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Master Document
Small Employer

FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

THIS BOOK IS A SUMMARY OF THE PROVISIONS OF OUR PLAN. WHILE EVERY EFFORT HAS BEEN MADE TO HAVE THESE MATERIALS BE AS COMPLETE AND ACCURATE AS POSSIBLE, IF THERE IS ANY CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE TERMS OF OUR PLAN, THE PROVISIONS OF THE PLAN WILL CONTROL.

Priority Health Managed Benefits, Inc.
1231 East Beltline, NE
Grand Rapids, Michigan 49525-1954

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FLEXIBLE BENEFITS PLAN

INTRODUCTION

This Flexible Benefits Plan provides you the opportunity to pay on a pre-tax basis

- Your premium contribution for coverage under the employer-sponsored benefit plan(s) listed on Appendix A
- Certain uninsured health and dependent care costs on a pre-tax basis, and,
- If you are eligible, contributions to a tax-advantaged health savings account (HSA).

This Summary Plan Description is intended to answer most of your questions regarding the Plan. You should contact the Plan Administrator if you need additional information.

Self-employed individuals are not eligible to participate in this Plan. "Self-employed individuals" include partners in a partnership, more than 2% owners in an S-corporation, and members of a limited liability corporation if the limited liability corporation is treated as a partnership for federal income tax purposes.

The Plan Administrator is responsible for the administration of the Plan and has the final discretionary authority to decide all questions of eligibility for Plan participation and benefit payments, to determine all issues of fact and to supply any omission and interpret any ambiguous provision of the Plan.

Type of Plan

Section 125 (Flexible Benefits) Plan
- Pre-Tax Premium Program
- HSA Contributions Program
- Health Flex Spending Arrangement (FSA) Program
- Dependent Care Assistance Program (DCAP)

Type of Administration

Pursuant to a contract with the Employer, claims under the Health FSA Program and Dependent Care Program are administered by:

Priority Health Managed Benefits, Inc. ("Claims Administrator")
1231 East Beltline, NE
Grand Rapids, Michigan 49525-4501
(616) 956-1954 or (800) 956-1954

Priority Health Managed Benefits, Inc. as a third party administrator merely processes claims. It does not insure that qualified health care expenses of any individual participating in the Health FSA Program will be paid. Complete and proper claims for benefits made by individuals covered by the plan will be promptly processed. In the event there are delays in processing claims, the individuals covered by the plan have no greater rights to interest or other remedies against the third-party administrator than as otherwise afforded them by law. Benefits under the Health FSA are not insured. If this plan or employer does not ultimately pay qualified health care expenses that are eligible for payment under the Program for any reason, the individuals covered by that program may be liable for these expenses.

HOW DOES THE PLAN OPERATE?

You may elect to have your Employer withhold a portion of your compensation each pay period to make pre-tax contributions to the following component programs under the Plan:

* Pre-Tax Premium Program - your required premium contributions for coverage under the Employer's group benefit programs listed on Appendix A.

* HSA Contributions Program - contributions to your health savings account (HSA).

* Health Flex Spending Program - certain uninsured medical expenses.

* Dependent Care Program - certain dependent care expenses.

As long as the Plan is operated in a nondiscriminatory manner, you will not pay income or employment (FICA) taxes on the amounts you elect to have withheld from your pay. Therefore, over the course of the plan year, you will pay less in taxes and have more take-home pay than if you paid the contributions or expenses on an after-tax basis.

Your employer may, but is not required to, make a contribution to the Plan each year on behalf of each participant ("employer contribution"). If the Employer intends to do so, you will be notified of the amount of the contribution at the time of open enrollment for the upcoming plan year.

If you become eligible to participate in the Plan after the plan year begins, your employer contribution will be pro-rated. If you terminate employment before the end of the plan year, you will not receive an employer contribution for any period following termination.

If you pay less tax because you elect to participate in the Plan, your Social Security benefits may be reduced slightly. This is because you and your Employer will pay less FICA tax. Whether or not your Social Security benefits will actually be lower depends on a number of factors such as your current age, your current earnings, and your future pay levels; however, in most cases the current tax savings will outweigh any slight impact on future Social Security benefits.

WHO IS ELIGIBLE TO PARTICIPATE?

The eligibility requirements for participation are described in each component program section of this Summary Plan Description. However, self-employed individuals are not eligible to participate in any part of this Plan. "Self-employed individuals" include partners in a partnership, more than 2% owners in an S-corporation, and members of a limited liability corporation if the limited liability corporation is treated as a partnership for federal income tax purposes.

CAN MY EMPLOYER CHANGE OR TERMINATE THIS PLAN?

Although the Employer intends to continue the Plan indefinitely, it may amend or terminate this Plan (or any of the component programs) at any time.

CAN MY BENEFITS UNDER THE PLAN BE TRANSFERRED OR ASSIGNED TO SOMEONE ELSE?

Your benefits under the Plan cannot be sold or otherwise transferred or assigned to another person. However, if the Plan Administrator receives a medical child support order from a court or administrative agency directing the Plan Administrator to extend coverage under the Health FSA to your dependent child(ren), the Plan Administrator will follow the directions in the order, provided it meets the requirements under federal law for a Qualified Medical Child Support Order (QMCSO). Upon request or upon receipt of an order submitted on behalf of your child, you will be given, free of charge, a copy of the procedures for determining whether or not it is a QMCSO.

