by electing continuation coverage under COBRA; further information on COBRA is described in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

A participant whose employment classification changes to temporary or who is out on a leave of absence may continue to participate if electing continuation coverage under COBRA. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

4 Who are my eligible dependents?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26.

Coverage for an employee's lawful spouse or domestic partner terminates on the divorce date or the termination of the domestic partnership. The divorce date is the date the divorce decree is signed by the judge or court. The domestic partnership termination date is the date the notarized termination agreement is signed.

An eligible employee whose spouse or domestic partner is also an Institute employee must be enrolled separately. An eligible employee cannot be enrolled as a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as a dependent of both employees.

A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the Delta Dental PPO plan?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the Delta Dental PPO plan at any time after electing coverage?

Unless you have a qualifying event, coverage in the Delta Dental PPO plan for eligible dependents may only be cancelled during the annual Open Enrollment period, and coverage will terminate as of the end of the current calendar year.

7 Am I enrolled in the Delta Dental PPO plan when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Delta Dental PPO plan. Your enrollment in the Section 125 Plan only allows you to pay participant contributions for dependent coverage in the Delta Dental PPO plan, as well as certain other benefits, with pre-tax dollars through salary reduction.

8 Can I continue my enrollment in the Delta Dental PPO plan if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in the Delta Dental PPO plan for 24 months under COBRA. Premiums are available by contacting the Employee Benefits Office at (210) 522-2227.

9 What happens to my coverage in the Delta Dental PPO plan when my employment at the Institute ends?

Coverage in the Delta Dental PPO plan ends as of the last day of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. In such cases, participation may continue if the employee elects to continue coverage under the COBRA program and pays the required premiums. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

C Summary of Benefits, Limitations and Exclusions

Benefits, limitations and exclusions of the Delta Dental PPO plan are described fully in the Delta Dental Employee Benefit Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. A summary of benefits, limitations and exclusions is described below. In the event of any discrepancy between the information described below and the Delta Dental Employee Benefit Booklet, the Delta Dental Employee Benefit Booklet is controlling.

1 What dental benefits are generally provided in the Delta Dental PPO Plan?

The Delta Dental PPO plan provides benefits for covered dental services. The cost of covered services is limited to the Maximum Allowance Limitation (see question 6). These services must be performed by a dentist or as directed by a dentist, be essential for the necessary care of teeth, and be started and completed while the person is enrolled in the plan.

2 What is the annual maximum benefit for dental services?

The Delta Dental PPO plan pays a maximum $2,000 toward the cost of a participant's covered dental services performed during a calendar year. Diagnostic and preventive services and orthodontia services do not count toward a participant's annual maximum.

Participants are strongly encouraged to obtain a predetermination from the Delta Dental customer service representative when a treatment plan exceeds $350.

3 What is the lifetime maximum benefit for dental and orthodontic services?

The Delta Dental PPO plan has no lifetime maximum benefit payable for covered dental services of a participant. Orthodontia services are limited to a $1,500 lifetime maximum benefit for a participant's covered orthodontia services and are in addition to the $2,000 annual maximum benefit.

4 What is the annual deductible?

The Delta Dental PPO annual deductible is $50 for each participant during a calendar year. The annual deductible can be applied only toward the cost of covered services. When three family members have satisfied

their $50 annual deductible (i.e., $150 per family amount), no further deductible amounts will be applicable to other covered family members for the remainder of that calendar year. Deductible amounts do not apply to diagnostic and preventive services and orthodontia services.

5 How does the percentage co-insurance work?

After the individual or family annual deductible is met (except for diagnostic and preventive services), the Maximum Allowance Limitation (see question 6) of covered dental services is shared based on the percentage applicable to the particular category of dental service. These percentages are displayed below for the following categories of services:

	Paid by Delta Dental	Paid by Participant
Diagnostic & Preventive Services	100%	0%
Endodontics (after deductible)	80%	20%
Basic Services (after deductible)	80%	20%
Oral Surgery (after deductible)	80%	20%
Major Services (after deductible)	50%	50%
Prosthodontics (after deductible)	50%	50%

Orthodontics are subject to 50% participant co-insurance and the amount paid by the plan is limited to $1,500 per participant per lifetime (see question 3).

6 How does a Preferred Provider Organization Plan work?

A Preferred Provider Organization (PPO) plan provides savings to the participant and the Institute because it makes available a large group of dentists who have agreed to provide dental services for agreed-upon prices. Dentists in the PPO network have agreed to the highest discount; therefore, participant costs are the lowest. Premier network dentists charge slightly higher fees. When you use either a PPO or Premier network dentist, the dentist will submit a claim on your behalf, and you will receive an Explanation of Benefits. When dental services are provided by a network dentist, the savings to the employee is increased because there are no additional charges billed by the dentist after your claim is processed. You can locate either a PPO or Premier network dentist by going to www.deltadentalins.com.

Under this plan you may also use a non-network dental provider, but you may have to pay the full cost at the time of services and submit a claim to Delta Dental for processing, or the dentist may submit a claim on your behalf. Your share of covered expenses is based on the same schedule of benefits for co-insurance (see question 5) except the co-insurance and applicable deductible for charges submitted by a non-network dental provider are calculated based on the plan's Maximum Allowance Limitation. In addition to your co-insurance and annual deductible, you will also be responsible for payment to the non-network dental provider any billed charges exceeding the Maximum Allowance Limitation. The Maximum Allowance Limitation is determined by Delta Dental.

7 Will I receive an identification card?

Yes. You will receive a Delta Dental PPO plan identification card when you become a member. You may call Delta Dental at 1-800-521-2651 or register at www.deltadentalins.com to request new or replacement cards.

8 What does the term "covered expenses" mean?

The term "covered expenses" means expenses incurred by or on behalf of you or any one of your covered dependents for charges made by a dentist for the performance of a covered dental service defined in the Delta Dental Employee Benefit Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

9 What limitations and exclusions are applicable to covered expenses?

Many services have limitations to restrict the frequency of certain covered expenses. Certain dental procedures are also excluded from coverage. These limitations and exclusions are described in the Delta Dental Employee Benefit Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

10 Does the Delta Dental PPO plan cover dental services related to missing teeth?

Yes.

11 How does the Delta Dental PPO plan work if I have coverage from another group dental plan?

When you, your dependents, or both are covered by more than one group dental care plan, the combined benefits payable by this plan and all other group plans will not exceed 100 percent of the covered expense to this plan. In cases of your or your dependent's enrollment in another dental care plan(s), one plan will always have primary (pays first) coverage and the other dental care plan(s) will be secondary. This is called coordination of benefits (COB). The plan with primary coverage determines its benefits first without regard to the other group dental care plan(s). The COB rules for the Delta Dental PPO plan are described in the Delta Dental Employee Benefit Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

12 How do I file a claim?

No claim form is required for services provided by a PPO or Premier Network provider. To file a claim for services from a non-network provider, you may be required to pay in advance for services and submit an original bill to Delta Dental.

You can download a claim form on the Employee Benefits website or by registering at www.deltadentalins.com.

13 How does the subrogation reimbursement work?

When an injury involves a third party, and that third party may have insurance to pay your dental bills or provide a settlement, those conditions will require that you assign your rights for reimbursement of costs to the plan. This is known as subrogation.

The Delta Dental PPO plan includes a right of subrogation on behalf of the plan to seek and obtain reimbursement for the costs of dental care paid by the plan prior to any other parties if the related injury resulted from acts or omissions for which a third party may be liable. The plan recovers its costs through attaching a lien to the insurance settlement from the third party. This procedure is necessary and fair in as much as dental costs from accidents that third parties have responsibility for increases the cost of premiums to

all participating employees. Note that when insurance settlements are not sufficient to fully reimburse the plan, the plan absorbs the difference.

14 What does "assignment of benefits" mean?

An assignment of benefits is an authorization you make to allow Delta Dental to pay its share of covered expenses directly to the provider. This only applies when a non-network provider is willing to bill the Delta Dental for its share instead of collecting full payment from you.

15 What information will I receive that explains how my benefit was determined or which amounts were not covered?

You will receive an Explanation of Benefits statement for each claim by registering and logging into your account at www.deltadentalins.com. The statement will list each provider and service billed with the percentage and amount covered by the plan. If the service is not covered by the plan, an explanation will be given on this statement. If you do not understand why a provider billing was not covered, you should contact Delta Dental.

16 How long should it take to process a claim?

Generally, claims that do not require any additional information are processed in less than 15 days. Delta Dental may require additional information from you or your dentist to make a determination on your claim. If additional information is required, you or your dentist will receive a request in writing specifying the nature of the information needed and an explanation why it is needed.

17 What if a claim for benefits is denied?

If your claim for benefits is denied in whole or part, you will receive written notice of such denial from Delta Dental. Each written notice of denial shall set forth:

- The specific reason(s) for the denial of the claim
- A specific reference to the provision(s) on which the denial is based
- Notice of your right to appeal the denial

18 If I disagree with Delta Dental's claim determination, what are my rights for a review of the claim determination?

You can appeal the determination of your claim by filing a written or oral appeal to Delta Dental within 180 days of a denied claim for benefits. Responses to all appeals will be completed within 60 days. You will be provided with a notice of the appeal decision.

19 What is the second-level appeal process?

If you receive a written notice of denial, and the denial has been upheld by Delta Dental upon appeal, you may appeal the claim denial by giving written notice to the Plan Administrator. This request for a review must be made to the Plan Administrator within 60 days of your receipt of the first-level appeal decision. If such request is not made within 60 days, you will have waived your right to an appeal to the Plan Administrator. On the completion of a full and thorough review, the Plan Administrator will notify you in writing of the results, citing plan provisions that control the decision. For a pre-service request for benefits, the Plan Administrator has 15

days to respond to the second-level appeal notify you of his decision or 30 days to respond to the second-level appeal for a post-service request for benefits. If special circumstances require an extension for the Plan Administrator to provide a decision, you will be notified in writing of that extension before the end of the initial 15-day or 30-day period.

The right to a second-level appeal may not be assigned to a dentist or other health care provider from whom dental services were received. The right to a second-level appeal is only available to a participant enrolled in the Delta Dental PPO plan.

20 What other rights for an adverse claim determination is available?

After satisfying the requirement above for an appeal to Delta Dental and the Plan Administrator, legal action may be brought under section 502(a) of ERISA. Legal action must be brought within one year after the completion of the second-level appeal process. The Delta Dental PPO plan is not subject to state insurance law.

The right to legal action may not be assigned to a dentist or other health care provider from whom dental services were received. The right to legal action is only available to a participant enrolled in the Delta Dental PPO plan.

The Plan Administrator has full authorization and discretion to allow and deny claims, and any determination made by the Plan Administrator shall be given deference, if subject to judicial review, and shall be overturned only if it determined to be arbitrary and capricious.

XI EMPLOYEE ASSISTANCE PROGRAM

A Introduction

The Employee Assistance Program (EAP) provides counseling and other services related to personal concerns and other work/life needs. The EAP is included in the Southwest Research Institute Employee Assistance Program Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employee Assistance Program Plan in any way. The actual Southwest Research Institute Employee Assistance Program Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employee Assistance Program Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employee Assistance Program Plan documents, the Southwest Research Institute Employee Assistance Program Plan documents are controlling. Benefits, limitations, exclusions, and other features of the EAP are described in a contract between Southwest Research Institute and the EAP provider.

B Eligibility and Participation

1 Who is eligible to participate in the EAP?

You are eligible and required to participate in the EAP if you are employed by the Institute as a regular full-time employee, a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week, or a temporary employee. Temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

Dependents are eligible to participate in the EAP. Dependents include household members residing in the employee's home on an ongoing basis.

2 How do I enroll in the EAP?

No enrollment is required to participate in the EAP. Coverage will be effective as of your hire date.

3 How is the EAP funded?

The EAP is fully funded by Institute contributions.

4 Can I cancel my enrollment in the EAP at any time after electing coverage?

No. Because coverage in the EAP is required for all regular and temporary Institute employees, you may not cancel your coverage.

5 Am I enrolled in the EAP when I enroll in the Section 125 Plan?

No enrollment is required to participate in the EAP. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain other benefits with pre-tax dollars through salary reduction.

6 Can I continue my enrollment in the EAP if I am called to Military Active-Duty Service?

You and your eligible dependents will automatically be covered for benefits through the EAP for the first six months following the start of your military active-duty service. Eligible employees and your eligible dependents may continue participation for an additional 18 months by electing continuing coverage under

COBRA and paying the required premiums through after-tax premium payments. Premiums are equivalent to COBRA rates and are available by contacting the Employee Benefits Office at (210) 522-2227.

7 What happens to my coverage in the EAP when I terminate my employment at the Institute?

You will automatically be covered for six months following your termination of employment. Participation can be continued under the COBRA program for an additional 12 months. Further information on continuation of EAP coverage under COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

C Summary of Benefits, Limitations and Exclusions

Benefits, limitations, exclusions, and other features of the EAP are described in a contract between Southwest Research Institute and the EAP provider. A summary of benefits, limitations, and exclusions in the EAP is described below. In the event of any discrepancy between the information described below and the contract between Southwest Research Institute and the EAP provider, the contract between Southwest Research Institute and the EAP provider is controlling.

1 What benefits are provided under the EAP?

EAP services can assist with many different personal concerns including, but not limited to the following examples:

- Depression and anxiety
- Relationships or family conflicts
- Workplace conflicts
- Parent training and family communications
- Grief, death and dying counseling
- Healthy lifestyles
- Attention deficit hyperactivity disorder (ADHD) and conduct concerns
- Alcohol abuse/substance abuse
- Stress management
- Caring for an elderly parent
- Emergencies
- Legal difficulties
- Domestic violence
- Financial difficulties
- Work/Life balance

You can find additional information about EAP services and many of the above subjects by accessing the Employee Assistance Program link on the Employee Benefits website.

2 What counseling services are provided?

A counselor assists the employee/family member to evaluate the concern(s) and develop an approach for solving it. The employee/family member may participate in individual, marriage, or family therapy. A counselor can provide up to eight (8) sessions per issue per calendar year at no cost to the employee. Specialized services, including consultations with a financial counselor, to help employees resolve their issues or to provide them with additional resources are also offered. The cost of services provided by professionals other than the counselor or services beyond the eight (8) session maximum are the responsibility of the employee. The employee's financial situation will always be considered, and Institute sponsored health care plans may also be available for sharing the cost of extended services.

When an employee or family member uses up their eight (8) sessions, they may not borrow sessions from other family members. If multiple family members are seen together, as in family therapy, only eight (8) sessions will be provided. For example, a couple in marriage counseling would receive eight (8) conjoint sessions, not sixteen (16).

Consultation is available to managers and supervisors about how to handle various difficult employee situations. Personality conflicts, suspected drug use, chronic poor performance, and behavior issues are examples of appropriate topics for consultation. This is a separate service from the counseling described above and will not count toward the eight (8) sessions per family unit.

3 How does the referral system work?

There are three ways for an employee to access EAP services. The first two are voluntary.

Self-referral: An employee or family member may privately refer himself or herself for help with an issue.

Informal referral: An employee may be referred to the EAP by a manager. In an informal referral, the employee would be encouraged to talk to an EAP counselor for reasons, such as work performance standards not being met or a violation of Institute policy. This serves as a reminder to the employee of the availability of EAP services. This is a voluntary referral.

Formal referral: Referrals following a violation of the Institute Drug-Free Workplace Policy, a violation of another serious conduct policy or other behavior circumstances can be made by the Cost Center Head, the Vice President of Human Resources, or the Institute's Medical Review Officer. The Vice President of Human Resources is responsible for the administration of the formal referral program in accordance with procedures approved by Institute senior management.

4 How are routine and emergency services administered?

Routine and emergency services are available by contacting the EAP provider.

5 Are out of the San Antonio area counseling services available?

Yes. Employees and/or eligible dependents in need of counseling services but either reside outside of the San Antonio metropolitan area or are on travel may call the EAP provider and arrange for a counseling referral, if needed.

