Pluckers Wing Bar

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2026

GUIDE TO YOUR BENEFITS

JULY 2026 – JUNE 2027

Pluckers Wing Bar

FULL-TIME RESTAURANT STAFF

WELCOME TO YOUR BENEFITS!

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We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation.

You have the flexibility to choose from a comprehensive benefits package designed to support your health and well-being, protect you financially in the event of unexpected circumstances, and provide added peace of mind for you and your family. This brochure was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this brochure to make sure you understand the benefits that are available to you and your family, and be sure to act before the enrollment deadline.

This brochure highlights the main features of our employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. The Company reserves the right to change or discontinue its employee benefits plans at any time.

Scan the QR Code to see the notices and disclosures pertaining to your health and welfare plans.

ELIGIBILITY

As a variable employee, you must establish full-time status by working an average of 30 hours per week in your first six months. After your hours are computed, you'll be notified of your eligibility date. Each year, employee hours are reviewed to determine full- or part-time status.

If eligible for benefits, you may also enroll eligible dependents in coverage.

Eligible dependents could be:

- Your legal spouse
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. If you do not make changes to your benefits within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event	
Loss of spouse/parent coverage	
Change in marital status	· Marriage · Divorce/Legal Separation · Death
Change in number of dependents	· Birth or adoption · Stepchild · Death
Change in employment	· Change in your eligibility status (i.e., full-time to part-time) · Change in spouse's benefits or employment status

Note: Some Qualified Life Events may require documentation.

How to Request a Qualified Life Event

Contact benefits@pluckers.net.

HOW TO ENROLL

If you qualify for benefits, you must enroll by the deadline assigned. You can check your enrollment portal and/or your Benefits Team will send reminders as this deadline approaches. **You must complete your enrollment to receive new benefits or change benefit coverage for the plan year.** Current elections will roll over automatically.

Before You Enroll

Carefully review the benefits listed in this guide and determine coverage that's best for you and your family.

Ensure family members meet the eligibility requirements.

Understand the cost of the plans you selected.

Be sure to consider a beneficiary for life insurance.

Enrollment Assistance – SMBO Call Center

Need help making decisions? No problem! You can now contact SMBO between 7 AM and 5 PM, Monday through Friday. They'll walk you through your options — and even take your enrollment over the phone.

That's right, no need to log in to the bSwift portal if you don't want to.

Just call **888-598-2040** to get started.

Enrollment Instructions

bswift

To enroll, simply follow these steps:

- Log on at **pluckers.bswift.com**
- Username: first name initial + your last name
- Password: Last four digits of your SSN

STAYING CONNECTED YEAR-ROUND

Key Benefit Administrators (KBA)

Key Benefit Administrators (KBA) administers Pluckers' MEC Plan and provides access to member support resources and benefit information.

With KBA member resources, you can:

- Access your member portal
- View member ID card information
- Review eligibility and claims information
- Find participating providers
- Get support for benefits and service questions

For additional information and member resources, visit **keybenefit.com** or refer to the phone number listed on your ID card.

Member Support Center

Marsh McLennan Agency's Member Support Center is here for you — to answer your questions, including insurance claim questions, by phone and email. The representatives are licensed agents, are familiar with your benefits package.

They can assist with the following:

- Central point of contact for benefits questions and coverage inquiries
- Assist with ID Card request
- Assist employees with entering enrollment elections (New Hires/Life Events)
- Claims Inquiries
- Assist with finding in-network providers/facilities
- Assist with determining covered services

Contact the Member Support Center

855-550-9885, PIN 2158

pluckers@marshmma.com

Representatives are available Monday through Friday, from 8 AM – 6 PM Central.

Spanish-speaking representatives are available.

MEC PLAN

Pluckers' Minimum Essential Coverage (MEC) Plan, offered through Key Benefit Administrators, provides you and your family coverage for preventive care services only.

How MEC Plans Work

- MEC plans are limited medical benefit plans and do not cover catastrophic or most illnesses.
- MEC plans are designed to offer coverage for limited, basic medical services, specifically wellness visits, flu shots, and discounts on prescription drugs.
- MEC plans ONLY cover treatment from providers in the Open Access Solution network.

	MEC Plan
	IN-NETWORK ONLY
	You pay
Calendar Year Deductible	
Individual	$0
Family	$0
Calendar Year Out-of-Pocket Maximum (Includes Deductible)	
Individual	$0
Family	$0
Coinsurance	0%
Preventive Care	$0 of the 84 listed Preventive and Wellness Benefits
Emergency Room Services	Not Covered
Inpatient Hospital Services	Not Covered
Primary Care Visit to Treat an injury or illness	Not Covered
Specialist Visit	Not Covered
Mental/Behavioral Health and Substance Abuse Disorder Services	Not Covered
Advanced Imaging (CT, PET Scans, MRIs)	Not Covered
Outpatient Facility Fee	Not Covered
Outpatient Surgery Physician/Surgical Services	Not Covered
Life AD&D Benefit	Not Covered

Preventive / Wellness Benefits

The MEC benefits cover 100% of the cost of certain preventive health services when delivered by a doctor or provider in your plan's network.

Visit **healthcare.gov/center/regulations/prevention.html** for the most current listing of covered services.

Monthly Medical Rates	
Employee Only	$16.58
Employee + Spouse	$51.44
Employee + Child(ren)	$107.50
Family	$142.34

ADDITIONAL BENEFITS

Working Advantage Discount Program

We're here to support your personal and financial well-being through exclusive deals and limited-time offers on products, services and experiences you need and love.

Visit **pluckers.savings.workingadvantage.com** to get started!

Skechers Discount

The perks of the Skechers Corporate Shoe Program:

- 30% off Skechers slip-resistant work shoes
- Free shipping and returns
- 500+ Skechers retail stores
- Quarterly friends and family days

Shop online at **skechers.com/direct/pluckers**. No promo codes needed. Just shop and save! Show this flyer when shopping at our Skechers retail stores nationwide or mention Retail Code G9P.

GLOSSARY

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference (see Balance Billing).

Annual Maximum Benefit

A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance

The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Copayment (copay)

A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Deductible

The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Guarantee Issue Amount

The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount you will have to complete an Evidence of Insurability form and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network

Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network

Providers who don't contract with your insurance carrier. Out-of-network coinsurance and copayments usually cost you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

Out-of-Pocket Maximum

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you may spend for services your plan doesn't cover.

Prescription Drug Formulary

A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

IMPORTANT CONTACTS

Coverage	Contact	Phone	Website
MEC Plan	Key Benefit Administrators	888-342-7427	www.keyopenaccess.com
Discount Program	Working Advantage	800-565-3712	customerservice@workingadvantage.com https://pluckers.savings.workingadvantage.com
Skechers Discount	Skechers	855-759-7463	info@skechersdirect.com
The Benefits Team	Pluckers	512-236-9110	benefits@pluckers.net
SMBO Call Center	SMBO	888-598-2040	
Member Support Center	Marsh McLennan Agency	855-550-9885 PIN 2158	pluckers@marshmma.com

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