PRE-TAX PREMIUM PROGRAM

WHAT BENEFITS ARE PROVIDED UNDER THE PRE-TAX PREMIUM PROGRAM?

The Pre-Tax Premium Program provides you the opportunity to pay on a pre-tax basis your required premium contribution for coverage under the Benefit Programs listed on Appendix A – Schedule of Benefits. Your compensation will be reduced by the amount of the premium contribution for the coverage you elect. If you are considered to be highly compensated, in rare cases your election may be restricted so that the Plan will satisfy nondiscrimination rules imposed by the Internal Revenue Service.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR THE PRE-TAX PREMIUM PROGRAM?

To participate in the Pre-Tax Premium Program you must be enrolled in a Benefit Program listed on Appendix A.

WHAT IF I'M COVERED UNDER OTHER HEALTH INSURANCE ?

If you are covered under other health insurance (for example, your spouse's employer's plan), you may decline coverage under your Employer's health plan and instead may receive additional cash compensation. The amount of the cash compensation will be determined each year by the Employer and announced at open enrollment time. It will be added to your regular paychecks and will be taxable the same as your regular pay. If you opt out of health coverage and later change your mind, you will have to wait until the beginning of the next plan year to join the plan (except in certain situations discussed under "Can I Change My Elections During the Plan Year?"). You may also be subject to any penalties for late enrollment in the Employer's health plan, such as pre-existing condition exclusions and the like. Therefore, if you decline health coverage, you should make sure that you have other coverage through a spouse's plan or elsewhere. Otherwise, a major illness or injury could be a severe financial hardship. For this reason, you may be required to provide proof or certification of alternative coverage in order to receive the additional compensation.

If you decline coverage under the Employer's group health plan, you can still participate in this Plan's other component programs.

CAN I CHANGE MY ELECTION UNDER THE PRE-TAX PREMIUM PROGRAM?

You may change the amount of your salary reduction election under the Pre-Tax Premium Program if you experience a "change in status."

A "change in status" includes:

* Change in Employee's Legal Marital Status. Marriage, death of a spouse, divorce, legal separation and annulment.

* Change in Number of Dependents. Birth, adoption, placement for adoption and death of a child.

* Change in Employment Status. For example, termination or commencement of employment by the employee, spouse or dependent; commencement of, or return from, an unpaid leave of absence; a strike or lockout; a change in worksite or any other change in status that effects eligibility for benefits.

* Change in Residence. Change in residence of employee, spouse or dependent that affects eligibility for benefits.

* Change in Dependent Status. Dependent starts or stops meeting the requirements (such as age, student status, marriage) to be eligible for any coverage under this Plan.

However, the election change must be consistent with and necessary or appropriate as a result of the change in status. Generally, this means **the change in status must result in the gain or loss of eligibility for coverage, and your election change must correspond to the gain or loss of coverage**. For example, if you become divorced, you can change your pre-tax premium election to eliminate the premium cost for your former spouse who is no longer eligible for health coverage through your Employer but you cannot eliminate the cost of coverage for your children if they remain eligible under the health plan.

You may also change your election under the following circumstances.

* HIPAA Enrollment Rights. You or a dependent become entitled to special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) because you lose coverage under another employer's group health plan, you gain a dependent, you become eligible for health plan premium assistance under Medicaid or a State Children's Health Plan (**CHIP**) program or you lose eligibility for Medicaid or CHIP coverage.

* Judgment, Decree, or Order. You are ordered to provide health coverage for your child under a judgment, decree, or order resulting from a divorce, legal separation, or change in legal custody (or someone else is ordered to provide the coverage that you previously provided to the child).

* Change in Medicare/Medicaid Eligibility. You, your spouse or a dependent child become enrolled in Medicare or Medicaid and you desire to cancel group health coverage for that individual, or you lose Medicare

or Medicaid and desire to enroll in your Employer's group health coverage on a pre-tax basis.

Your Employer may automatically adjust the amount of your Pre-Tax Premium election if the cost of any coverage you elected is increased or decreased during the plan year. If the cost change is significant or if the coverage terminates or is significantly reduced, you can revoke your election and, instead, elect coverage under another option with similar coverage on a pre-tax basis (if one is offered). In some circumstances you may drop the coverage completely.

If your Employer adds a new benefit option, you may change your election to add the new coverage even if you did not previously participate in this Plan. Finally, if there is a change in the coverage of your spouse or dependent under another employer's plan, you may make a corresponding election change under this Plan.

WHAT ARE THE NOTICE REQUIREMENTS FOR A MID-YEAR ELECTION CHANGE?

If you wish to change your election for any reason permitted above, you must notify the Plan Administrator within 30 days of the event (within 60 days in the event of a HIPAA special enrollment right due to a change in Medicaid or CHIP entitlement or premium assistance). All changes will apply on the first day of the next month except that if you gain a new dependent by birth, adoption or placement for adoption, the change will be effective as of the date of the birth, adoption or placement.

HOW DO I MAKE A CLAIM UNDER THE PRE-TAX PREMIUM PROGRAM?

To receive benefits from the coverages offered under the Pre-Tax Premium Program, you should follow the claims and appeal procedure outlined in the summary plan description or benefit booklet for that coverage. If you have any questions about your ability to pay your required contributions for these benefits on a pre-tax basis through this Plan, you should contact the Plan Administrator.