6 Are EAP services confidential?

Topics discussed in counseling sessions, as well as the identity of persons receiving counseling, is confidential regardless of whether the employee is self-referred or informally-referred. The Institute will not be aware that the employee or family member is using the EAP when self-referrals or informal referrals occur. An employee who is formally referred by a manager as indicated on the Formal Referral to the Employee Assistance Program Form is required to sign a Release of Information Form. Staff of the EAP provider can then give general feedback to the Human Resources and the employee's manager. A Formal Referral Work Agreement will be required following an employee's initial visit with the EAP under a formal referral. Statistical reports of program utilization furnished by the EAP provider to Institute staff will contain no names.

In situations where there is a danger to the individual or others, appropriate notification will be made.

Additional information on EAP services can be obtained from the Employee Services Section of the Human Resources Department at (210) 522-6225 or by visiting the third floor of Building 84.

7 May an employee use M&BL for a voluntary appointment with an EAP counselor?

Because there is ample opportunity for an employee to schedule an appointment with an EAP counselor outside of regular work hours, appointments during regular work hours should be avoided. If an appointment must be scheduled during regular work hours, this time generally would be more appropriately accounted for as personal leave and not as M&BL.

8 Can a non-covered individual participate with the employee in an EAP counseling session?

Anyone living in the employee's household may access services. These individuals may participate with the employee in an EAP counseling session. Such situations must be cleared with the EAP counselor at the time the appointment is made.

9 Are there any exclusions under the EAP?

Services for which EAP services are not available include but are not limited to:

- Services covered under any workers compensation policy;
- Services related to any matter of employment law; and
- Counseling services beyond the annual limit as described in question 2 above.

For additional services which may be excluded under the EAP, you may call the EAP provider.

10 What additional benefits are available to eligible participants in the Southwest Research Institute Employee Assistance Program Plan?

Benefits in the Southwest Research Institute Employee Assistance Program Plan also include eligible services provided by the on-site physician at the Southwest Research Institute Medical Clinic. Information regarding available services and eligibility requirements can be received by contacting the Medical Clinic at (210) 522-2220 between 8 A.M. and 5 P.M. Monday through Friday. Access to services provided by the on-site physician is not available under COBRA.

Benefits in the Southwest Research Institute Employee Assistance Program Plan also include participation for eligible participants in the annual biometric screenings held on campus or at available off-site locations.

Regular full-time and part-time employees are eligible to participate in the annual biometric screenings. Spouses who are enrolled in an Institute-sponsored medical plan are also eligible to participate in the annual biometric screenings. The cost for the biometric screenings is paid by the Southwest Research Institute Employee Assistance Program Plan and there is no cost to employees or spouses who participate. Information regarding the annual biometric screenings is available by contacting the Wellness Team at wellness@swri.org. When an individual is no longer classified as a regular employee, participation in the annual biometric screenings program may continue, but the individual will be responsible to pay the full cost of the screening.

XII LEGAL PLAN

A Introduction

The Legal Plan is a fully-insured benefit program underwritten by the insurer that provides legal assistance for covered services to enrolled employees and dependents. This benefit is not subject to ERISA. Plan features, limitations, and exclusions of the Legal Plan are described in the Legal Plan's Fact Sheet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

B Eligibility and Participation

1 Who is eligible to participate in the Legal Plan?

You and your eligible dependents (see question 4) are eligible to participate in the Legal Plan if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Legal Plan?

To participate in the Legal Plan, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is during the first week of the pay period, a full bi-weekly premium is required for the full payroll period. If your hire date is during the second week of the pay period, no premium is required until the following pay period.

If you declined coverage during your first 31 days of employment, you may enroll at the next Open Enrollment period.

3 How is the Legal Plan funded?

The Legal Plan is fully funded by participant contributions. Participant contributions are provided by payroll deduction on an after-tax basis. On a periodic basis, the insurer may increase the required premium from participants for each of the coverage levels.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue after-tax premium payments by converting eligible accumulated leave hours. If no leave hours are available, participants must make arrangements with the Employee Benefits Office for payment of premiums. A participant whose employment classification changes to temporary or who is out on a leave of absence may continue to participate by contacting the insurer to continue coverage.

4 Who are my eligible dependents in the Legal Plan?

An eligible dependent is defined as the:

- Enrolled employee's lawful spouse; whether by ceremony or common law;

- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26 or other children as defined in the Group Policy as an eligible dependent

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26. Coverage for an employee's lawful spouse terminates on the divorce date. The divorce date is the date the divorce decree is signed by the judge or court.

An eligible employee whose spouse or domestic partner is also an Institute employee may enroll one spouse or domestic partner as a dependent of the other, or each spouse or domestic partner may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as dependents of both employees.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the Dependent Life program?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the Legal Plan at any time after electing coverage?

No. A participant has the right to cancel coverage only at the end of each calendar year. To cancel, you must decline coverage in the Legal Plan and sign and submit an electronic Open Enrollment form before the Open Enrollment period ends. Cancellations are effective as of the end of the calendar year.

7 Am I enrolled in the Legal Plan when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Legal Plan. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain benefit programs with pre-tax dollars through salary reduction. Premiums in the Legal Plan are paid on an after-tax basis through payroll deduction.

8 Can I continue my enrollment in the Legal Plan if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and your dependents in the Legal Plan by contacting the insurer to continue coverage.

9 What happens to my coverage in the Legal Plan when my employment at the Institute ends?

Coverage in the Legal Plan ends as of the end of the pay period during which an employee's employment ends. In such cases, participation may continue by contacting the insurer to continue coverage. Eligible retiring employees may re-enroll in the Legal Plan as part of the retirement benefit program.

C Summary of Benefits, Limitations and Exclusions

Plan features, limitations, and exclusions of the Legal Plan are described in the Legal Plan's Fact Sheet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. A summary of the plan features, limitations and exclusions is described below. In the event of any discrepancy between the information described below and the Legal Plan's Fact Sheet, the Legal Plan's Fact Sheet is controlling.

1 What benefits are provided under the Legal Plan?

To use the Legal Plan, visit www.members.legalplans.com or call 1-800-821-6400. You will need to provide your Membership Number (sent to you in January after you elect the Legal Plan during Open Enrollment).

If you call the Client Service Center, the Client Service Representative who answers your call will:

- verify your eligibility for services;
- make an initial determination of whether and to what extent your case is covered (the network attorney will make the final determination of coverage);
- give you a case number (you will need a new case number for each new case you have);
- give you the telephone number of the network attorney most convenient to you; and
- answer any questions you have about your benefits in the Legal Plan.

After you have received a case number, you will call the network attorney and identify yourself as a legal plan member. You should request an appointment for a consultation. You should be prepared to give them your case number, the name of the legal plan you belong to and the type of legal matter you are calling about. Evening and Saturday appointments may be available. If you wish, you may choose an out-of-network attorney.

In a few areas, where there are no participating law firms, you will be asked to select your own attorney and will be reimbursed for these non-network attorneys' fees based on a set fee schedule.

Plan benefits are described in the Legal Plan's Fact Sheet. Plan benefits vary based on enrollment in either the High or Low legal plan services option. The available benefits are very comprehensive, but there are limitations and other conditions which must be met. Please take time for yourself and your family to read the Fact Sheet carefully. Unless otherwise noted, all covered benefits are available to you and your covered eligible dependents. The Legal Plan pays only for attorney's legal fees. Network attorneys will charge you for court costs, filing fees, subpoena, witness fees, etc. It is suggested that you ask your attorney for an estimate for these costs before legal work begins.

2 What are the exclusions to the Plan?

Excluded services are those legal services that are not provided under the Legal Plan. Exclusions are described in the Legal Plan's Fact Sheet.

3 What about confidentiality?

Your use of the Legal Plan and the legal services is confidential. The network attorney will maintain strict confidentiality of the traditional lawyer-client relationship. The Institute will know nothing about your legal problems or the services you use under the Legal Plan. The Institute and its representatives will have access only to limited statistical information needed for orderly administration of the Legal Plan.

No one will interfere with your network attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Legal Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Legal Plan and he or she will not receive any further instructions, direction, or interference from anyone else connected with the Legal Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. The law firm providing services under the Legal Plan is responsible for all services provided by their attorneys.

You should understand that your employer and the insurer have no liability for the conduct of any network attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Legal Plan. You have the right to retain at your own expense any attorney authorized to practice law.

Network attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. You may call 1-800-821-6400 if you have a complaint about the legal services you have received or the conduct of an attorney.

4 Any limitations when a participant is enrolled in more than one legal services plan?

If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Legal Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Legal Plan, so long as you meet the eligibility requirements.

5 What if I am involved in a legal dispute with one of my dependents?

You may need legal help with a problem involving your spouse or domestic partner or your children. In some cases, both you and your spouse, domestic partner, or child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by a

network attorney under this Legal Plan. Your dependent will not be eligible for representation by a network attorney under this Legal Plan.

6 What if I am involved in a legal dispute with another employee of Southwest Research Institute?

If you or one of your covered eligible dependents is involved in a dispute with another eligible employee or that employee's dependents, the insurer will arrange for legal representation with independent and separate counsel for both parties.

7 What if the court awards attorneys' fees as part of a settlement?

If you are awarded attorneys' fees as a part of a court settlement, the insurer must be repaid from the award to the extent that it paid the fee for your attorney.

XIII Life Insurance: GROUP LIFE

A Introduction

The Group Life program is a fully-insured benefit program that provides a death benefit to the beneficiary(ies) of a covered employee in the event of a covered employee's death. The Group Life program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the Group Life program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible life insurance benefits, their respective payments and policy exclusions and limitations are contained in the Group Life Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the Group Life program?

You are eligible and required to participate in the Group Life program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

Dependents are not eligible to participate in the Group Life program.

2 How do I enroll in the Group Life program?

To participate in the Group Life program, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premium is required until the following pay period.

If you are not in active service—as defined in the Group Policy—on the date insurance would otherwise go into effect, it will be effective on the date you return to active service.

3 How is the Group Life program funded?

The Group Life program is fully funded by participant contributions on an after-tax basis via payroll deduction.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue after-tax

premium payments by converting eligible accumulated leave hours. If no leave hours are available, participants must make arrangements with the Employee Benefits Office for manual payment of premiums via personal check. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid after the termination effective date will be reversed.

As long as premiums are paid, participation in the Group Life program may continue for the period of time described in the Group Policy. At such time, participants may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

Coverage for a participant whose employment classification changes to temporary or who is out on a leave of absence may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

4 Can I cancel my enrollment in the Group Life program at any time after electing coverage?

No. Because coverage is required for all regular Institute employees, you may not cancel your coverage in the Group Life program.

5 Am I enrolled in the Group Life program when I enroll in the Section 125 Plan?

No. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain other benefits with pre-tax dollars through salary reduction. Participant contributions for the Group Life program are paid on an after-tax basis through payroll deduction.

6 What happens to my coverage in the Group Life program when my employment at the Institute ends?

Coverage in the Group Life program ends at the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. Participation cannot be continued under the COBRA program. Participation may be continued by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the Group Life program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible life insurance benefits, their respective payments and policy exclusions and limitations are contained in the Group Life Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What benefits are provided under the Group Life program?

You will receive life insurance coverage payable to your designated beneficiary(ies) or estate upon your death if it occurs while this coverage is in effect. Your coverage amount is two times your annual base salary rounded to the next highest $1,000. The coverage cannot exceed a maximum of $1,000,000.

Regular staff aged 60 or older may elect an irrevocable one-time change to one times their annual base salary.

2 Who is my beneficiary in the Group Life program?

As required by law, payments for death benefits under the Group Life program must be made to the last-named beneficiary(ies). It is imperative that regular employees check their beneficiary designations. It is a good idea to review spousal or domestic partner or minor children beneficiary designations with a legal advisor. Group Life and other beneficiary designations can be reviewed by going to Employee Self-Service through the ITC Portal on the i2net and checking on View Your Benefit Elections Report. If you want to revise any beneficiary designations, go to Update Employee Benefit Elections accessible at Employee Self-Service through the ITC Portal on the i2net. If you have any questions about how to change your designations, contact the Employee Benefits Office at (210) 522-2227.

3 How are benefits claimed and disbursed in the Group Life program?

For benefits relating to your death, your beneficiary or the administrator of your estate will need to file a claim with the insurer for benefits in the Group Life program through the Employee Benefits Office and provide evidence of your death. The Employee Benefits Office is available to provide the necessary forms, to assist with the completion of these forms, and to answer questions.

Benefits greater than $5,000 will be deposited into a free, interest-bearing account, called the NYL GBS Survivor Assurance account, in the name of the beneficiary. If your benefit is less than $5,000, New York Life will send the beneficiary a check for the total benefit amount.

4 What is the assignment of benefits option in the Group Life program?

An assignment is a process whereby a beneficiary may designate a portion of life insurance proceeds to a third party elected by the beneficiary. For example, upon the death of an employee or dependent covered under the Group Life program, the beneficiary may voluntarily elect the assignment of benefits option and designate that a portion of the life insurance proceeds be paid by the insurer directly to the funeral home or other party. The amount of benefits assigned will be reduced from the total benefit amount paid by the insurer to the beneficiary. A beneficiary must contact the Employee Benefits Office at (210) 522-2227 for assistance in utilizing the assignment of benefits option.

5 Are there any reductions in the amount of coverage in the Group Life program?

Yes. As described in the Group Policy, the Group Life program includes a provision whereby the participant's coverage is reduced upon the attainment of certain ages. The amount of life insurance coverage will be reduced by 35 percent of the pre-age 75 amount at age 75 and will be further reduced by an additional 15 percent of the pre-age 75 amount at age 80.

6 When does coverage in the Group Life program end?

Coverage in the Group Life program ends when you cease employment at the Institute or are no longer classified as a regular employee. Under certain conditions described in the Group Policy, participation may continue by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer. The premiums for continuation of group life insurance are based on the insurer's age-based rates.

7 What happens to my Group Life coverage if I am approved for long-term disability benefits?

If your disability started before July 1, 2014, your coverage in the Group Life program will remain in effect at the amount described in Question 1 until your disability claim is closed with applicable premiums paid by the Institute. If you are enrolled for Voluntary Life coverage, that premium will continue to be your responsibility.

If your disability started after June 30, 2014, your Group Life coverage will remain in effect for the first 30 months that you are no longer working or until your disability claim has been closed. During the first 12 months of an out-in-full disability, it will be your responsibility to make timely payments if you do not have accrued leave to cover this cost. If you continue to be disabled and out-in-full after 12 months, your life insurance premium will be paid by the Institute for the next 18 months. Following 30 months from your disability date, you will have Group Life coverage of $20,000 until your disability claim has been closed with the required premiums paid by the Institute. You may continue coverage after your long-term disability claim has been closed through the life insurance policy's continuation of insurance provision.

8 What is the terminal illness benefit in the Group Life program?

The Group Life program includes a one-time feature permitting payment of a portion of the participant's coverage when he or she is diagnosed as "terminally ill." This feature is referred to as the terminal illness benefit. For purposes of administering this benefit feature, terminally ill means that a participant has a life expectancy of 12 months or less. Under this benefit feature, an eligible employee may elect to receive a lump sum payment up to 75 percent of the employee's Group Life coverage, subject to a maximum benefit of $500,000. This benefit will be received by the participant as a deposit into a NYL GBS Survivor Assurance account. The remaining life insurance amount will be paid to the employee's designated beneficiary(ies) after death.

Because income received as an accelerated death benefit may be taxable, a qualified tax advisor should be consulted. Receiving the terminal illness benefit may also affect a recipient's eligibility for public assistance programs, such as Medicaid, aid to families with dependent children (ADC), and supplementary social security income (SSI). Employees considering the terminal illness benefit are advised to consult with the appropriate social service agency regarding how receiving this income may affect public assistance programs.

Eligible employees are not required to apply for the terminal illness benefit. Income from the terminal illness benefit will not affect benefits otherwise available under the Institute's retirement, health care, long-term disability, accidental death, and voluntary life insurance programs. If a terminal illness benefit is received, premiums will continue to be based on the pre-terminal illness benefit coverage amount.

9 Am I covered in the Group Life program while serving in the military reserves or National Guard for 30 days or less?

Yes. Your participation in the Group Life program will continue while you are serving in the military reserves or National Guard if you are participating in regularly scheduled or routine training of 30 days or less or attending a Service School regardless of how long it is as long as you pay the required premiums. Coverage applies during travel to and from the training or school.

10 Can I continue my participation in the Group Life program if I am called to active military duty for greater than 30 days?

Yes. You can elect to continue your participation in the Group Life program for up to 24 months after your status is approved military leave by paying the required premiums through after-tax payment.

11 Is my participation in the Group Life program effective during a family or medical leave absence or an absence due to an approved long-term disability claim?

Yes, but arrangements must be made to pay your share of premiums at employee rates by utilization of eligible accumulated leave hours or by after-tax payment. Coverage remains in effect only while premiums are fully paid.

12 What is taxable imputed income and how is it computed?

Imputed income results when the IRS value of group term life insurance coverage exceeds the premium cost paid by an employee.

There are two deductions related to the Group Life Insurance program. The deduction labeled "Group Life 2x Coverage" is the actual cost of group life insurance. The group life coverage amount is multiplied by the premium rate to determine the biweekly premium amount paid by the employee. This amount will change whenever an employee receives a salary increase which increases the life insurance coverage amount.

The second deduction is labeled “Taxable Group Life”. The IRS considers a portion of the premium for group life insurance coverage to be taxable income to the employee based on the premium amount and the employee's age as of the end of the current calendar year. Therefore, an additional earnings amount is added to the employee’s regular pay (shown as “ExLife Taxable” on the employee’s pay advice) for this amount and then this additional earnings amount is offset by an equal deduction amount. Because this is not earnings from which the employee receives additional net pay and is done only to ensure taxes are withheld based on total taxable income, a deduction is added so that the employee’s net pay is not impacted. The additional income and related deduction will change whenever an employee’s life insurance coverage amount changes or at the beginning of a new calendar year if an employee will attain a higher age during the year that aligns with a higher cost tier presented in the Group-Term Life Insurance Coverage section of IRS Publication 15-B.

XIV Life Insurance: DEPENDENT LIFE

A Introduction

The Dependent Life program is a fully-insured benefit program that provides an additional benefit when your covered dependents die. The Dependent Life program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the Dependent Life program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible life insurance benefits, their respective payments and policy exclusions and limitations are contained in the Group Life Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the Dependent Life program?

Your eligible dependents (see question 4) are eligible to participate in the Dependent Life program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Dependent Life program?

To participate in the Dependent Life program, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If you are hired in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If you are hired in the second week of the pay period, no premium is required until the following period.

If you are not in active service—as defined in the Group Policy—on the date insurance would otherwise go into effect, it will be effective on the date you return to active service.

If you declined coverage during your first 31 days of employment, you may enroll at any time by completing an electronic Benefit Change Form, and coverage will be effective as of the date the Benefit Change Form is submitted.

3 How is the Dependent Life program funded?

The Dependent Life program is fully funded by participant contributions. Participant contributions are provided by payroll deduction on an after-tax basis. On a periodic basis, the insurer may increase the required premium from participants.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue after-tax premium payments by converting eligible accumulated leave hours. If no leave hours are available, participants must make arrangements with the Employee Benefits Office for manual payment of premiums via personal check. Coverage for employees continuing enrollment through manual payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid following the termination effective date will be reversed.

As long as premiums are paid, participation in the Dependent Life program may continue for the period of time described in the Group Policy. At such time, participants may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

Coverage for a participant whose employment classification changes to temporary or who is out on a leave of absence may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

4 Who are my eligible dependents in the Dependent Life program?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee’s domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26or other children as defined by the Group Policy.

Coverage for an employee’s stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26. Coverage for an employee’s lawful spouse or domestic partner terminates on the divorce date or when a domestic partner relationship ends. The divorce date is the date the divorce decree is signed by the judge or court. The domestic partnership termination date is the date the notarized termination agreement is signed.

An eligible employee whose spouse or domestic partner is also an Institute employee may enroll one spouse or domestic partner as a dependent of the other, or each spouse or domestic partner may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as a dependent of both employees.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the Dependent Life program?

To add a new dependent, you must initiate an electronic Benefit Change Form. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

6 Can I cancel my enrollment in the Dependent Life program at any time after electing coverage?

Coverage may be cancelled at any time. If coverage is cancelled, you must submit an electronic Benefit Change Form and select coverage in the Dependent Life program if you choose to re-activate your coverage.

7 Am I enrolled in the Dependent Life program when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Dependent Life program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain benefit programs, with pre-tax dollars through salary reduction. Premiums in the Dependent Life program are paid on an after-tax basis through payroll deduction.

8 Can I continue enrollment in the Dependent Life program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for your dependent(s) in the Dependent Life program for 24 months by paying required premiums through after-tax premium payments.

9 What happens to my coverage in the Dependent Life program when my employment at the Institute ends?

Coverage in the Dependent Life program ends at the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. Continuing coverage under the COBRA program is not available. In such cases, participation may be continued by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the Dependent Life program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible life insurance benefits, their respective payments and policy exclusions and limitations are contained in the Group Life Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What benefits are provided under the Dependent Life program?

The Dependent Life program is optional life insurance protection available for coverage of eligible and enrolled dependents. Insurance coverage under this program is $20,000 for your spouse or domestic partner and $10,000 for each dependent child.

2 Who is the beneficiary for my covered dependents?

The employee is automatically the beneficiary for covered dependents.

3 How are benefits in the Dependent Life program claimed and disbursed?

Upon the death of a covered dependent, the employee will need to file a claim for Dependent Life program benefits with the insurer through the Employee Benefits Office and provide evidence of the dependent's death. The Employee Benefits Office is available to provide the necessary forms, to assist with the completion of these forms, and to answer questions.

Benefits greater than $5,000 will be deposited into a free, interest-bearing account, called the NYL GBS Survivor Assurance account, in the name of the employee, as the beneficiary. If your benefit is less than $5,000, New York Life will send the beneficiary a check for the total benefit amount.

4 What is the assignment of benefits option?

An assignment is a process whereby a beneficiary may designate a portion of life insurance proceeds to a third party elected by the beneficiary. For example, upon the death of a covered dependent under the Dependent Life program, the employee or the designated beneficiary may voluntarily elect the assignment of benefits option and designate that a portion of the life insurance proceeds be paid by the insurer directly to the funeral home or other party. The amount of benefits assigned will be reduced from the total benefit amount paid by the insurer to the beneficiary. You must contact the Employee Benefits Office at (210) 522-2227 for assistance in utilizing the assignment of benefits option.

5 What is the terminal illness benefit?

The Dependent Life program includes a one-time feature permitting payment of a portion of the participant's coverage when he or she is diagnosed as "terminally ill." This feature is referred to as the terminal illness benefit. For purposes of administering this benefit feature, terminally ill means that a participant has a life expectancy of 12 months or less. Under this benefit feature, an eligible dependent may elect to receive a lump sum payment up to 75 percent of the Dependent Life coverage, subject to a maximum benefit of $500,000. This benefit will be received by the participant as a deposit into a NYL GBS Survivor Assurance account. The remaining life insurance amount will be paid after death to the employee as the designated beneficiary of the dependent.

Because income received as an accelerated death benefit may be taxable, a qualified tax advisor should be consulted. Receiving the terminal illness benefit may also affect a recipient's eligibility for public assistance programs, such as Medicaid, aid to families with dependent children (ADC), and supplementary social security income (SSI). Employees considering the terminal illness benefit are advised to consult with the appropriate social service agency regarding how receiving this income may affect public assistance programs.

Eligible dependents are not required to apply for the terminal illness benefit. Income from the terminal illness benefit will not affect benefits otherwise available under the Institute's retirement, health care, long-term disability, accidental death, and voluntary life insurance programs. If a terminal illness benefit is received, premiums will continue to be based on the pre-terminal illness benefit coverage amount.

6 When does Dependent Life coverage end?

Coverage in the Dependent Life program ceases when your employment at the Institute ends, you are no longer classified as a regular employee, your dependent reaches the maximum age of 26, or when you fail to make the required premium payments. As long as coverage did not end due to the failure to make the required premium payments, you may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

XV Life Insurance: VOLUNTARY LIFE

A Introduction

The Voluntary Life program is a fully-insured benefit program that provides an additional benefit when you and your covered dependents die. The Voluntary Life program is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the Voluntary Life program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible life insurance benefits, their respective payments and policy exclusions and limitations are contained in the Group Life Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this the information described below and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the Voluntary Life program?

You and your eligible dependents (see question 4) are eligible to participate in the Voluntary Life program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Voluntary Life program?

To participate in the Voluntary Life program, you must complete, sign, and submit an electronic Benefit Enrollment Change Form within the first week of your employment; coverage will be effective as of your hire date. If you enroll within the first 31 days of your employment or a life status change, coverage for the Guaranteed Issue amount, defined in Section C., *Summary of Benefits, Limitations and Exclusions*, will be provided without approval required from the insurer of your evidence of insurability. If your hire date is during the first week of the pay period, a full bi-weekly premium is required for the full payroll period. If your hire date is during the second week of the pay period, no premium is required until the following pay period.

If you declined coverage during your first 31 days of employment or wish to increase your coverage amount, you can enroll at any time by completing an electronic Benefit Change Form and submitting the required evidence of insurability form to the Employee Benefits Office for approval by the insurer. Once your evidence of insurability has been approved by the insurer, coverage will be effective, and the required premiums will be paid.

If you are not in active service—as defined in the Group Policy—on the date your initial insurance or any increase in coverage amount would otherwise go into effect, it will be effective on the date you return to active service.

3 How is the Voluntary Life program funded?

The Voluntary Life program is fully funded by participant contributions. Participant contributions are provided by payroll deduction on an after-tax basis. On a periodic basis, the insurer may increase the required premium from participants. Premiums are based on age and increase when an enrolled employee or dependent attains a higher premium age group, as described in the Group Policy.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue after-tax premium payments by converting eligible accumulated leave hours. If no leave hours are available, participants must make arrangements with the Employee Benefits Office for manual payment of premiums via personal check. Coverage for employees continuing enrollment through manual payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid following the termination effective date will be reversed.

As long as premiums are paid, participation in the Voluntary Life program may continue for the period of time described in the Group Policy. At such time, participants may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

Coverage for a participant whose employment classification changes to temporary or who is out on a leave of absence may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

4 Who are my eligible dependents in the Voluntary Life program?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26 or other children as defined in the Group Policy.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26. Coverage for an employee's lawful spouse or domestic partner terminates on the

divorce date or the termination of the domestic partnership. The divorce date is the date the divorce decree is signed by the judge or court. The domestic partnership termination date is the date the notarized termination agreement is signed.

An eligible employee whose spouse or domestic partner is also an Institute employee may enroll one spouse or domestic partner as a dependent of the other, or each spouse or domestic partner may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as a dependent of both employees.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the Voluntary Life program?

To add a new dependent, you must initiate an electronic Benefit Change Form and add your dependent to the Voluntary Life Program. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic b Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you enroll or increase coverage within the first 31 days of your life status change, coverage for the Guaranteed Issue amount for you and your dependents, defined in Section C., *Summary of Benefits, Limitations and Exclusions*, will be provided without approval required from the insurer of your evidence of insurability. When adding a new spouse or domestic partner within 31 days of marriage, coverage for the new spouse or domestic partner in excess of $75,000 up to the program maximum of $150,000 will not begin until the evidence of insurability is approved by the insurer.

6 Can I cancel my enrollment in the Voluntary Life program at any time after electing coverage?

Coverage may be cancelled at any time. If coverage is cancelled, you must submit evidence of insurability and receive approval from the insurer if you choose to re-activate your coverage.

7 Am I enrolled in the Voluntary Life program when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Voluntary Life program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in certain benefit programs, with pre-tax dollars through

salary reduction. Premiums in the Voluntary Life program are paid on an after-tax basis through payroll deduction.

8 Can I continue my enrollment in the Voluntary Life program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for their dependents in the Voluntary Life program for 24 months by paying required premiums through after-tax premium payments.

9 What happens to my coverage in the Voluntary Life program when my employment at the Institute ends?

Coverage in the Voluntary Life program ends at the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. Continuing coverage under COBRA is not available. In such cases, an employee may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the Voluntary Life program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible life insurance benefits, their respective payments and policy exclusions and limitations are contained in the Group Life Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What benefits are provided under the Voluntary Life program?

The Voluntary life program is an optional program that is available for regular employees and an eligible spouse and/or dependent(s). The cost of this coverage is based on age and fully paid by the employee.

Eligible employees may choose voluntary life insurance protection in increments of $10,000 to a maximum of the lesser of $1,000,000 or 7 times base salary. Coverage over $500,000 is subject to a medical review by the insurer. The first $500,000 of coverage (or 7 times base salary, if lower) is referred to as the Guaranteed Issue amount. The Guaranteed Issue amount is only available if coverage is elected during the first 31 days of eligibility or within 31 days of a life status change. After this period, all coverage is subject to submission of evidence of insurability and must be approved by the insurer.

Spouse or domestic partner coverage is available in increments of $5,000 up to a maximum of the lesser of 100 percent of the employee's coverage or $150,000. Coverage over $75,000 requires evidence of insurability and must be approved by the insurer. The first $75,000 of coverage is referred to as the Guaranteed Issue amount.

Coverage for eligible children is $10,000 per child and is the Guaranteed Issue amount.

During the Institute's Open Enrollment period:

- an eligible employee not enrolled in voluntary life insurance or who has less than $100,000 of coverage can add/increase voluntary life coverage up to $100,000 without answering health questions.
- an eligible employee with voluntary life coverage greater than $100,000 but less than $500,000 and no more than 7 times their annual salary may increase their voluntary life coverage by $10,000 without answering health questions.
- any coverage amounts requested for the eligible employee's spouse or domestic partner during open enrollment will require answering health questions.
- Coverage requested for eligible child dependent(s) do not require health questions.

2 Who is the employee's beneficiary in the Voluntary Life program?

As required by law, payments for death benefits under the Voluntary Life program must be made to the last-named beneficiary(ies). It is imperative that regular employees check their beneficiary designations. It is a good idea to review spousal or domestic partner or minor children beneficiary designations with a legal advisor. Voluntary Life and other beneficiary designations can be reviewed by going to Employee Self-Service through the ITC Portal on the i2net and checking on View Your Benefit Elections Report. If you want to revise your beneficiaries, go to Update Employee Benefit Elections accessible at Employee Self-Service through the ITC Portal on the i2net. If you have any questions about how to change your beneficiary(ies), contact the Employee Benefits Office at (210) 522-2227.

3 Who is the beneficiary for covered dependents in the Voluntary Life program?

The employee is automatically the beneficiary for covered dependents.

4 How are benefits in the Voluntary Life program claimed and disbursed?

For Voluntary Life benefits relating to your death, your beneficiary or the administrator of your estate will need to file a claim with the insurer through the Employee Benefits Office and provide evidence of your death. For Voluntary Life benefits relating to the death of a covered spouse or domestic partner or child, the employee will need to file a claim with the insurer through the Employee Benefits Office and provide evidence of the spouse or domestic partner or child's death. The Employee Benefits Office is available to provide the necessary forms, to assist with the completion of these forms, and to answer questions.

Benefits greater than $5,000 will be deposited into a free, interest-bearing account, called the NYL GBS Survivor Assurance account, in the name of the beneficiary. If your benefit is less than $5,000, New York Life will send the beneficiary a check for the total benefit amount.