WHAT IF MY EMPLOYMENT ENDS?

Your participation in the Pre-Tax Premium Program terminates on the day your employment ends. If you are rehired within the same plan year and within 30 days of termination, your prior election will remain in effect. If you are rehired more than 30 days after termination, you will make a new election for the remainder of the plan year.

WHAT HAPPENS IF I TAKE AN UNPAID LEAVE OF ABSENCE?

If you take an unpaid leave of absence (including leave under the Family and Medical Leave Act (FMLA) if applicable), coverage under the Pre-Tax Premium Program will terminate while you are on leave. Any contributions for coverage must be paid on an after-tax basis since you will not be receiving a paycheck.

HSA CONTRIBUTIONS PROGRAM

WHAT BENEFITS ARE PROVIDED UNDER THE HSA CONTRIBUTIONS PROGRAM?

A health savings account (HSA) is a tax-advantaged trust or custodial account for payment of qualifying medical expenses established under the requirements of the Internal Revenue Code. The HSA Contributions Program allows you to make pre-tax contributions that your Employer will forward to your HSA trustee/custodian for deposit in your account. Your HSA belongs to you, is completely portable and it goes with you if you change jobs or terminate employment. You (not your Employer or your HSA trustee/custodian) are responsible for meeting any IRS requirements or limitations to assure favorable tax treatment.

You can use amounts in your HSA and the earnings on those amounts to pay for qualifying medical expenses on a tax-free basis. With certain exceptions for death, disability or attainment of age 65, you must pay a 10% penalty as well as regular income tax on amounts you withdraw from your HSA that are not used to pay qualifying medical care expenses. For a description of qualifying medical care expenses, consult the materials provided to you by your HSA trustee/custodian.

HOW DO I ENROLL IN THE PLAN?

If you are eligible for the HSA Contributions Program, you can become a participant by filing an election form with the Plan Administrator. There will be an annual enrollment period for each plan year. If you become an HSA-eligible individual after the beginning of the Plan Year, you should contact the Plan Administrator for enrollment information.

If you choose to participate, you must agree to reduce your compensation by the amount you elect on your election form. Each paycheck you receive during the plan year will be reduced in a substantially equal amount.

WHAT IS MY EMPLOYER'S ROLE IN MY HSA?

Your HSA is not part of this Plan and is not sponsored by your Employer. Your Employer has no control over the funds deposited in your HSA.

WILL MY EMPLOYER CONTRIBUTE TO MY HSA?

Your Employer may, but is not required to, make contributions to your HSA. You will be informed of the amount of any Employer contribution when you enroll.

AM I REQUIRED TO MAKE CONTRIBUTIONS TO MY HSA?

No, but you are encouraged to make pre-tax contributions to an HSA so that you will be prepared for out-of-pocket medical expenses you incur under your HDHP.

CAN I CHANGE MY ELECTION UNDER THE HSA CONTRIBUTIONS PROGRAM?

Yes, you may revoke your election or change your contributions under the HSA Contributions Program at any time. The change will be effective on the first day of the following month. You need not wait until the next open enrollment period.

WHAT ARE THE LIMITS ON CONTRIBUTIONS TO MY HSA?

Your total HSA contributions each year may not exceed the IRS limit for the calendar year in which the contribution is made ($3,000 for single HDHP coverage and $5,950 for double or family HDHP coverage in 2009, adjusted annually thereafter for cost of living). If you are age 55 or older by the end of the plan year, you may contribute an additional $1,000 "catch-up" amount. You are responsible for ensuring you do not exceed the HSA contribution limit.

Generally, the maximum limit for HSA contributions is pro-rated on a monthly basis if you are not an HSA-eligible individual for the entire plan year. For example, if you are an HSA-eligible individual for only 9 months of the year, your contribution limit will be 9/12 of the above limits. However, under a special IRS rule, if you become HSA-eligible after the first day of the year and you are still eligible during the last month of that year (December), you may contribute up to the full annual limit for that tax year. But if your HSA eligibility ends for any reason other than death or disability prior to the last day of the following 12-month period (for example, because you no longer have HDHP coverage), the contributions that would not have been allowed except for the special IRS rule will be included in your gross income and subject to a 10% penalty.

For example, if you become HSA-eligible on July 1, 2009, and you are still HSA-eligible in December of 2009, you can contribute the full annual limit for the year. However, if you drop HDHP coverage at any time during the year 2010, the extra six months of contributions you were allowed to make in 2009 will be included in your gross income and subject to a 10% penalty.

The maximum HSA contribution limit described above applies to all contributions made by you or on your behalf, including any HSA contributions made outside this Program. Contributions made in excess of the IRS limit are subject to a 6% excise tax, so it is important that you make sure you do not exceed this limit.

WHAT HAPPENS TO AMOUNTS LEFT IN MY HSA AT THE END OF THE YEAR?

Your HSA belongs to you as the account owner. Amounts remaining in your HSA at the end of the year are yours and will carry forward to the next year. These amounts will not be forfeited.

HOW DO I MAKE WITHDRAWALS FROM MY HSA?

You can withdraw money from your HSA at any time. To make withdrawals, follow the procedures of the trustee/custodian of your HSA. The HSA is not sponsored or maintained by your Employer and your Employer has no control over contributions deposited to or withdrawals from your HSA.

WHAT HAPPENS IF I TAKE AN UNPAID LEAVE OF ABSENCE?