5 What is the assignment of benefits option?

An assignment is a process whereby a beneficiary may designate a portion of insurance proceeds to a third party elected by the beneficiary. For example, upon the death of an employee or dependent covered under the Voluntary Life program, the beneficiary may voluntarily elect the assignment of benefits option and designate that a portion of the Voluntary Life benefits be paid by the insurer directly to the funeral home or other party. The amount of benefits assigned will be reduced from the total benefit amount paid by the insurer to the beneficiary. You must contact the Employee Benefits Office at (210) 522-2227 for assistance in utilizing the assignment of benefits option.

6 What is the terminal illness benefit in the Voluntary Life program?

The Voluntary Life program includes a one-time feature permitting payment of a portion of the participant's coverage when he or she is diagnosed as "terminally ill." This feature is referred to as the terminal illness benefit. For purposes of administering this benefit feature, terminally ill means that a participant has a life expectancy of 12 months or less. Under this benefit feature, an enrolled employee or dependent may elect to receive a lump sum payment up to 75 percent of the Voluntary Life coverage, subject to a maximum benefit of $500,000. This benefit will be received by the participant as a deposit into a NYL GBS Survivor Assurance account. The remaining life insurance amount will be paid to the designated beneficiary(ies) after death.

Because income received as an accelerated death benefit may be taxable, a qualified tax advisor should be consulted. Receiving the terminal illness benefit may also affect a recipient's eligibility for public assistance programs, such as Medicaid, aid to families with dependent children (ADC), and supplementary social security income (SSI). Employees considering the terminal illness benefit are advised to consult with the appropriate social service agency regarding how receiving this income may affect public assistance programs.

Enrolled employees and dependents are not required to apply for the terminal illness benefit. Income from the terminal illness benefit will not affect benefits otherwise available under the Institute's retirement, health care, long-term disability, accidental death, and voluntary life insurance programs. If a terminal illness benefit is received, premiums will continue to be based on the pre-terminal illness benefit coverage amount.

7 Are there any exclusions under the Voluntary Life program?

Benefits will not be paid for any covered death which, directly or indirectly, in whole or in part, is caused by or results from any of the circumstances described in the Group Policy. These exclusions include that during the first 24 months of initial coverage or increased coverage, applicable Voluntary Life benefits are not paid when the death is due to suicide.

XVI LONG-TERM DISABILITY

A Introduction

The Long-Term Disability (LTD) program is an insurance program which provides disability income benefits for covered employees who are unable to work due to an illness/injury, are under the care of a medical professional, and whose disability claim has been approved by the insurer after meeting the benefit elimination period as defined in the Group Policy. The LTD program is described below in the Southwest Research Institute Employees' Long-Term Disability Income Benefits Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Long-Term Disability Income Benefits Plan in any way. The actual Southwest Research Institute Employees' Long-Term Disability Income Benefits Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Long-Term Disability Income Benefits Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Long-Term Disability Income Benefits Plan documents, Southwest Research Institute Employees' Long-Term Disability Income Benefits Plan documents are controlling. Terms and conditions of coverage for the LTD program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible disabilities, disability payment duration and policy exclusions and limitations are contained in the Group Long-Term Disability Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the LTD program?

You are eligible and required to participate in the LTD program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

Dependents are not eligible to participate in the LTD program.

2 How do I enroll in the LTD program?

Since LTD is a mandatory benefit, you are automatically enrolled in the LTD program as of your hire date, and you will complete, sign, and submit an electronic Benefit Enrollment Change Form within the first week of your employment. If your hire date is in the first week of the pay period, a full bi-weekly premium will be required in the first pay period. If your hire date is in the second week of the pay period, no premium is required until the following pay period.

3 How is the LTD program funded?

The LTD program is funded by Institute and participant contributions. On a periodic basis, Institute senior management reviews and approves participant contributions. Participant contributions are provided by salary reduction on a pre-tax basis.

No premium is required for participants whose claim has been approved and are receiving LTD benefits.

Participants on family and medical leave or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid following the termination effective date will be reversed.

As long as premiums are paid, participation may continue for the period of time described in the Group Policy. At such time, participants may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

Coverage for a participant whose employment classification changes to temporary or who is out on a leave of absence may elect to continue to participate by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

4 Can I cancel my enrollment in the LTD program at any time after electing coverage?

No. Because coverage in the LTD program is required for all regular Institute employees, you may not cancel your coverage.

5 Am I enrolled in the LTD Program when I enroll in the Section 125 Plan?

No. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in the LTD program and certain other benefits with pre-tax dollars through salary reduction. Since LTD is a mandatory benefit, you are automatically enrolled in the LTD program as of your hire date, and you will complete, sign and submit an electronic Benefit Enrollment Change Form within the first week of your employment.

6 Can I continue enrollment in the LTD program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation in the LTD program for 24 months by paying required premiums through after-tax premium payments.

7 What happens to my enrollment in the LTD program when my employment at the Institute ends?

Enrollment in the LTD program ceases when an employee's employment as a regular full-time employee or part-time employee ends. Enrollment cannot be continued under the COBRA program. Enrollment may continue by contacting the Employee Benefits Office for an application to continue coverage and the participant submits the application directly to the insurer within 31 days of the date coverage ends. If coverage is continued, required premiums are paid by the participant directly to the insurer.

When employment ends prior to the last day of a pay period, coverage will end on the last day of the pay period and your last paycheck will include a full biweekly premium by salary reduction.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the LTD program are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible disabilities, payment duration and policy exclusions and limitations are contained in the Group Long-Term Disability Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the group policy, the information in the Group Policy takes precedence.

1 What are the requirements for disability benefits in the LTD program?

For purposes of the LTD program and the underlying group long-term disability insurance policy, you qualify for disability benefits when you have met the benefit elimination period of 90 continuous or aggregated days of absence, as defined in the Group Policy, have met the requirements described in the Group Policy, and your disability claim is approved by the insurer.

If your claim for disability benefits is approved, continuation of long-term disability benefits is subject to your compliance with requests by the insurer to submit supporting medical documentation and to cooperate in medical examinations deemed necessary to support your claim. You must continue to be under the regular care of a physician.

2 What if I return to work during the benefit elimination period but subsequently am unable to perform my job?

If you return to work before the completion of the benefit elimination period and subsequently are unable to perform your regular occupation due to the same disability, you may resume the continuous absence requirement without restarting a new benefit elimination period if you meet the requirements described in the Group Policy.

In such situations, the period in which you return to work may not exceed 30 work days. The total days absent related to the disability count toward the benefit elimination period.

3 What income benefit is paid by the LTD program?

Once approved by the LTD insurer, benefits in the LTD program pay you a monthly disability income benefit that is the lesser of 60 percent of your monthly earnings (one-twelfth of your annual base salary) or $15,000. This amount will be reduced for certain “other benefits” as described in the Group Policy.

4 How long does it usually take to receive the first benefit income check?

It usually takes the insurer at least 4 to 6 weeks to make a claim decision once all completed claim information is received and you have met a 90-day elimination period. The first check for an approved claim is a partial monthly benefit to cover the 91st day through the end of the month. Thereafter, monthly income benefits are paid at the end of each 30-day period for which a benefit is due.

5 If I elect to receive retirement program benefits under the Southwest Research Institute retirement program, will my retirement income benefits reduce my disability income benefit?

No. Your Institute retirement program benefits are not considered in other benefits that will reduce your monthly disability income benefit. You must end your employment at the Institute to begin receiving your Institute retirement program income.

6 What happens to my disability income if I return to work on a part-time basis?

As described in the Group Policy, the monthly disability income benefit that you receive for your first 24 monthly payments will not be reduced for monthly earnings unless the sum of your monthly income benefit, income from other sources, and earnings while disabled exceed 100 percent of your monthly base salary. After the first 24 months of partial disability, the insurer's monthly benefit formula will change. For more information, contact the insurer or the Employee Services Section of the Human Resources Department at (210) 522-6225.

7 When do monthly LTD disability income benefits end?

Your monthly LTD disability income benefits will end when you no longer meet the insurer's definition of a disability as described in the Group Policy or you attain the maximum age benefit described in the Group Policy.

8 When must I apply for a Social Security disability benefit if my claim is approved?

The LTD insurer will notify you when to apply for a Social Security disability benefit. The LTD insurer will offset your disability income benefit for estimated Social Security disability benefits payable unless the required application for benefits and proof of loss have been filed with and declined by the Social Security Administration (SSA). If you are denied social security disability benefits, the LTD insurer may assist you in pursuing an appeal of that decision.

9 If I am approved for a Social Security disability benefit, will my disability income be reduced?

If your claim is approved by the SSA, you will receive a benefit from the SSA, and your disability income from the LTD insurer will be reduced as described in the Group Policy.

10 Are there any exclusions under the LTD program?

Yes. Benefits will not be paid for any injury or illness which, directly or indirectly, in whole or in part, is caused by or results from any of the circumstances described in the Group Policy.

11 What if I have successive periods of disability?

As described in the Group Policy, when two disability periods are less than 12 months apart and result from the same cause, the separate periods will be considered one period of disability. When two disability periods from unrelated causes are separated by at least one full-day return to active service, each period will be considered a separate disability period. If you return to work 12 months or more, any recurrence of the same disability will be treated as a new disability. The new disability is subject to meeting a new 90-day benefit elimination period and a new maximum duration of benefits as described in the Group Policy.

12 What is the Survivor Benefit?

As described in the Group Policy, if you were receiving a monthly disability benefit from the LTD insurer at the time of your death, the insurer may pay a survivor benefit.

13 Are disability income benefit payments subject to social security and federal income taxes?

All disability income paid is fully taxable for purposes of social security and federal income taxes. You will receive an IRS Form W-2 from the insurer related to the disability income benefit received from the insurer each calendar year. Because your disability income is taxable, the insurer will provide you with instructions on how to request federal tax withholding at the time your disability claim is approved.

14 Will I need to continue long-term disability premium payments once my disability claim is approved?

Once your disability claim has been approved and you are receiving disability benefits, your employment status will be changed to out-in-full long-term disability status. In this status your premiums to the LTD program will cease until a full return to work is made.

15 How do I file a claim for LTD benefits?

A claim for disability income benefits should be filed at the time one realizes that the recovery time for an injury or illness (disabling event) will probably exceed 90 days. To file a claim, you must complete and sign an LTD application. An Institute LTD claim coordinator from the Employee Services Section of the Human Resources Department will assist you through this process in obtaining employer information required by the insurer. You will need to furnish the LTD insurer with a signed authorization to obtain medical information from your physician. An Institute LTD claim coordinator will send your LTD application form to the insurer and assist the insurer as needed in processing your claim.

If you receive a written notice of denial, you or your authorized representative may submit an appeal of the denial by giving written notice to the insurer and following the process and time frames described in the Group Policy.

XVII Medical: KAISER HMO

A Introduction

The Kaiser HMO plan is a fully-insured medical plan which provides benefits for covered medical, behavioral health and pharmacy services to eligible participants enrolled in the plan. The Kaiser HMO plan is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Benefits, limitations, exclusions, and other features of the Kaiser HMO plan are described in the Kaiser HMO Evidence of Coverage available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

B Eligibility and Participation

1 Who is eligible to participate in the Kaiser HMO plan?

You and your eligible dependents (see question 4) are eligible to participate in the Kaiser HMO plan if you are employed by the Institute in the Boulder, Colorado office as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. You must also reside in an area serviced by the Kaiser HMO plan. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Kaiser HMO plan?

To participate in the Kaiser HMO plan, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premium is required until the following pay period.

If you have declined coverage and now wish to elect it or need to change your current enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

Further information on qualifying events for which enrollment changes can be submitted outside of Open Enrollment is included in Section III, *Section 125 Plan*.

3 How is the Kaiser HMO plan funded?

The Kaiser HMO plan is funded by Institute and participant contributions. On an annual basis, Institute senior management reviews and approves participant contributions. Participant contributions are provided by salary reduction on a pre-tax basis.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid service dates following the termination effective date will be reversed.

As long as premiums are paid, participation may continue until the employee's employment ends or the employee no longer meets the eligibility to participate in the Kaiser HMO plan. In this case, coverage may be continued by electing continuation coverage under COBRA; further information on COBRA is described in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

A participant whose employment classification changes to temporary or who is out on a leave of absence may continue to participate if electing continuation coverage under COBRA. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

4 Who are my eligible dependents in the Kaiser HMO plan?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26 or an individual described in the Kaiser HMO Evidence of Coverage as a dependent child.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26.

Coverage for an employee's lawful spouse or domestic partner terminates on the divorce date or the termination of the domestic partnership. The divorce date is the date the divorce decree is signed by the judge or court. The domestic partnership termination date is the date the notarized termination agreement is signed.

An eligible employee whose spouse or domestic partner is also an Institute employee may enroll one spouse or domestic partner as a dependent of the other, or each spouse or domestic partner may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as a dependent of both employees.

A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the Kaiser HMO plan?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the Kaiser HMO plan at any time after electing coverage?

Unless you have a qualifying event, coverage in the Kaiser HMO plan may only be cancelled during the annual Open Enrollment period, and coverage will terminate as of the end of the current calendar year.

7 Am I enrolled in the Kaiser HMO plan when I enroll in the Section 125 Plan?

No. You must complete a separate enrollment form for participation in the Kaiser HMO plan. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in the Kaiser HMO plan, as well as certain other benefits, with pre-tax dollars through salary reduction.

8 Can I continue my enrollment in the Kaiser HMO plan if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in the Kaiser HMO plan for 24 months under COBRA. Premiums are available by contacting the Employee Benefits Office at (210) 522-2227.

9 What happens to my coverage in the Kaiser HMO plan when my employment at the Institute ends?

Coverage in the Kaiser HMO plan ends at the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. In such cases, participation may continue if the employee elects to continue coverage under the COBRA program and pays the required premiums. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

C Summary of Benefits, Limitations and Exclusions

Benefits, limitations, and exclusions of the Kaiser HMO plan are described fully in the Kaiser HMO Evidence of Coverage available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

XVIII Medical: UNITEDHEALTHCARE CHOICE EPO

A Introduction

The Choice EPO plan is a self-insured medical plan which provides benefits for covered medical, behavioral health, and pharmacy services. The Choice EPO plan is included in the Southwest Research Institute Employees' Health Care Expense Benefits Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Health Care Expense Benefits Plan in any way. The actual Southwest Research Institute Employees' Health Care Expense Benefits Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Health Care Expense Benefits Plan from time to time. In the event of any discrepancy between information included in this SPD for the Choice EPO plan and the Southwest Research Institute Employees' Health Care Expense Benefits Plan documents, the Southwest Research Institute Employees' Health Care Expense Benefits Plan documents are controlling. Benefits, limitations, exclusions, and other features of the Choice EPO plan are described in the separate Choice EPO plan Summary Plan Description available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

B Eligibility and Participation

1 Who is eligible to participate in the Choice EPO plan?

You and your eligible dependents (see question 4) are eligible to participate in the Choice EPO plan if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Choice EPO plan?

To participate in the Choice EPO plan, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the period, no premium is required until the following pay period.

If you have declined coverage and now wish to elect it or need to change your current enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

Further information on qualifying events for which enrollment changes can be submitted outside of the Open Enrollment period is included in Section III, *Section 125 Plan*.

3 How is the Choice EPO plan funded?

The Choice EPO plan is funded by Institute and participant contributions. On an annual basis, Institute senior management reviews and approves participant contributions. Participant contributions are provided by salary reduction on a pre-tax basis.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid for service dates following the termination effective date will be reversed.

As long as premiums are paid, participation may continue until the employee's employment ends or the employee no longer meets the eligibility to participate in the Choice EPO plan. In this case, coverage may be continued by electing continuation coverage under COBRA; further information on COBRA is described in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

A participant whose employment classification changes to temporary or who is out on a leave of absence may continue to participate if electing continuation coverage under COBRA. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

4 Who are my eligible dependents in the Choice EPO plan?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26:

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26.

Coverage for an employee's lawful spouse or domestic partner terminates on the divorce date or the termination of the domestic partnership. The divorce date is the date the divorce decree is signed by the judge or court. The domestic partnership termination date is the date the notarized termination agreement is signed.

An eligible employee whose spouse or domestic partner is also an Institute employee may enroll one spouse or domestic partner as a dependent of the other, or each spouse or domestic partner may be enrolled

separately, but an eligible employee may not be enrolled as both an employee and a spouse or domestic partner. Eligible dependents may be enrolled under either spouse or domestic partner but cannot be enrolled as dependents of both employees.

A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the Choice EPO plan?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the Choice EPO plan at any time after electing coverage?

No. Unless you have a qualifying event, coverage in the Choice EPO Plan may only be cancelled during the annual Open Enrollment period, and coverage will terminate as of the end of the current calendar year.

7 Am I enrolled in the Choice EPO plan when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Choice EPO plan. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in the Choice EPO plan, as well as the cost of certain other benefits, with pre-tax dollars through salary reduction.

8 Can I continue my enrollment in the Choice EPO plan if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in the Choice EPO plan for 24 months under COBRA. Premiums are available by contacting the Employee Benefits Office at (210) 522-2227.

9 What happens to my coverage in the Choice EPO plan when my employment at the Institute ends?

Coverage in the Choice EPO plan ends at the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. In such cases, participation may continue if the employee elects to continue coverage under the COBRA program and pays the required premiums. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

C Summary of Benefits, Exclusions and Limitations

Benefits, limitations and exclusions of The Choice EPO plan are described fully in the separate UnitedHealthcare Choice EPO plan Summary Plan Description available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

D Notices

1 What are Patient Protection Notices?

If required, UnitedHealthcare generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in UnitedHealthcare's 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, contact UnitedHealthcare at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from UnitedHealthcare 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 UnitedHealthcare's 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, contact UnitedHealthcare at the number on your ID card.

2 What is the Women's Health and Cancer Rights Act of 1998?

As required by the Women's Health and Cancer Rights Act of 1998, the Choice EPO plan provides Benefits under the Choice EPO plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

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

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

3 What is the Statement of Rights under the Newborns' and Mothers' Health Protection Act?

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Choice EPO plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify UnitedHealthcare. For information on notification or prior authorization, contact your issuer.

4 What is the Premium Assistance Program?

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the states listed on the following website, you may be eligible for assistance paying your employer health plan premiums. This site contains a list of states. Contact your State for more information on eligibility – https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf.

XIX Medical: UNITEDHEALTHCARE TEXAS PREMIER CHOICE

A Introduction

The Texas Premier Choice plan is a fully-insured medical plan which provides benefits for covered medical, behavioral health and pharmacy services. The Texas Premier Choice plan is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Benefits, limitations, exclusions, and other features of the Texas Premier Choice plan are described in the Texas Premier Choice plan Certificate of Coverage available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

B Eligibility and Participation

1 Who is eligible to participate in the Texas Premier Choice plan?

You and your eligible dependents (see question 4) are eligible to participate in the Texas Premier Choice plan if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan document.

2 How do I enroll in the Texas Premier Choice plan?

To participate in the Texas Premier Choice plan, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premium is required until the following pay period.

If you have declined coverage and now wish to elect it or need to change your current enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

Further information on qualifying events for which enrollment changes can be submitted outside of Open Enrollment is included in Section III, *Section 125 Plan*.

3 How is the Texas Premier Choice plan funded?

The Texas Premier Choice plan is funded by Institute and participant contributions. On an annual basis, Institute senior management reviews and approves participant contributions. Participant contributions are provided by salary reduction on a pre-tax basis.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid for service dates following the termination effective date will be reversed.

As long as premiums are paid, participation may continue until the employee's employment ends or the employee no longer meets the eligibility to participate in the Texas Premier Choice plan. In this case, coverage may be continued by electing continuation coverage under COBRA; further information on COBRA is described in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227

A participant whose employment classification changes to temporary or who is out on a leave of absence may continue to participate if electing continuation coverage under COBRA. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

4 Who are my eligible dependents in the Texas Premier Choice plan?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26 or other children as defined in the Group Policy as an eligible dependent.;
- Individual described in the Texas Premier Choice plan Certificate of Coverage as a dependent child.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26.

Coverage for an employee's lawful spouse or domestic partner terminates on the divorce date. The divorce date is the date the divorce decree is signed by the judge or court.

An eligible employee whose spouse is also an Institute employee may enroll one spouse as a dependent of the other, or each spouse may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse. Eligible dependents may be enrolled under either spouse but cannot be enrolled as dependents of both employees.

A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the Texas Premier Choice plan?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the Texas Premier Choice plan at any time after electing coverage?

No. Unless you have a qualifying event, coverage in the Texas Premier Choice plan may only be cancelled during the annual Open Enrollment period, and coverage will terminate as of the end of the current calendar.

7 Am I enrolled in the Texas Premier Choice plan when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Texas Premier Choice plan. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in the Texas Premier Choice plan, as well as cost of certain other benefits, with pre-tax dollars through salary reduction.

8 Can I continue my enrollment in the Texas Premier Choice plan if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in the Texas Premier Choice plan for 24 months under COBRA. Premiums are available by contacting the Employee Benefits Office at (210) 522-2227.

9 What happens to my coverage in the Texas Premier Choice plan when my employment at the Institute ends?

Coverage in the Texas Premier Choice plan ends at the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. In such cases, participation may continue if the employee elects to continue coverage under the COBRA program and pays the required premiums. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

C Summary of Benefits, Limitations and Exclusions

Benefits, limitations and exclusions of the Texas Premier Choice plan are described fully in the UnitedHealthcare Texas Premier Choice plan Certificate of Coverage available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

XX Medical: TRICARE SUPPLEMENTAL

A Introduction

The TRICARE Supplemental insurance program is provided by Selman Company. This program is not subject to ERISA. Information regarding the TRICARE Supplemental insurance program is available on the Employee Benefits website.

As required by the Warner Act, the Institute may only collect and remit premiums for eligible employees who enroll and participate in the TRICARE Supplemental insurance programs. The cost of this program is entirely paid by participants.

XXI Flexible Spending Account: DEPENDENT CARE REIMBURSEMENT ACCOUNT

A Introduction

The Dependent Care Reimbursement Account program provides a method through which you can accumulate pre-tax funds for reimbursing yourself for eligible child or elder care expenses or day care for a disabled dependent while you are employed. Generally, using pre-tax dollars to pay for your eligible dependent care costs will result in tax savings. Current tax law also allows a tax credit for dependent care expenses paid with after-tax dollars. You should determine which method is best for you.

The Dependent Care Reimbursement Account program is included in the Southwest Research Section 125 Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Section 125 Plan in any way. The actual Southwest Research Institute Section 125 Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Section 125 Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Section 125 Plan documents, the Southwest Research Institute Section 125 Plan documents are controlling.

B Eligibility and Participation

1 Who is eligible to participate?

You are eligible to participate in the Dependent Care Reimbursement Account program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary and leased employees are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan document.

Under current Internal Revenue Service regulations, to participate in the Dependent Care Reimbursement Account program, you must be employed and satisfy one of the following requirements:

- You must be single; or
- You and your spouse must both be employed; or
- Your spouse must be a full-time student for five months of the calendar year or totally disabled.

2 How do I enroll in the Dependent Care Reimbursement Account program?

To participate in the Dependent Care Reimbursement Account program, you must complete, sign, and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full biweekly salary reduction is required for the first payroll period. If your hire date is in the second week of the pay period, no salary reduction is required until the follow pay period.

If you have declined coverage and now wish to elect it or you need to change your current enrollment elections in the Dependent Care Reimbursement Account program, you can do so at the earliest of one of the

following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Changes to the amount of your future contributions for the Dependent Care Reimbursement Account program due to a qualifying event must be consistent with the qualifying event. For example, you may only increase and cannot decrease your contribution due to the birth of a child.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

Further information on qualifying events for which enrollment changes can be submitted is included in Section III, *Section 125 Plan*.

3 How is the Dependent Care Reimbursement Account funded?

The Dependent Care Reimbursement Account program is funded entirely by participant contributions. During the annual Open Enrollment period, you will have the opportunity to decide for the following calendar year how much of your annual base salary, if any, you want deducted each pay period and deposited in your Dependent Care Reimbursement Account.

Participants in long-term disability, family and medical leave, or leave without pay status must pay their bi-weekly participant contributions throughout such periods to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent.

A participant whose employment classification changes to temporary or who is out on a leave of absence may not continue to contribute under COBRA, however any positive Dependent Care Reimbursement Account balance may be reimbursed by submitting claims for services incurred prior to his or her change in classification.

4 Am I enrolled in the Dependent Care Reimbursement Account program when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Dependent Care Reimbursement Account program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in the Dependent Care Reimbursement Account program, as well as certain other benefits, with pre-tax dollars through salary reduction.

5 What happens to my participation in the Dependent Care Reimbursement Account program when my employment at the Institute ends?

Participation in the Dependent Care Reimbursement Account program ends when an employee's employment as a regular full-time employee or part-time employee ends. Any unreimbursed funds in your Dependent Care

Reimbursement Account may be reimbursed by submitting claims for services incurred prior to the termination date.

When employment ends prior to the last day of a pay period, your last paycheck will include a full biweekly salary reduction; no prorated premium reimbursement is made for days not worked in the payroll period.

C Summary of Benefits, Limitations and Exclusions

1 How does the Dependent Care Reimbursement Account work?

The purpose of this account is to provide a method through which you can accumulate pre-tax funds for reimbursing yourself for child or elder care expenses or day care for a disabled dependent while you are employed. Generally, using pre-tax dollars to pay for your eligible dependent care costs will result in substantial tax savings. Current tax law does allow a tax credit for dependent care expenses paid with after-tax dollars. You should determine which alternative is best for you, especially if you and your spouse have a combined adjusted gross income of less than $24,000.

Before the beginning of each calendar year, you will have the opportunity during Open Enrollment to decide how much of your annual base salary, if any, you want deducted each pay period and deposited in your Dependent Care Reimbursement Account. The annual amount you can set aside for this purpose is typically limited to the lesser of your earned income, your spouse's earned income, $5,000 ($192.31 per pay period), or $2,500 ($96.15 per pay period) if you are married and file separate federal income tax returns. Your annual deposit can be no more than your earnings or your spouse's earnings, whichever amount is less. Your spouse - if a full-time student or incapable of caring for himself or herself - is deemed to have earnings of $200 per month ($400 if there are two or more dependents) for each month such status or condition continues. On your Open Enrollment Form, indicate the amount of money you wish to have set aside from each paycheck and credited to your Dependent Care Reimbursement Account if you intend to establish such an account.

2 What expenses are eligible for your Dependent Care Reimbursement Account?

For eligible expenses to be reimbursable from a Dependent Care Reimbursement Account, you must be employed and must satisfy one of the following requirements. First:

- You must be single; or
- You and your spouse must both be employed; or
- Your spouse must be a full-time student for five months of the calendar year or totally disabled.

Then, you must satisfy all of the following requirements:

- The dependent care service must be incurred during the calendar year and enable you to be employed.
- The dependent care service must be provided by someone who is not your dependent for income tax purposes.
- If the dependent care service is provided outside your home by a facility that cares for six or more children, it must be a “qualified day care center.”

If you satisfy the above requirements, your eligible day care expenses for reimbursement from a Dependent Care Reimbursement Account are restricted to costs for services provided for:

- A dependent who is under age 13; or
- Your spouse or an adult dependent, if she/he is physically or mentally incapable of taking care of her/himself. (Nursing home care expenses are eligible only if the dependent spends at least eight hours a day in your home.)

Expenses for an overnight camp are not covered or eligible for reimbursement.

For purposes of Dependent Care Reimbursement Account program, eligible day care expenses are only permitted for reimbursement for an individual who either (1) a dependent of the taxpayer (as defined in Code Section §152(a)(1)) who has not attained age 13, or (2) the spouse or other dependent of the taxpayer who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the taxpayer for more than one-half of the taxable year. An individual is considered to be physically or mentally incapable of caring for himself or herself if, because of a physical or mental defect, the individual is "incapable of caring for his or her hygiene or nutritional needs or requires full-time attention of another person for his or her own safety or the safety of others." The mere fact that an individual is unable to engage in substantial gainful activity or to perform the normal household functions of a homemaker or care for minor children is not sufficient.

Under current IRS regulations, the dependent care reimbursement account cannot be used for dependent care expenses of a domestic partner's child(ren).

3 What period of time do I have to incur eligible dependent care expenses?

You are permitted to receive reimbursement for eligible dependent care expenses incurred during the current plan year which begins on January 1 and ends on December 31

If your employment terminates during a calendar year and you have a balance remaining in your Dependent Care Reimbursement Account, you may be reimbursed for eligible dependent care expenses that are incurred prior to the employment termination date.

4 Do I need to fund covered Dependent Care Reimbursement claims?

Yes, there is no provision in the Dependent Care Reimbursement Account Program to reimburse a claimant more than the current account balance for an eligible dependent care assistance claim.

5 What day care center expenses may be reimbursed?

Only the expenses of a "qualified dependent care center" may be reimbursed. A qualified dependent care center is a facility that provides care for more than six individuals other than individuals who reside there, receives a fee, payment, or grant for providing services for any of these individuals, and has established that it complies with applicable laws and regulations of the state where it is located.

You cannot be reimbursed for dependent care expenses paid to one of your dependents, your spouse, or one of your children who is under the age of 19.

6 What does it mean to incur an eligible expense?

Dependent care expenses must have been incurred to be eligible for reimbursement. This means that the day care or other dependent care service must have been provided before the expense can be reimbursed. This is a firm requirement under IRS regulations.

7 How do forfeitures occur?

If, by the end of the March following the calendar year in which you are enrolled in the Dependent Care Reimbursement Account program, you have not requested reimbursement from your Dependent Care Reimbursement Account for expenses in an amount equal to or greater than the amount deposited in your reimbursement account, you will forfeit the balance remaining in that account. The IRS regulations state that if you instruct your employer to set aside an amount of your salary in these accounts, you can use those dollars only for those specific expenses incurred during the calendar year in which you are enrolled in the Dependent Care Reimbursement Account program. Therefore, you should estimate carefully what you will need. You may utilize the worksheets available in the Section 125 Plan Enrollment Information booklet available on the Employee Benefits website to assist you in estimating the amounts you wish to contribute to your Dependent Care Reimbursement Account in a given calendar year. You are responsible for providing the IRS with sufficient documentation of incurred expenses for which you have been reimbursed through your account(s).

8 What happens if I am called to active duty military service?

When you receive orders for greater than 30 days and your status becomes military leave, you are no longer eligible to participate in the Dependent Care Reimbursement Account program. Any unreimbursed balance in your Dependent Care Reimbursement Account can only be recovered by incurring eligible day care expenses before the end of the calendar year.

9 What happens if I die during the year and have an unclaimed balance in my Dependent Care Reimbursement Account?

In the event that a participant who has an unreimbursed dependent care spending account balance dies during the calendar year in which he or she is enrolled in the Dependent Care Reimbursement Account program, the estate of the deceased may submit eligible dependent care expense claims for which the service was performed on or before the date of death for reimbursement. Any balance that remains after all eligible claims are processed is forfeited.

10 What filing requirements apply if I elect a Dependent Care Reimbursement Account?

The Internal Revenue Service requires that you file a Form 2441 with your Individual Federal Income Tax Form 1040 annually. Failure to file this form could result in disallowance of the tax savings from the use of pre-tax dollars to pay eligible dependent care expenses.

11 How do I submit an eligible claim?

When you have expenses that qualify for reimbursement from your Dependent Care Reimbursement Account, you are responsible for paying the bills directly. You must submit an electronic claim form, along with a copy of the supporting documentation for the amounts paid in order to be reimbursed from your account. You can access the "FSA – View Reimbursement Request" option through the Employee Self Service, after signing into the ITC Portal on the i2net. See the Section 125 Plan Enrollment Information booklet available at

https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227 for additional reimbursement and documentation requirements.