If you take an unpaid leave of absence (whether under the Family and Medical Leave Act or otherwise), coverage under the HSA Contributions Program will terminate while you are on leave and any contributions to your HSA during an unpaid leave must be made on an after-tax basis (but can be deducted when you file your tax return).

WHAT IF MY EMPLOYMENT ENDS?

No further pre-tax HSA contributions will be made under this Plan after your employment with the Employer ends. However, you may continue to make HSA contributions outside the Plan (so long as you are an HSA eligible individual) and you may at all times use the amount in your HSA for medical (or other) expenses.

HEALTH FLEXIBLE SPENDING ARRANGEMENT (FSA) PROGRAM

WHAT BENEFITS ARE PROVIDED UNDER THE HEALTH FSA PROGRAM?

This Health FSA Program allows you to make pre-tax contributions to a Health FSA account and be reimbursed from the account on a tax-free basis for eligible medical expenses incurred by you, your spouse, and your dependents during the plan year.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR THE HEALTH FSA PROGRAM?

The eligibility requirements for participation in the Health FSA Program are listed on Appendix A.

HOW DO I ENROLL IN THE HEALTH FSA PROGRAM?

When you first become eligible for the Health FSA Program, you will receive an election form. To participate, you must file the completed election form within the time period specified by the Plan Administrator. You will become a participant as soon as administratively feasible after you timely file the election form with the Plan Administrator.

There will then be an annual enrollment period for each subsequent plan year. If you do not timely file an election form, you cannot participate during the next plan year unless you have a change in status described below in *"Can I Change My Elections During the Plan Year?"* You cannot make changes to your Health FSA elections after the beginning of a plan year unless you have a change in status.

Whether or not you participate in the Health FSA Program is entirely your decision. If you choose to participate, you must agree to reduce your compensation by the amount you elect on your election form.

WHAT ARE "ELIGIBLE MEDICAL EXPENSES"?

The Medical expenses that are eligible for reimbursement under this Health FSA Program depend on whether you elect the "general purpose" or "limited purpose" option.

General Purpose (Should be elected only if you or your spouse do not intend to make HSA contributions during the plan year.)

If you and your spouse do not intend to contribute (or have contributions made on your behalf) to an HSA during the plan year, you should elect the "general purpose" option. Eligible medical expenses that can be paid by your general purpose

Health FSA include the following, provided they are not payable under any other insurance policy or health care plan:

* Expenses not paid by your health plan, such as deductible or co-payment amounts, co-insurance, expenses over the maximum payable under the plan and medical care expenses that are excluded or otherwise not covered under the plan;

* Dental expenses;

* Orthodontic expenses;

* Vision expenses, including examinations, eyeglasses, contact lenses, laser surgery and seeing-eye dogs;

* Hearing expenses, including examinations and hearing aids;

* Physical examinations;

* Psychoanalysis, psychiatric therapy, learning disability counseling by a licensed professional, inpatient care, treatment and services provided by a licensed psychologist;

* Acupuncture;

* Therapeutic treatment for drug or alcohol addiction, including meals and lodging if necessary for the treatment;

* Medical equipment purchased or rented because of a medical condition, such as wheelchairs, crutches, and orthopedic shoes, or for the repair or replacement of prosthetic devices due to normal wear and tear;

* Prescription drugs;

* Over-the-counter medications purchased for medical care (e.g., cold or allergy medicine, antacids, pain relievers), but not items purchased simply because they are beneficial to general health (e.g., vitamin supplements);

* Insulin;

* Transportation primarily for, and essential to, medical care; and

* Any other expense that qualifies as a medical care deduction for federal income tax purposes unless specifically excluded in the next section.

***Limited Purpose* (Should be elected if you or your spouse intend to make HSA contributions during the plan year.)**

The limited purpose option under the Health FSA Program is designed for employees who intend to make contributions to an HSA (or have contributions made on their behalf) during the plan year. In order to assure your eligibility for HSA contributions, expenses that can be paid from your limited purpose Health FSA are limited to the following:

* Dental Expenses - Dental expenses, including orthodontics;

* Vision Expenses - Vision expenses, including examinations, eyeglasses, contact lenses, laser surgery and seeing-eye dogs;

* Preventive Care Expenses - Preventive care expenses, including periodic health evaluations, tests and diagnostic procedures ordered in connection with routine exams such as annual physicals, routine prenatal and well-child care, immunizations and selected screening services. Preventive care does not include any prescription or over-the-counter medications or any service or benefit intended to treat an existing illness, injury, or condition.

* Post Deductible Expenses - Medical expenses that are incurred after the minimum annual deductible under your HDHP has been satisfied.

Expenses will be reimbursed only if they are not paid under any other insurance policy or health care plan.

WHAT MEDICAL EXPENSES CANNOT BE PAID THROUGH MY HEALTH FSA?

Current tax law prohibits a health FSA from paying or reimbursing the following:

* Expenses incurred prior to the beginning or after the end of the current plan year;

* Cosmetic surgery or similar procedures unless the surgery or procedure is necessary to ameliorate a deformity due to a congenital abnormality, an injury, or a disfiguring disease;

* Premiums for health insurance coverage;

* Long-term care services and premiums for long-term care (e.g., nursing home) insurance; or

* Any expense incurred before the effective date of this Health FSA Program, or while you were not participating in the Health FSA Program.