12 When must claims be submitted?

You may submit claims on the electronic claim form at any time during the year. Expenses incurred in any calendar year must be submitted no later than March 31 following the end of the calendar year. For example, if a reimbursable expense is incurred in August 2025, your electronic claim form for this expense must be submitted by March 31, 2026 to be eligible for reimbursement.

Each claim you submit on the electronic claim form will be reviewed and, if approved, you will receive payment for the amount of the claim. At that point, your total annual election or account balance for the calendar year will be reduced by the amount of the payment related to your Dependent Care Reimbursement Account.

If you leave the Institute, you may submit claims for expenses you incurred prior to your termination date during the year up until March 31 following the end of the calendar year in which you leave. If you leave the Institute, any claims for services incurred during the remainder of the calendar year after your termination date are not eligible for reimbursement.

13 What are my rights if my claim is denied?

If your claim is wholly or partially denied, you will be advised of the specific reason for the denial. If an appeal is desired, you must file a written request to the Plan Administrator within 60 days after the date you are notified of the denial of your claim. Your request, including all pertinent documents and comments supplied by you, will be considered by the Plan Administrator and you will be informed in writing of the decision within 60 days of the date your request was received.

A participant must pursue all administrative remedies in seeking resolution of a claim determination before taking legal action. The Plan Administrator has full authorization and discretion to allow and deny claims, and any determination made by the Plan Administrator shall be given deference, if subject to judicial review, and shall be overturned only if it determined to be arbitrary and capricious.

XXII Flexible Spending Account: HEALTH CARE REIMBURSEMENT ACCOUNT

A Introduction

The Health Care Reimbursement Account program provides a method through which you can accumulate pre-tax funds for reimbursing yourself for eligible health care expenses not otherwise reimbursed by your medical, dental, or vision care coverage and incurred for health care services received by you, your spouse, and your eligible child dependents who have not attained age 27 during the calendar year.

The Health Care Reimbursement Account program is included in the Southwest Research Institute Section 125 Plan and the Southwest Research Institute Health Care Reimbursement Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Section 125 Plan and the Southwest Research Institute Health Care Reimbursement Plan in any way. The actual Southwest Research Institute Section 125 Plan and the Southwest Research Institute Health Care Reimbursement Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Section 125 Plan and the Southwest Research Institute Health Care Reimbursement Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Section 125 Plan and the Southwest Research Institute Health Care Reimbursement Plan documents, the Southwest Research Institute Section 125 Plan and the Southwest Research Institute Health Care Reimbursement Plan Documents are controlling.

B Eligibility and Participation

1 Who is eligible to participate in the Health Care Reimbursement Account program?

You are eligible to participate in the Health Care Reimbursement Account program if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the Health Care Reimbursement Account program?

To participate in the Health Care Reimbursement Account program, you must complete, sign and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full biweekly salary reduction is required for the first payroll period. If your hire date is in the second week of the pay period, no biweekly salary reduction is required until the following pay period.

If you have declined coverage and now wish to elect it or you need to change your current enrollment elections in the Health Care Reimbursement Account program, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;

- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Changes to the amount of your future contributions for the Health Care Reimbursement Account program due to a qualifying event must be consistent with the qualifying event. For example, you may only increase and cannot decrease your contribution due to the birth of a child.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

Further information on qualifying events for which enrollment changes can be submitted is included in Section III, *Section 125 Plan*.

3 How is the Health Care Reimbursement Account program funded?

The Health Care Reimbursement Account program is funded entirely by participant contributions. During the annual Open Enrollment period, you will have the opportunity to decide for the following calendar year how much of your annual base salary, if any, you want deducted each pay period and deposited in your Health Care Reimbursement Account.

Participants in long-term disability, family and medical leave, or leave without pay status must pay their bi-weekly participant contributions throughout such periods to maintain coverage. Participants may continue pre-tax payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent.

A participant whose employment classification changes to temporary or who is out on a leave of absence may submit claims for services incurred prior to his or her change in classification for any positive Health Care Reimbursement Account balance. To submit claims for services incurred after his or her change in classification, an employee must elect to continue the Health Care Reimbursement Account on an after-tax basis under COBRA.

4 Am I enrolled when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the Health Care Reimbursement Account program. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in the Health Care Reimbursement Account program, as well as certain other benefits, with pre-tax dollars through salary reduction.

5 What happens to my participation in the Health Care Reimbursement Account program when my employment at the Institute ends?

Participation ceases when an employee's employment as a regular full-time employee or part-time employee ends. Any positive balance in your Health Care Reimbursement Account may be reimbursed by submitting claims for services incurred prior to the termination date by emailing your request to benefits@swri.org with required receipts/documentation. If you wish to continue to contribute to your Health Care Reimbursement Account on an after-tax basis, you must elect continuation coverage under COBRA. Further information about

COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

When employment ends prior to the last day of a pay period, your last paycheck will include a full biweekly contribution by salary reduction; no prorated reimbursement is made for days not worked in the payroll period.

C Summary of Benefits, Limitations and Exclusions

1 How does the Health Care Reimbursement Account work?

The purpose of this account is to provide a method through which you can accumulate pre-tax funds for reimbursing yourself for payment of eligible health care expenses (applicable to you, your spouse and your eligible child dependents who have not attained age 27 during the calendar year) not otherwise reimbursed by your medical, dental, or vision care coverage. Under current IRS regulations, healthcare reimbursement account reimbursements cannot be made for the eligible expenses of a domestic partner (and/or a domestic partner's children).

During the Open Enrollment period preceding each calendar year, you will have the opportunity to decide how much of your annual base salary, if any, you want salary reduced (subtracted) each pay period and deposited in your Health Care Reimbursement Account. You may put aside any amount you choose, up to the maximum established by the IRS.

On your electronic Open Enrollment Form, specify the amount of money you wish to have set aside from each bi-weekly paycheck and credited to your Health Care Reimbursement Account each pay period if you intend to establish such an account.

The medical, dental, and vision care expense reimbursements you receive from your Health Care Reimbursement Account cannot be deducted as itemized expenses on your individual Federal Income Tax Return. If you do not pay these expenses through your Health Care Reimbursement Account, you can then deduct them on your tax return if you are able to itemize your deductions.

2 What expenses are eligible for your Health Care Reimbursement Account?

Generally, most medical, dental, vision, and other health-related expenses that are not paid under medical, dental, or vision plan covering you or your dependents, are reimbursable to you from your Health Care Reimbursement Account.

Expense(s) submitted for reimbursement that are covered by the participant's medical, dental, or vision care plan must have been submitted to such plan for payment under plan benefits prior to submitting the electronic claim form for reimbursement under the participant's flexible spending account. If an expense is reimbursed from a participant's flexible spending account and is later paid by the participant's medical, dental, or vision care plan, the participant is responsible under IRS rules for reflecting the excessive reimbursement on his or her personal income tax return filed with the IRS.

Examples of eligible expenses (as described in Internal Revenue Code Section 213; see also the Section 125 Plan Enrollment Information booklet available at https://benefits.swri.org or by contacting the Employee

Benefits Office at (210) 522-2227) for you and your eligible dependents that may be paid by your Health Care Reimbursement Account include, but are not limited to:

- Expenses used to satisfy the deductible amounts under the medical, dental, or vision care plans
- Any amount of co-insurance or co-payment (your share of medical, dental, or vision expenses not paid in full by the medical, dental, or vision care plans)
- Other reimbursable expenses not covered by your medical, dental, or vision care plan:
- The amount in excess of covered expenses that you are required to pay
- Eye examinations, eyeglasses, and contact lenses (except for premiums for the voluntary vision care plan paid by salary reduction)
- Custodial care
- Lasik Surgery
- Over-the-counter drugs and medicines. (Dietary supplements which maintain one's general health, such as vitamins, are not reimbursable unless it is medically necessary to treat a medical condition and a physician's prescription is provided.)
- Weight loss drugs if in response to a physician's diagnosis of an obesity condition

You may be reimbursed for COBRA premiums for yourself and enrolled dependents if you elect to continue participation in the Health Care Reimbursement Account through the end of the calendar year under COBRA. COBRA premiums must be for Institute-sponsored health care plans to be eligible.

Additionally, if your child loses coverage under a medical, dental, or vision care plan due to eligibility status not being met, you may be reimbursed for COBRA premiums related to an Institute sponsored plan if he/she is your dependent for IRS purposes.

3 Is elective cosmetic surgery an eligible expense?

No. Elective cosmetic surgery is not an expense eligible for reimbursement under a Health Care Reimbursement Account. Examples of cosmetic surgery that do not qualify and are not reimbursable include liposuction, hair transplant, electrolysis, tummy tucks, and face-lift. For cosmetic surgery to be a reimbursable expense, it must be medically necessary to correct a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Before you include the cost of cosmetic surgery in your election, you should obtain advice from your physician as to its medical necessity.

4 What does it mean to incur an eligible expense?

Health care expenses must have been incurred to be eligible for reimbursement. This means that the service must have been provided in the case of medical professional services or the prescription drug or medical equipment/supplies delivered before the expense can be reimbursed. Services paid for in advance are not an eligible expense until the service has been incurred. This is a firm requirement under IRS regulations.

5 What period of time do I have to incur eligible health care expenses?

Generally, you must incur eligible expenses over a 14-month period that begins on January 1 and ends at the end of the succeeding February. The coverage period for eligible expenses starts on the latter of January 1 or the date the employee is enrolled in the Health Care Reimbursement Account.

6 Do I need to fund covered Health Care Reimbursement Account claims?

No. You may submit eligible claims and be reimbursed for them up to the full amount of your annual election regardless of adequacy of your funding. If your reimbursed claims exceed your deposits at the time you are no longer eligible to participate in the plan or you separate from the Institute, no refund is required to be made to your Health Care Reimbursement Account.

7 How do forfeitures occur?

If, by the end of the March following the calendar year in which you are enrolled in the Health Care Reimbursement Account program, you have not requested reimbursement from your Health Care Reimbursement Account for expenses in an amount equal to or greater than the amount deposited in either reimbursement account you will forfeit the balance remaining in that account. The IRS regulations state that if you instruct your employer to set aside an amount of your salary in these accounts, you can use those dollars only for those specific expenses incurred during the calendar year in which you are enrolled in the Health Care Reimbursement Account program including the grace period (i.e., through February following the calendar year in which you are enrolled). Therefore, you should estimate carefully what you will need. You may utilize the worksheets available in the Section 125 Plan Enrollment Information booklet available on the Employee Benefits website to assist you in estimating the amounts you wish to contribute to your Health Care Reimbursement Account in a given calendar year. You are responsible for providing the IRS with sufficient documentation of incurred expenses for which you have been reimbursed through your account(s).

8 What happens if I am called to active duty military service?

When you receive orders for greater than 30 days and your status becomes military leave, you are no longer eligible to participate in the Health Care Reimbursement Account. Any unreimbursed balance in your Health Care Reimbursement Account can be reimbursed when claims are submitted for services received prior to the date of your military leave.

9 What happens if I die during the year and have an unclaimed balance in my Health Care Reimbursement Account?

In the event that a participant who has a positive health care spending account balance dies during the calendar year in which he or she is enrolled in the Health Care Reimbursement Account program, the estate of the deceased may submit eligible health care expense claims for which the service was performed on or before the date of death for reimbursement. Any balance that remains after all eligible claims are processed is forfeited.

In the event that the deceased has a spouse, claims following the date of death may be submitted for reimbursement if a timely COBRA election is made. By doing so, the remaining positive balance plus any after-tax monthly contributions can be applied to future claims incurred by the electing spouse. COBRA status may be terminated at any time by failure to pay contributions when due.

10 What are my rights if my claim is denied?

If your claim is wholly or partially denied, you will be advised of the specific reason for the denial. If an appeal is desired, you must file a written request to the Plan Administrator within 60 days after the date you are notified of the denial of your claim. Your request, including all pertinent documents and comments supplied by you, will be considered by the Plan Administrator and you will be informed in writing of the decision within 60 days of the date your request was received.

A participant must pursue all administrative remedies in seeking resolution of a claim determination before taking legal action. The Plan Administrator has full authorization and discretion to allow and deny claims, and any determination made by the Plan Administrator shall be given deference, if subject to judicial review, and shall be overturned only if it determined to be arbitrary and capricious.

XXIII SHORT-TERM INCOME REPLACEMENT (STIR) PLAN

A Introduction

The Short-Term Income Replacement (STIR) Plan is a fully-insured insurance program which provides income replacement benefits for covered employees who are unable to work due to an illness/injury, are under the care of a medical professional, and whose claim has been approved by the insurer after meeting the benefit elimination period as defined in the insurance certificate. The STIR Plan is described in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the STIR Plan are set forth in the Group Short-Term Disability Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible disabilities, disability payment duration and policy exclusions and limitations are contained in the Group Short-Term Disability Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Short-Term Disability Policy, the information in the Group Short-Term Disability Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the STIR Plan?

You are eligible to participate in the STIR Plan if you are employed by the Institute as a regular employee (full-time or part-time). Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

Dependents are not eligible to participate in the STIR Plan.

2 How do I enroll in the STIR Plan?

To participate in the STIR Plan, you must complete, sign and submit an electronic Benefit Enrollment Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premiums is required until the following period.

If you have declined coverage and now wish to elect it, you can do so at the earliest of one of the following events, when you complete, sign, and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event as described in Section III; or

- at the next Open Enrollment period.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

If you are not in active service—as defined by the Group Policy—on the date your coverage would otherwise be effective, coverage will be effective on the date you return to active service.

3 How is the STIR Plan funded?

The STIR Plan is funded primarily by participant contributions. On a periodic basis, the insurer may increase or decrease the required premium cost, although the Institute's senior management reviews and approves participant contributions. Participant contributions are provided by salary reduction on a pre-tax basis.

No premium is required for participants whose claim has been approved and are receiving STIR income benefits.

Participants on family and medical leave (FMLA) or leave without pay status must pay premiums throughout such periods while awaiting the insurer's decision. Premiums during these periods are based on the employee rates and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid after the termination effective date will be reversed.

As long as premiums are paid, participation in the STIR Plan may continue for the period of time described in the Group Policy. After that period ends, enrollment cannot be continued under the COBRA program or by submitting an application to continue coverage with the insurer.

Coverage will be terminated for a participant whose employment classification changes to temporary or who is on a leave of absence. Enrollment cannot be continued under the COBRA program or by submitting an application to continue coverage with the insurer

4 Can I cancel my enrollment in the STIR Plan after electing coverage?

Yes. After enrolling in coverage, you may cancel your coverage by declining enrollment during the next Open Enrollment period or within 31 days of a qualifying event (see question 2). If you cancel enrollment during the Open Enrollment period, your coverage will end on December 31 of the current calendar year.

5 Am I enrolled in the STIR Plan when I enroll in the Section 125 Plan?

No. You must separately enroll in the STIR Plan. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in the STIR Plan and certain other benefits with pre-tax dollars through salary reduction.

6 Can I continue enrollment in the STIR program if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation in the LTD program for 24 months by paying required premiums through after-tax premium payments.

7 What happens to my coverage in the STIR Plan when my employment at the Institute ends?

Coverage in the STIR Plan ends at the end of the pay period during which an employee's employment as a regular full-time employee or part-time employee ends. Enrollment cannot be continued under the COBRA program or by submitting an application to continue coverage with the insurer.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the STIR Plan are set forth in the Group Short-Term Disability Policy. This Summary Plan Description is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, disabilities, payment duration and policy exclusions and limitations are contained in the Group Short-Term Disability Insurance Certificate available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Short-Term Disability Policy, the information in the Group Short-Term Disability Policy takes precedence.

1 What are the requirements for disability benefits in the STIR program?

For purposes of the STIR Plan and the underlying Group Short-Term Disability Policy, you qualify for income benefits when you have met the benefit elimination period of 14 continuous days of absence, as defined in the Group Short-Term Disability Policy, have met the requirements described in the Group Short-Term Disability Policy, and your claim is approved by the insurer.

If your claim for income benefits is approved, continuation of income benefits is subject to your compliance with requests by the insurer to submit supporting medical documentation and to cooperate in medical examinations deemed necessary to support your claim. You must continue to be under the regular care of a physician.

2 What income benefit is paid by the STIR Plan?

Once approved by the insurer, benefits in the STIR Plan pay you a weekly income benefit of 60 percent of your weekly base salary. The maximum weekly benefit payable is $1,500. The benefit amount will be reduced for certain “other benefits” as described in the Group Short-Term Disability Policy.

3 If I elect to receive retirement program distribution income under the Southwest Research Institute retirement program, will my retirement income benefits reduce my STIR income benefit?

Yes. Your Institute retirement program benefits are considered other benefits that will reduce your monthly STIR income benefit.

4 What happens to my STIR income benefit if I return to work on a part-time basis?

As described in the Group Short-Term Disability Policy, the weekly income benefit that you receive will not be reduced for earnings received from part-time work hours unless the sum of your weekly income benefit received from the insurer, “Other Income” as defined in the Group Short-Term Disability Policy from other sources, and earnings while disabled exceed 100 percent of your weekly base salary.

5 When do weekly STIR income benefits end?

Your weekly income benefits under the STIR Plan will end when you no longer meet the insurer's definition of a disability as described in the Group Short-Term Disability Policy or you attain the maximum benefit period described in the Group Short-Term Disability Policy.

6 Are there any exclusions under the STIR Plan?

Yes. Benefits will not be paid for any injury or illness which, directly or indirectly, in whole or in part, is caused by or results from any of the circumstances described in the Group Short-Term Disability Policy.

7 What if I have successive periods of disability?

As described in the Group Short-Term Disability Policy, when two periods of absence due to an injury or illness are less than 14 days apart and result from the same injury or illness, the separate periods will be considered one period of absence. When two periods of absences from an unrelated injury or illness are separated by at least one full-day return to active service, each absence will be considered a separate injury or illness. If you return to work 14 days or more, any recurrence of the same injury or illness will be treated as a new claim. The new absence due to injury or illness is subject to meeting a new 14-day benefit elimination period and a new maximum duration of benefits as described in the Group Short-Term Disability Policy.

8 Are STIR income benefit payments subject to social security and federal income taxes?

Yes. All income benefits in the STIR Plan are fully taxable as is related to social security and federal income taxes. You will receive an IRS Form W-2 at the end of each calendar year from the insurer for your short-term disability income benefit received which should be reported to the IRS on your federal tax return.

9 Will I need to continue STIR Plan premium payments once my claim is approved?

No. Once your STIR claim for income benefits has been approved and you are receiving income benefits, your employment status will be changed to out-in-full STIR status. In this status your premiums to the STIR Plan will cease until a return to work is made and your claim closed.

10 How do I file a claim for benefits under the STIR Plan?

A claim for income benefits under the STIR Plan should be filed at the time one realizes that the recovery time for an injury or illness will probably exceed 14 continuous days. To file a claim, you must contact the insurer and file a claim by phone. Upon the filing of the claim, an Institute STIR claim coordinator will assist you in obtaining employer information required by the insurer. You will be required to furnish medical information from your physician, in addition to furnishing the insurer with a signed and/or verbal authorization to obtain medical information from your physician.

If you receive a written notice of denial, you or your authorized representative may submit an appeal of the denial by giving written notice to the insurer and following the process and time frames required by the insurer and described in the Group Short-Term Disability Policy.

XXIV Vision: VSP VISION CARE

A Introduction

The VSP Vision Care plan is a fully-insured vision care plan which provides benefits for covered vision services. The VSP Vision Care plan is included in the Southwest Research Institute Employees' Insurance Programs Plan. The information described below is not intended to interpret, extend, or change the Southwest Research Institute Employees' Insurance Programs Plan in any way. The actual Southwest Research Institute Employees' Insurance Programs Plan documents consist of the Plan Document and amendments that may be made to the Southwest Research Institute Employees' Insurance Programs Plan from time to time. In the event of any discrepancy between the information described below and the Southwest Research Institute Employees' Insurance Programs Plan documents, the Southwest Research Institute Employees' Insurance Programs Plan documents are controlling. Terms and conditions of coverage for the VSP Vision Care plan are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible benefits, their respective payments and policy exclusions and limitations are contained in the VSP Vision Client Care Plan Evidence of Coverage available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

B Eligibility and Participation

1 Who is eligible to participate in the VSP Vision Care plan?

You and your eligible dependents (see question 4) are eligible to participate in the VSP Vision Care plan if you are employed by the Institute as a regular full-time employee or as a regular part-time employee whose regularly assigned hours of work are at least twenty hours per week. Temporary employees and temporary agency workers are not eligible. All determinations with respect to eligibility are made by the Plan Administrator based on Institute records and the Plan Document.

2 How do I enroll in the VSP Vision Care plan?

There are two VSP Vision Care plan options to select from, a Low Option and a High Option. To participate in the VSP Vision Care plan, you must complete, sign and submit an electronic Benefit Change Form within the first week of your employment; coverage will be effective as of your hire date. If your hire date is in the first week of the pay period, a full bi-weekly premium is required for the first payroll period. If your hire date is in the second week of the pay period, no premium is required until the following pay period.

If you have declined coverage and now wish to elect it or you need to change your current enrollment elections, you can do so at the earliest of one of the following events, when you complete, sign and submit an electronic Benefit Change Form within the following time periods:

- within 31 days of employment;
- within 31 days of a qualifying event; or
- at the next Open Enrollment period.

Enrollment changes submitted during an Open Enrollment period will be effective as of the first day of the following calendar year.

Further information on qualifying events for which enrollment changes can be submitted outside the Open Enrollment period is included in Section III, *Section 125 Plan*.

3 How is the VSP Vision Care plan funded?

The VSP Vision Care plan is fully funded by participant contributions. On a periodic basis, the insurer may increase the required premium from participants for each of the coverage levels. Participant contributions are provided by salary reduction on a pre-tax basis.

Participants in long-term disability, family and medical leave, or leave without pay status must pay premiums throughout such periods. Premiums during these periods are based on the employee rates for the level of coverage selected and must be paid when due to maintain coverage. Participants may continue pre-tax premium payments by converting eligible accumulated leave hours, otherwise premium payments will be made on an after-tax basis. Coverage for employees continuing enrollment through after-tax payment will be cancelled if premiums are greater than 90 days delinquent. If coverage is cancelled due to non-payment, the cancellation will be effective as of the last date through which premiums have been paid, and any benefits paid for service dates after the termination effective date will be reversed.

As long as premiums are paid, participation may continue until the employee's employment ends or no longer meets the eligibility to participate in the VSP Vision Care plan. In this case, coverage may be continued by electing continuation coverage under COBRA; further information on COBRA is described in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

A participant whose employment classification changes to temporary or who is out on a leave of absence may continue to participate if electing continuation coverage under COBRA. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

4 Who are my eligible dependents in the VSP Vision Care plan?

An eligible dependent is defined as the

- Enrolled employee's lawful spouse; whether by ceremony or common law;
- Enrolled employee's domestic partner for which a notarized Declaration of Domestic Partnership has been submitted;
- Enrolled employee's natural or legally adopted child or stepchild who is under the age of 26
- Individual described in the Group Policy as a dependent child.

A common law spouse must be declared and registered in accordance with the applicable state law (or, when applicable, the law of a foreign jurisdiction), and supporting documentation must be submitted to the Employee Benefits Office.

Coverage for an employee's stepchild ends upon divorce or death of the natural parent if sooner than it would otherwise end. Coverage for a child attaining age 26 terminates at the end of the calendar month in which he or she attains age 26.

Coverage for an employee's lawful spouse terminates on the divorce date. The divorce date is the date the divorce decree is signed by the judge or court.

An eligible employee whose spouse is also an Institute employee may enroll one spouse as a dependent of the other, or each spouse may be enrolled separately, but an eligible employee may not be enrolled as both an employee and a spouse. Eligible dependents may be enrolled under either spouse but cannot be enrolled as dependents of both employees.

A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

5 How do I add new dependents acquired by marriage, remarriage, or adoption to the VSP Vision Care plan?

To add a new dependent, you must initiate an electronic Benefit Change Form within 31 days of acquiring the dependent, such as the marriage date or the child's birth or adoption date. When adding a new dependent, you must submit requested documentation to the Employee Benefits Office to evidence the eligibility of your new dependent. Your new dependent's coverage will begin as follows:

- Marriage: Your new spouse's coverage (and any acquired stepchild's coverage, if applicable) will begin on the date you submit the electronic Benefit Change Form. Please remember that you must submit the electronic Benefit Change Form within 31 days of your marriage date. For coverage to begin on your marriage date, you must submit the electronic Benefit Change Form prior to the marriage date.
- Declaration of Domestic Partnership: Domestic Partners must be added within 31 days of submitting a Declaration of Domestic Partnership to the Employee Benefits Office. Further information is available on the Enrolling & Making Changes page on the Employee Benefits website.
- Birth: Your new child's coverage will begin on your new child's birth date. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's birth date.
- Adoption: Your adopted child's coverage will begin on the date that the adoption is finalized. Please remember that you must submit the electronic Benefit Change Form within 31 days of your child's adoption finalization date.

If you do not add your new dependent(s) within 31 days of the qualifying event, you must wait until the next Open Enrollment period to add your new dependent(s), and coverage will not begin until the first day of the following calendar year.

6 Can I cancel my enrollment in the VSP Vision Care plan at any time after electing coverage?

Unless you have a qualifying event, coverage may only be cancelled during the annual Open Enrollment period, and coverage will terminate as of the end of the current calendar year.

7 Am I enrolled in the VSP Vision Care plan when I enroll in the Section 125 Plan?

No. You must separately enroll to participate in the VSP Vision Care plan. Your enrollment in the Section 125 Plan only allows you to pay participant contributions in the VSP Vision Care plan, as well as certain other benefits, with pre-tax dollars through salary reduction.

8 Can I continue my enrollment in the VSP Vision Care plan if I am called to Military Active-Duty Service?

Eligible employees whose employment status is military leave may continue participation for you and/or your dependents in the VSP Vision Care plan for 24 months under COBRA. Premiums are available by contacting the Employee Benefits Office at (210) 522-2227.

9 What happens to my coverage in the VSP Vision Care plan when my employment at the Institute ends?

Coverage in the VSP Vision Care plan ends at the end of the pay period during which an employee's employment as a regular full-time or part-time employee ends. In such cases, participation may continue if the employee elects to continue coverage under the COBRA program and pays the required premiums. Further information about COBRA is available in the COBRA Information Booklet available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

C Summary of Benefits, Limitations and Exclusions

Terms and conditions of coverage for the VSP Vision Care plan are set forth in the Group Policy. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including eligible benefits, their respective payments and policy exclusions and limitations are contained in the VSP Vision Client Care Plan Evidence of Coverage available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227. If there are any differences between this summary and the Group Policy, the information in the Group Policy takes precedence.

1 What are the advantages of using a member doctor in the VSP Vision Care plan?

VSP preferred doctors generally are optometrists. They are licensed and otherwise qualified to practice vision care and/or provide vision care materials. Materials and services from VSP preferred doctors are provided at contracted rates. A listing of preferred doctors can be obtained by registering at www.vsp.com. The advantages of using a preferred doctor are that the preferred doctor handles all the paperwork for payment from VSP and there is less likelihood of a participant incurring additional expenses not covered by this VSP Vision Care plan.

2 What benefits are available in the VSP Vision Care plan?

Vision examination: Each participant is entitled to one eye examination during a calendar year. If this examination is conducted by a preferred doctor, the only cost is a $10 co-payment made to the preferred doctor at the time of examination. preferred doctors will perform a complete examination to determine vision problems and the appropriate lens or contact fitting requirements necessary for corrected vision.

If you use an out-of-network doctor, you will be reimbursed based on the coverage option you are enrolled in and the reimbursement amount described in the VSP Evidence of Coverage, which is available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

Lenses: Each participant is entitled to one set of corrective plastic lenses through a network doctor at no additional cost once every calendar year. Further information is described in the VSP Evidence of Coverage, which is available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

Your cost for any purchased lens options will vary based on your enrollment in the Low Option or High Option program. Your cost may also vary depending on the doctor you purchase your lenses is in-network or out-of-network with the insurer. Further details on member costs for lens options are described in the VSP Evidence of Coverage, which is available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

Frames: Each participant is entitled to one eyeglass frame once every calendar year. All participants requiring vision correction may choose from a wide selection of frames at the office of a preferred doctor and select a frame. An annual allowance for frames is provided based on the member's benefits described in the VSP Evidence of Coverage and the applicable Low Option or High Option in which the member is enrolled. The member is responsible for payment of any amount that exceeds the applicable annual allowance.

If you purchase a frame from a non-preferred doctor, you will be reimbursed based on the coverage option you are enrolled in and the reimbursement amount described in the VSP Evidence of Coverage, which is available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

Contact lenses: The vision options offer contact lens coverage, which may be elected in lieu of benefits for lenses and frames in any calendar year. An annual allowance for contact lenses is provided based on the member's benefits described in the VSP Evidence of Coverage and the applicable Low Option or High Option in which the member is enrolled. The member is responsible for payment of any amount that exceeds the applicable annual allowance. If you choose to purchase your examination and contact lenses from an out-of-network provider, you will be reimbursed based on the coverage option you are enrolled in and the reimbursement amount described in the VSP Evidence of Coverage, which is available at https://benefits.swri.org or by calling the Employee Benefits Office at (210) 522-2227.

3 What criteria must be met for medically necessary contact lenses?

In either enrollment option of the VSP Vision Care plan, medically necessary contact lenses are covered in full in lieu of frame and spectacle lenses after the applicable examination co-payment is met.

Generally, one of the following circumstances must be met for medically necessary contact lenses in the VSP Vision Care plan:

- Contacts prescribed following cataract surgery
- Contacts prescribed to correct extreme acuity problems that cannot be corrected with spectacle lenses
- Certain conditions of an isometropia
- Keratoconus

Contact lenses for any purpose, other than described above, are not considered medically necessary and thus, are considered to be elective contact lenses.

4 Does the VSP Vision Care plan offer safety lenses?

No. The VSP Vision Care plan is not intended to provide any required industrial safety lenses. Such lenses are provided by the Institute, under a separate program, to employees whose work requires their use. If safety glass lenses are desired for personal reasons, the participant will be charged.

5 Does the VSP Vision Care plan cover a second set of eyeglasses?

No. The VSP Vision Care plan does not provide for a second set of eyeglasses in any calendar year. However, you should contact the insurer to inquire of any discount which may be available for the purchase of additional glasses and/or sunglasses during the same calendar year.

6 What are the limitations and exclusions in the VSP Vision Care plan?

Limitations and exclusions in the VSP Vision Care plan are described fully in the Group Policy.

7 How do I obtain in-network services in the VSP Vision Care plan?

You can receive quick and direct access to vision care without completing a request card or calling for a benefit form. The VSP preferred doctor will contact VSP on your behalf to obtain authorization for services. Follow the convenient steps below:

- Find a VSP preferred doctor by registering at www.vsp.com.
- Call a VSP preferred doctor for an appointment and identify yourself as a VSP member.

When you call, the VSP preferred doctor will also need to know the covered member's identification number (usually the social security number).

- After you've scheduled your appointment, the VSP preferred doctor will contact VSP to verify your eligibility and plan coverage. The doctor will also obtain authorization for services and materials.
- If you need any assistance in arranging in-network services or have questions, you may call VSP at (800) 877-7195.

8 How do I obtain out-of-network services in the VSP Vision Care plan?

You can elect to make an appointment and obtain vision services and materials with a non-preferred doctor of your choice. You may be required to pay the doctor his/her full fee and obtain an itemized receipt, which must contain the following information: patient's name, date, date services began, services and materials received, and type of lenses received. Next, you must register and log into www.vsp.com to access the VSP Member Reimbursement Form. Fill out the Reimbursement Form in its entirety, attach the itemized receipts and mail the form back to the address listed on the form. Claims may also be submitted online when receipts are uploaded. You will be reimbursed directly according to the VSP Vision Care's non-preferred doctor reimbursement schedule. Claims must be received within three hundred sixty-five (365) days of the date of service.