WHOSE EXPENSES CAN BE PAID UNDER THE HEALTH FSA PROGRAM?

You may use the Health FSA Program to pay eligible medical expenses for yourself, your spouse and your qualifying dependents. A qualifying dependent must meet the requirements of a dependent under the Internal Revenue Code for medical plan purposes.

If you elect the general purpose option but want to preserve your spouse's status as an HSA-eligible individual, you should not include your spouse's name as an eligible dependent on your enrollment form for the Health FSA.

WHAT IS THE MAXIMUM AMOUNT I CAN CONTRIBUTE TO THE HEALTH FSA PROGRAM?

The maximum amount you may elect to contribute to the Health FSA Program for a plan year is specified in Appendix A. If you are considered to be highly compensated, in rare cases your election may be restricted so that the Plan will satisfy nondiscrimination rules imposed by the Internal Revenue Service.

IS THERE A LIMIT ON HOW MUCH REIMBURSEMENT I CAN RECEIVE?

The amount of reimbursement available to you at any time during the plan year is the entire annual amount you have elected to contribute to your Health FSA Account, less any previous reimbursement for expenses incurred during the plan year. Your Employer may establish a minimum claim amount.

WHAT HAPPENS TO AMOUNTS LEFT IN MY HEALTH FSA ACCOUNT AT THE END OF THE YEAR?

If you do not incur sufficient expenses by the end of the plan year to use all the money in your Health FSA Account, the unused amount will be forfeited. It will not be refunded to you. An expense is considered to be "incurred" when the medical care service is provided, not when it is billed or paid.

Since you can only use your Health FSA Account to pay eligible medical expenses, **it is very important that you estimate your expected medical expenses for the upcoming year carefully** in deciding how much of your compensation to direct toward benefits under the Health FSA Program**.** Overestimating your expenses may cause you to forfeit unused amounts. Forfeited amounts will be used to offset excess reimbursements and administrative expenses for the Plan.

CAN I CHANGE MY ELECTIONS DURING THE PLAN YEAR?

Although elections are generally irrevocable during a plan year, you may change the amount of your election under the Health FSA Program if you experience a "change in status" or any other event that the Plan Administrator determines permits an election change under IRS regulations.

A "change in status" includes:

* Change in Employee's Legal Marital Status. Marriage, death of a spouse, divorce, legal separation and annulment.

* Change in Number of Dependents. Birth, adoption, placement for adoption and death of a child.

* Change in Employment Status. For example, termination or commencement of employment by the employee, spouse or dependent; commencement of, or return from, an unpaid leave of absence; a strike or lockout; a change in worksite or any other change in status that effects eligibility for benefits.

* Change in Residence. Change in residence of employee, spouse or dependent that affects eligibility for benefits.

* Change in Dependent Status. Dependent starts or stops meeting the requirements (such as age, student status, marriage) to be eligible for any coverage under this Plan.

Your election change must be consistent with and necessary or appropriate as a result of the change in status. Generally, this means **the change in status must result in the gain or loss of eligibility for coverage, and your election change must correspond to the gain or loss of coverage**. For example, if you become divorced, you could decrease (but not increase) your rate of contribution to the Health FSA Program since, on account of your divorce, you would have lost a covered dependent whose medical expenses are payable.

Note that a situation that prevents you from incurring an anticipated expense is not a change in status allowing you to change your elections mid-year. For example, you may not reduce your Health FSA Program election because you were unable to have an anticipated surgery due to a change in your medical condition or physician availability.

WHAT ARE THE NOTICE REQUIREMENTS FOR A MID-YEAR ELECTION CHANGE?

If you wish to change your election for any reason permitted above, you must notify the Plan Administrator within 30 days of the event. All changes will apply on the first day of the next month except that if you gain a new dependent by birth, adoption or placement for adoption, the change will be effective as of the date of the birth, adoption or placement.

HOW DO I MAKE A CLAIM UNDER THE HEALTH FSA PROGRAM?

Unless you notify the Claims Administrator that you do not desire to participate in its automatic reimbursement program, the Claims Administrator will automatically deduct up to the amount available in your general purpose Health FSA Account for deductible, copayment and coinsurance expenses incurred by you and your dependents under your Priority Health medical coverage. This means you do not have to file a claim for these out-of-pocket payments. The automatic reimbursement does not apply to a limited purpose Health FSA or if you or your dependents have other medical coverage which coordinates benefits with your Priority Health medical coverage.

To be reimbursed for other medical expenses, you must file a benefit claim form with the Claims Administrator, together with a bill, receipt, or other satisfactory proof of the medical expense from your medical provider as well as any additional information required by the Claims Administrator, including certification that the expense has not been, and will not be, reimbursed under any other health plan. If you elect the limited purpose option under the Health FSA Program, you must also submit evidence (such as an invoice or Explanation-of-Benefits Form) from an independent third party showing that the applicable deductible has been met or that the expenses are for vision, dental, or preventive care.

Your Employer will have benefit claim forms available for your use. Your claim will either be paid or denied within 30 days unless the Claims Administrator notifies you that an extension (not to exceed 15 days) is necessary. If you are required to provide additional information to make your claim payable, you will be given 45 days to do so. The time for a decision on your claim will be suspended until after the specified information is provided. You will be required to repay benefit amounts which should not have been reimbursed.

If a claim is approved, the amount of the expense will be deducted from the balance in your Health FSA Account.

WHAT IS THE DEADLINE FOR SUBMITTING HEALTH FSA CLAIMS?

All claims for expenses incurred during a plan year must be filed no later than 90 days following the end of the Plan Year or, if you do not elect COBRA, no later than 90 days following termination of your employment.

WHAT IF MY HEALTH FSA CLAIM IS NOT APPROVED?

If a claim is denied in whole or in part, you will be notified in writing. The notice will contain: (i) the reason for the denial; (ii) the specific provisions of the Plan on which the denial was based; (iii) a description of any additional information needed to approve the claim; (iv) a description of any internal rules or guidelines relied upon in making the decision to deny your claim, and a statement that a copy of these rules will be provided free of charge at your request; and (v) an explanation of the claim review procedure including your right to bring civil suit under section 502(a) of ERISA in the event of a denial of an appeal.

You (or your representative) have the right to appeal the denial of your claim, in writing to the Plan Administrator, within 180 days after you receive the notice of denial. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons you believe your claim should not have been denied. It should include any additional facts and documents that support your claim. You may review (upon request and at no charge) and copy documents and other information relevant to your appeal.

Your appeal will be reviewed and decided by a person other than the person responsible for the initial denial (or a subordinate of that person) not later than 60 days after the Plan Administrator receives your request for review. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice stating: (i) the reason for the denial; (ii) the specific provisions of the Plan on which the denial was based; (iii) a statement that you are entitled to receive, at no cost, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; (iv) a description of any internal rules or guidelines relied upon in making the decision to deny your claim, and a statement that a copy of these rules will be provided free of charge at your request; and (v) an explanation of any additional appeal procedures, if any are available, including a statement of your right to bring civil suit under section 502(a) of ERISA (if applicable).

No legal action may be brought against the Plan until you have exhausted these claims and appeals procedures. If you have exhausted these procedures and you decide to bring legal action against the Plan, you must do so within one year of the date of the final denial on appeal.

WHAT IF MY EMPLOYMENT ENDS?

Unless you qualify for and elect COBRA continuation coverage (see below), your participation in the Health FSA terminates on the day your employment ends, and you will only be reimbursed for eligible medical expenses incurred before your termination of employment.

If your participation ends because your employment has terminated, but you are rehired during the same plan year and within 30 days of termination, your prior election will remain in effect. If you are rehired more than 30 days after termination, you will make a new election for the remainder of the plan year.

WHAT IS COBRA CONTINUATION COVERAGE?

If your Employer is subject to COBRA (20 or more employees on more than half the business days during the prior calendar year) you may elect to continue coverage under the Health FSA Program following the occurrence of certain events that would otherwise end your participation in the Program (e.g. termination of employment). You will be required to pay up to 102% of your regular payroll deduction contribution for this continuation coverage.

If your employment is terminated (for reasons other than gross misconduct) or your hours are reduced so that you no longer meet the program's eligibility requirements, you may elect to continue participation in the Health FSA Program for the remainder of the plan year. Your spouse and/or dependents may elect to continue participation until the end of the plan year if they are no longer eligible for coverage for the following reasons: (i) you die, (ii) you become divorced or legally separated, (iii) you become entitled to Medicare benefits, or (iv) your children cease to be dependents.

In the case of divorce, legal separation or loss of dependent status, COBRA continuation coverage is available only if you (or your spouse or dependent) notify your Employer, in writing, within 60 days after the qualifying event. The Plan Administrator will then provide you (and your spouse and/or dependents) with written notification of your right to COBRA continuation coverage (or the unavailability of such coverage). Assuming COBRA continuation coverage is available, you (or your spouse and/or dependent) then have 60 days from the date coverage would normally end or, if later, the date you receive notice of your COBRA rights, to return a signed election to the Plan Administrator indicating the choice to continue coverage under the Program. Otherwise, your COBRA rights will end.

COBRA continuation coverage will automatically end if a required contribution is not paid on a timely basis, if you (or your spouse and/or dependent) become covered by another group health plan that does not contain a limitation or exclusion with respect to any pre-existing condition you or they may have, if the Employer terminates all health coverage for all employees or if you (or your spouse and/or dependent)

become entitled to Medicare. For further information, consult the Plan Administrator or the COBRA notice provided to you by the Employer.

WHAT HAPPENS IF I TAKE AN UNPAID LEAVE OF ABSENCE?

If you take an unpaid leave of absence, you may choose to continue coverage under the Health FSA Program or you may revoke your prior election and terminate your coverage. If you choose to continue coverage while on an unpaid leave, you can submit claims incurred during your leave. The Plan Administrator will explain your payment options.

If your coverage terminates during leave, when you return from leave you may elect to reinstate your coverage for the rest of the plan year. You will be given two options: (1) make larger payments to make up for those missed while on leave and resume coverage with your original election amount or, (2) continue payments of the original amount and resume coverage with a reduced election amount for the year. You will not be reimbursed for expenses incurred while your coverage was terminated.

If your Health FSA Account is “overspent” when you return from leave, you will be required to resume payments. Your account is overspent if the amount of benefits remaining for the plan year is less than the amount you would be required to pay in premiums for the rest of the plan year.

WHAT IF I TAKE A LEAVE OF ABSENCE FOR MILITARY SERVICE?