There is no assurance that the non-preferred doctor reimbursement schedule will cover the entire cost of the examination, other services, or materials.

9 Do I receive an enrollment identification card in the VSP Vision Care plan?

No, an identification card is not required for service, but one is available for the primary subscriber on www.vsp.com.

10 What is the Diabetic EyeCare Plus Program in the VSP Vision Care plan?

The Diabetic EyeCare Plus Program in the VSP Vision Care plan is available to covered persons who have been diagnosed with Type 1 or Type 2 Diabetes and specific ophthalmological conditions. More information about the Diabetic EyeCare Plus Program can be found in the VSP Vision Client Care Plan Evidence of Coverage.

11 What is the TruHearing Program in the VSP Vision Care plan?

The TruHearing Program in the VSP Vision Care plan is a benefit available to covered persons that provides discounts for the purchase of a hearing aid. More information about the TruHearing Program can be found on the Employee Benefits website at https://benefits.swri.org/.

XXV ERISA NOTICE

As a participant in the Southwest Research Institute Employees' Insurance Programs Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, 6220 Culebra Road (Building 160), San Antonio, Texas, and at other specified locations as arranged by the Plan Administrator, all documents governing the plan, including the Plan document, related amendments, insurance contracts and certificates, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including the Summary Plan Description, insurance contracts and certificates, and copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's summary annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this report on an annual basis.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

While ERISA requirements are established by Federal law and regulation, Southwest Research Institute has always attempted to provide its employees with welfare benefit plans that meet or exceed the same high standards imposed by the law.

XXVI REQUIRED NOTICES

Notice about the Genetic Information Nondiscrimination Act (GINA)

GINA is a federal law that basically prohibits health plans and insurers from requiring genetic tests for plan participation, from collecting genetic testing information and from adjusting plan premiums based on genetic information. Family history of disease information collected in connection with the Institute wellness evaluations is genetic information that is protected health information under HIPAA and GINA. This information, accordingly, is not shared with employees who administer the health plan except in the form of aggregate, desensitized data.

Notice Required by the Department of Labor

Group health plans, including those described in this SPD, 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuers for prescribing a length of stay not in excess of the above periods.

Notice required under the Women's Health and Cancer Rights Act of 1998

Group health plans, including those described in this SPD, in the past have provided coverage for mastectomies. This coverage generally includes procedures necessary to effect reconstruction of the breast on which the mastectomy was performed as well as the cost of prostheses (implants, special bras, etc.) and physical complications of all stages of a mastectomy, including lymphedemas, as recommended by the patient's physician. Additionally, plans described in this guide provide coverage for any necessary surgery and reconstruction of the breast on which a mastectomy was not performed to produce a symmetrical appearance for any participant currently receiving plan benefits. This coverage is subject to the same co-insurance, deductibles, co-payments, and other limitations that apply to mastectomies under the plans' current terms.

HIPAA Privacy Rule Reminder

A federal law known as HIPAA (the Health Insurance Portability and Accountability Act) requires that Institute employees as well as those who administer health care plans take reasonable steps to ensure the privacy of personally identifiable health information (PHI). The term PHI includes all individually identifiable health information that is communicated orally, in writing, or in electronic form between a plan participant and those who provide health care services and who administer health care plans. PHI includes any combination of a member's name, address, date of birth, social security number, marital status, and sex when disclosed with the person's health history, medical records, or information about present or future health care. PHI should be disclosed only to health care providers for treatment, to third party administrators who make coverage determinations and payments, and to the people who administer the health care plan on behalf of the plan administrator.

Texas HIPAA Alert

Texas Statute H.B. 300 makes all individuals responsible for safeguarding protected health information (PHI) in the same manner that covered entities (doctors, hospitals, pharmacies, health plans, medical clinics, etc.) are required to do under the federal HIPAA privacy rules. You should not disclose information about your personal health to

anyone who does not need that information for a business reason. If you do so, the individual health information you disclosed is no longer protected. If you become aware of health information pertaining to someone that was not voluntarily provided to you by that person, you should not share that information without permission to do so. H.B.300 provides for both civil and criminal penalties when PHI is improperly disclosed. The privacy protection under Texas law exceeds the privacy protection extended under the federal HIPAA privacy rules and extends to information about your name, address, gender, social security number and banking information.

XXVII 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. “We” in this document refers to the members of the Southwest Research Institute Employee Benefits Office. Please review it carefully.

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

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

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

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/index.html**.**

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

For more information see: https://www.hhs.gov/hipaa/index.html**.**

Changes to the Terms of this Notice

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

Effective Date of this Notice

January 1, 2025

Privacy official:

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Southwest Research Institute HIPAA Privacy Official:

HIPAA Privacy Official
Southwest Research Institute
6220 Culebra Road
San Antonio, TX 78238-5166
privacyofficial@swri.org
(210) 522-5787

Texas Laws (https://www.texasattorneygeneral.gov/)

Effective September 1, 2012, the Texas Medical Records Privacy Act provides additional protections to consumers. The Act is broader in scope than HIPAA because it applies not only to health care providers, health plans and other entities that process health insurance claims but also to any individual, business, or organization that obtains, stores, or possesses PHI as well as their agents, employees and contractors if they create, receive, obtain, use or transmit PHI.

Under the Act, these individuals, businesses and organizations must comply with several requirements including mandatory training for employees regarding PHI. In most instances, the Act prohibits covered entities from using or disclosing PHI without first obtaining an individual's authorization.

To learn more about the Texas Medical Records Privacy Act go to
http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.181.htm

Overview of Your Rights under State and Federal Laws

Right of Access to Health Records
State and federal laws give you the right to ask to review and obtain a copy of your health records from most health care providers such as doctors, hospitals, pharmacies and nursing homes, as well as from your health plan. Your provider may have a form you can use to request your records. In a few special cases, such as instances in which your doctor decides that information in the file may endanger you, you may not be able to obtain all of your information.

A provider may charge for the reasonable costs of copying and mailing your records if you request copies and mailing but may not charge a retrieval fee.

Texas law specifies that if the provider is using an electronic health records system capable of fulfilling the request, the records must be provided not later than the 15th business day after the date your provider receives your written request. The records must be provided to you in electronic form unless you have agreed to accept the records in another form.

Right to amend information in your health records
If you believe that information in your medical records is incorrect, you have the right to request that the provider or health plan correct or amend the record and they must respond to your request. If the provider or health plan does not agree to make your requested corrections, they must notify you in writing and tell you why your request was denied. You have the right to submit a statement of disagreement that the provider or plan must add to your record.

Right to know how your personal health information will be used and shared and to limit who gets to see it
Your provider or health plan must give you a notice of their privacy practices that informs you of three things: (1) the uses and disclosures of your PHI which they are permitted to make; (2) other disclosures which require your authorization; and (3) that in the event of a breach of unsecured PHI, you will receive a notice of that breach. This notice of privacy practices will generally be provided on your first visit to a provider or in the mail from your health plan. You can also obtain a copy at any time that you request it.

In general, your health information cannot be used or shared for other purposes including sales calls or advertising, unless you first give your permission by signing a form authorizing such use. The authorization form must tell you who will get your information and what your information will be used for. Generally, this type of authorization is not required if the disclosure of your health information is for the purpose of treatment, payment, health care operations or performing certain insurance or health care maintenance organization functions.

Under certain circumstances, a covered entity may disclose PHI without the authorization of the person who is the subject of the protected information. Those circumstances include, but are not limited to, disclosures made to or in connection with a health oversight agency for audits and investigations, a threat to public safety, and situations involving victims of abuse or neglect. Also, if you are incapacitated or in an emergency, providers sometimes may use or disclose your PHI without your authorization if, in the exercise of medical judgment, they determine it is in your best interests. Your PHI may also be disclosed without your authorization if the disclosure is required by law, including a subpoena or court order.

Right to limit marketing uses of protected health information
In general, your health information cannot be used or shared for marketing communications without your authorization. Certain exceptions apply including face to face communications between a covered entity and an individual.

If your PHI is used or disclosed to send a written marketing communication through the mail, that mailing must include the name and toll-free number of the entity which sent you the marketing communication and an explanation of your right to have your name removed from the sender's mailing list. In addition, the mailing must be in an envelope which shows only the name and address of the sender and recipient.

OTHER TEXAS LAWS

Other Texas laws also serve to protect from disclosure specific types of medical records and information including certain doctor-patient communications, genetic information, test results for HIV and AIDS, hospital records, pharmacy records, donor records, regulatory records and mental health records.

TO FILE A COMPLAINT
Under the Texas Medical Records Privacy Act, consumers have the right to file a complaint with the state agencies that regulate covered entities as well as with the Texas Attorney General. For a list of those agencies, contact information and detailed information regarding each agency's complaint process, go to https://www.texasattorneygeneral.gov/consumer-protection/health-care/patient-privacy

To file a consumer complaint with the Office of the Texas Attorney General, go to https://www.texasattorneygeneral.gov/consumer-protection/health-care/patient-privacy

If you believe your protected health information has been used or disclosed in violation of HIPAA, you have the right to complain to the federal Office of Civil Rights which has authority to investigate complaints against HIPAA covered entities and their business associates: https://www.hhs.gov/ocr/about-us/contact-us/index.html

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F; HHH Bldg.
Washington, D.C. 20201
Toll-free: (800) 368-1019
TDD toll-free: (800) 537-7697

Southwest Region - (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)
Marisa Smith, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 106
Dallas, TX 75202
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697

XXVIII ERISA INFORMATION

PLAN YEAR:	January 1 through December 31
PLAN SPONSOR:	Southwest Research Institute
EMPLOYER TAX ID NUMBER:	74-1070544
PLAN ADMINISTRATOR AND AGENT FOR SERVING OF LEGAL PROCESS:	Mrs. Beth Ann Rafferty CFO and Vice President Southwest Research Institute 6220 Culebra Road San Antonio, Texas 78238-1566 210-684-5111
SPONSOR'S FISCAL YEAR ENDS:	Last Friday in September

BENEFIT PLAN	PLAN NAME, PLAN # and EFFECTIVE DATE OF PLAN:	TYPE OF PLAN/PROGRAM and FUNDING OF PLAN BENEFITS:	PLAN CLAIM PROCESSOR:	INSURER:
Section 125 Plan	Southwest Research Institute Section 125 Plan, Plan No. 504, established July 1, 1989	Fringe Benefit Welfare Benefits are funded through participant contributions	N/A	N/A
Accidental Death & Dismemberment (AD&D) Plan: Group AD&D Voluntary AD&D	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Life and Accident Insurance Programs Benefits are funded through participant contributions (Voluntary AD&D) and employer contributions (Basic AD&D) made out of the general assets of the Plan Sponsor	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 1-800-732-1603	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 1-800-732-1603 Policy No. OK967622
Accidental Death & Dismemberment (AD&D) Plan: Business Travel	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Life and Accident Insurance Programs Benefits are funded through employer contributions made out of the general assets of the Plan Sponsor	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 1-800-732-1603	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 1-800-732-1603 Policy No. ABL960599
Accidental Injury	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Health Care, Accident, Life, and other Insurance Programs Benefits are funded through participant contributions	Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Bloomfield, CT 06002 800-754-3207	Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Bloomfield, CT 06002 800-754-3207 Policy No. AI111501

BENEFIT PLAN	PLAN NAME, PLAN # and EFFECTIVE DATE OF PLAN:	TYPE OF PLAN/PROGRAM and FUNDING OF PLAN BENEFITS:	PLAN CLAIM PROCESSOR:	INSURER:
Cancer Plan: MetLife	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare Health Care, Accident, Life, and other Insurance Programs Benefits are funded through participant contributions	Bay Bridge Administrators, LLC P.O. Box 161690 Austin, Texas 78716 1-800-845-7519	MetLife Insurance Company (See Plan Claim Processor for address and phone number)
Critical Illness	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Health Care, Accident, Life, and other Insurance Programs Benefits are funded through participant contributions	Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Bloomfield, CT 06002 800-754-3207	Cigna Health and Life Insurance Company 900 Cottage Grove Rd. Bloomfield, CT 06002 800-754-3207 Policy No.CI111445
Dental Plan: Delta Dental	Southwest Research Institute Employees' Health Care Expense Benefits Plan, Plan No. 502, established June 1, 1978	Welfare: Dental benefits Benefits are funded through participant contributions and employer contributions made out of the general assets of the Plan Sponsor	Delta Dental Insurance Company 1130 Sanctuary Parkway, Suite 600 Alpharetta, GA 30009 (800) 521-2651	N/A
Employee Assistance Program (EAP)	Southwest Research Institute Employee Assistance Program, Plan No. 506, established January 1, 1999	Welfare-Employee Assistance Program Benefits under the Employee Assistance Program are funded entirely through Plan Sponsor contributions	Contact the Employee Services of the Human Resources Department at (210) 522-6225	Contact the Employee Services of the Human Resources Department at (210) 522-6225
Kaiser HMO	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Health Care Benefits Benefits under the Plan are funded through participant contributions and the general assets of the Plan Sponsor	Kaiser Permanente 2500 South Havana St. Denver, CO 80220 800-218-1059	Kaiser Permanente 2500 South Havana St. Denver, CO 80220 800-218-1059
Life Insurance Plans: Group Life Dependent Life Voluntary Life	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Life and Accident Insurance Programs Benefits are funded through participant contributions	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192 800-845-7519	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192 800-845-7519 Policy No. FLX966069

BENEFIT PLAN	PLAN NAME, PLAN # and EFFECTIVE DATE OF PLAN:	TYPE OF PLAN/PROGRAM and FUNDING OF PLAN BENEFITS:	PLAN CLAIM PROCESSOR:	INSURER:
Long-Term Disability	Southwest Research Institute Employees' Long-Term Disability Income Benefits Plan, Plan No. 503, established May 31, 1980	Welfare: Disability Insurance Benefits are funded through participant contributions and employer contributions made out of the general assets of the Plan Sponsor	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 800-732-1603	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 800-732-1603 Policy No. LK964166
Medical Plan: UHC Choice EPO	Southwest Research Institute Employees' Health Care Expense Benefits Plan, Plan No. 502, established June 1, 1978	Welfare: Health Care Benefits Benefits are funded through participant contributions and employer contributions made out of the general assets of the Plan Sponsor	UnitedHealthcare Insurance Company P. O. Box 30555 Salt Lake City, UT 84130-0555 877-370-0859	N/A
Medical Plan: UHC Texas Premier Choice	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Health Care Benefits Benefits are funded through participant contributions and employer contributions made out of the general assets of the Plan Sponsor	UnitedHealthcare Insurance Company P. O. Box 30555 Salt Lake City, UT 84130-0555 877-370-0859	UnitedHealthcare Insurance Company P. O. Box 30555 Salt Lake City, UT 84130-0555 877-370-0859
Reimbursement Plans: Health Care FSA Dependent FSA	Southwest Research Institute Section 125 Plan, Plan No. 504, established July 1, 1989 Southwest Research Institute Health Care Reimbursement Plan, Plan No. 505, established July 1, 1989	Fringe Benefit Welfare Benefits are funded through participant contributions	Employee Benefits Office Southwest Research Institute 6220 Culebra Road San Antonio, Texas 78238-5166 (210) 522-2227	N/A
Short-Term Income Replacement (STIR) Plan	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Disability Insurance Benefits are funded through participant contributions and employer contributions made out of the general assets of the Plan Sponsor	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 800-732-1603	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235 800-732-1603 Policy No. VDT962617
Vision: VSP	Southwest Research Institute Employees' Insurance Programs Plan, Plan No. 501, established May 31, 1980	Welfare: Health Care, Accident, Life, and other Insurance Programs Benefits are funded through participant contributions	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195