If you take a leave of absence for military service under the Uniformed Services Employment and Re-Employment Rights Act ("USERRA"), you can elect to continue participation in the Health FSA Program for up to 24 months from the day your leave begins or, if earlier, until the day after you are required to apply for or return to reemployment under USERRA. You will pay up to 102% of your regular payroll deduction contribution for this continuation coverage. Continuation coverage will end if you do not return to work within the time period specified under USERRA or if you lose USERRA rights.

If you intend to take a leave of absence for military service, contact the Plan Administrator. You will be provided more detailed information, including your payment options and any notices you are required to provide if you intend to continue coverage under the Plan during your leave of absence.

WHAT IS A QUALIFIED RESERVIST DISTRIBUTION?

If you are a reservist ordered or called to active duty for a period of at least 180 days or for an indefinite time period, you may request a distribution from your Health FSA account of any unspent amounts that you have contributed for the year. If you qualify, you should submit a written request for a qualified reservist distribution

along with a copy of your military orders or call to duty before the last day of the plan year. The distribution amount will be included in your taxable income for the year.

DO HIPAA PRIVACY RULES APPLY TO THIS HEALTH FSA PROGRAM?

Yes, HIPAA privacy and security rules apply to the Health FSA Program under this Plan. Provisions regarding these rules are contained in the Plan document as required. You should review the notice of privacy practices given to you by your Employer for information on your privacy rights under HIPAA.

WHAT RIGHTS DO I HAVE UNDER FEDERAL LAW?

The Health FSA Program is subject to the Employee Retirement Income Security Act of 1974 (ERISA) which entitles you to certain rights and protections.

Receive Information About Your Plan and Benefits

ERISA provides that all participants under the Health FSA Program shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan and, if applicable, 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 and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for 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 benefit of 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 Plan 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.

DEPENDENT CARE PROGRAM

WHAT BENEFITS ARE PROVIDED UNDER THE DEPENDENT CARE PROGRAM?

The Dependent Care Program allows you to make pre-tax contributions to a Dependent Care Account and be reimbursed from the account on a tax-free basis for eligible dependent care expenses incurred during the plan year. Dependent care services are not considered incurred until the care is actually provided. Even if you are required to pay for care in advance, you cannot be reimbursed until the care has been provided.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR THE DEPENDENT CARE PROGRAM?

The eligibility requirements for participation in the Dependent Care Program are listed on Appendix A.

HOW DO I ENROLL IN THE PLAN?

When you first become eligible for the Dependent Care Program, you will receive an election form. To participate, you must file the completed election form within the time period specified by the Plan Administrator. You will become a participant as soon as administratively feasible after you timely file the election form with the Plan Administrator.

There will then be an annual enrollment period for each subsequent plan year. If you do not file a new election form, you cannot participate during the next plan year unless you have a change in status described below in *"Can I Change My Elections During the Plan Year?"* Likewise, you cannot make changes to the amount of your Dependent Care elections after the beginning of a plan year unless you have a change in status. (See *"Can I Change My Elections During the Plan Year?"*)

Whether or not you participate in this plan is entirely your decision. If you choose to participate, you must agree to reduce your compensation by the amount you elect on your election form.

WHAT ARE "ELIGIBLE DEPENDENT CARE EXPENSES"?

Expenses for the care of a qualifying dependent and household services performed in connection with that care are eligible expenses provided their primary function is to assure the well-being and protection of your qualifying dependent and provided they are incurred to enable you and your spouse, if you are married, to be gainfully employed or to actively search for employment. Eligible dependent care expenses include:

* Fees for nursery schools, day care (including day camps) or other dependent care centers. If the school or center serves more than six children, it must comply with applicable state and local licensing laws;

* Fees for before- or after-school care programs;

* Fees for care centers that provide day care – not overnight care – for dependent adults (if the dependent adult spends at least eight hours a day in your household);

* Expenses for services of individuals who provide care for your dependent child or dependent adult in or outside of your home (but not including care services provided by (i) your own child who is under age 19, (ii) an individual you or your spouse can claim as a tax dependent, (iii) your spouse, or (iv) a parent of your qualifying dependent);

* Expenses for household services provided in connection with the care of a qualifying dependent in your home;

* Expenses for transportation to or from a caregiver if the transportation is provided by the caregiver;

* The cost of providing room and board to a caregiver; and

* Related expenses that are not directly for the care of an eligible dependent, such as application fees, agency fees and deposits required to obtain care.

If a portion of an expense is for household services or for the care of a qualifying dependent and a portion is for another purpose, a reasonable allocation must be made and, unless the portion of expense for the other purpose is minimal or insignificant, only the portion attributable to household services or care is considered a qualified expense.

If you are temporarily absent from work for a period not exceeding two consecutive weeks, dependent care expenses incurred during the absence will be considered eligible dependent care expenses if your caregiver agreement requires payment during the absence.

If you (or your spouse) work part-time, dependent care expenses incurred on a day you (or your spouse) are not scheduled to work will be considered eligible dependent care expenses provided your caregiver requires payment for a period that includes both working and nonworking days.

WHAT DEPENDENT CARE EXPENSES CANNOT BE REIMBURSED?

There are some dependent care expenses that cannot be reimbursed under this Plan. These include:

* Expenses for an overnight camp;

* Household services that are not related to the care of a dependent;

* Educational expenses (e.g., private school tuition from kindergarten up, summer school, or tutoring programs);

* Forfeited application or agency fees and deposits if care is not provided;

* Food, lodging, or clothing; and

* Any expense incurred before the effective date of this Dependent Care Program or while you were not participating in the Dependent Care Program.

WHO IS CONSIDERED A DEPENDENT UNDER THE DEPENDENT CARE PROGRAM?

For purposes of the Dependent Care Program, a dependent is:

* Your child under the age of 13; or

* Your spouse or a child (age 13 or over) or other relative who meets the requirements to be your dependent under section 152 of the Internal Revenue Code, and who is physically or mentally incapable of caring for himself or herself and who lives with you for more than one-half the calendar year.

A child whose parents are divorced, separated, or live apart at all times during the last six months of the year and who is under 13 or who is physically or mentally incapable of caring for himself or herself will be treated as a dependent of the parent with whom the child lives for the greater portion of the calendar year, even if the child is the dependent of the other parent for income tax purposes.

For an adult to be considered a qualifying dependent, he or she must spend at least eight (8) hours a day in your home.

WHAT IS THE MAXIMUM AMOUNT I CAN CONTRIBUTE TO THE DEPENDENT CARE PROGRAM?

The maximum amount you may contribute to a Dependent Care Account each calendar year (including employer contributions, if any) is the lesser of:

(i) $5,000 ($2,500 if you are married and file separate tax returns),

(ii) your earned income (wages or salary, not including the amount elected under this Program), or

(iii) the earned income of your spouse if you are married at the end of the year. If, during any month in which you have dependent care expenses, your spouse is mentally or physically incapable of self-care and shares your principal place of abode for more than half the year, or your spouse is a full-time student, your spouse will be considered to have earned, for each such month, not less than $250 ($500 if you have two or more dependents). Your spouse will be considered a full-time student if he or she is enrolled full-time during at least five calendar months at an educational institution that offers traditional classroom instruction on a regular basis.

IS THERE A LIMIT ON THE REIMBURSEMENT AMOUNT?

The amount available to you for reimbursement of an eligible dependent care expense is limited to the balance in your Dependent Care Account at the time of the claim. Your Employer may establish a minimum claim amount.

WHAT INFORMATION WILL THE IRS REQUIRE?

For amounts received as reimbursement under the Dependent Care Program to be tax free, you must report the correct name, address and taxpayer identification number of your dependent care provider on your federal income tax return. If the dependent care provider is a tax-exempt organization described in Section 501(c)(3) of the Internal Revenue Code, you must report the name and address and write “tax-exempt” in the space in which the taxpayer identification number of the provider generally would be reported.

Your dependent care provider is required to furnish you with the provider’s taxpayer identification number, unless the provider is a tax-exempt organization. A provider that fails to comply with this requirement is subject to a monetary penalty.

HOW DOES THE DEPENDENT CARE PROGRAM COORDINATE WITH THE FEDERAL CHILD TAX CREDIT?

The Internal Revenue Code also permits a "tax credit" for certain dependent care expenses, but amounts paid through this Dependent Care Program directly offset the maximum amount to which the tax credit can apply. The determination of which option (the tax credit or pre-tax payment) is more beneficial for you depends on a number of factors such as size of family, marital status, taxable income, itemized deductions, etc. You may want to consult a tax adviser to decide which option is more effective for you.

WHAT HAPPENS TO AMOUNTS LEFT IN MY ACCOUNT AT THE END OF THE YEAR?

If you have not incurred sufficient expenses by the end of the plan year to use all the money in your Dependent Care Account, the unused amount will be forfeited. It will not be refunded to you. An expense is considered to be "incurred" when the dependent care service is provided, not when it is billed or paid.

Since you can only use your Dependent Care Account for eligible dependent care expenses, **it is very important that you estimate your expected expenses for the upcoming year carefully** in deciding how much of your compensation to direct toward benefits under the Dependent Care Program**.** Overestimating your expenses will cause you to forfeit unused amounts. Forfeited amounts will be used to offset excess reimbursements and administrative expenses for the Plan.

CAN I CHANGE MY ELECTIONS DURING THE PLAN YEAR?

Although elections are generally irrevocable during a plan year, you may change the amount of your election under the Dependent Care Program if you experience a "change in status" (defined below) or any other event that the Plan Administrator determines permits an election change under IRS regulations. However, the election change must be consistent with and necessary or appropriate as a result of the change in status. Generally, this means **the change in status must cause a gain or loss of eligibility for coverage, and your election change must correspond to the gain or loss of coverage**.

A "change in status" includes:

* Change in Employee's Legal Marital Status. Marriage, death of a spouse, divorce, legal separation and annulment.

* Change in Number of Dependents. Birth, adoption, placement for adoption and death of a child.

* Change in Employment Status. For example, termination or commencement of employment by the employee, spouse or dependent; commencement of, or return from, an unpaid leave of absence; a strike or lockout; a change in worksite or any other change in status that effects eligibility for benefits.

* Change in Residence. Change in residence of employee, spouse or dependent that affects eligibility for benefits.

* Change in Dependent Status. Dependent starts or stops meeting the requirements (such as age, student status, marriage) to be eligible for any coverage under this Plan.

You may also change your Dependent Care Program election in a manner consistent with any of the following occurrences:

* Change in Cost. Cost of dependent care increases or decreases (unless a cost increase is imposed by a relative of yours who provides the care).

* Change in Coverage. For example, you change your day care provider or your child's enrollment in school decreases the hours of required day care service you need.

* Change Under Another Plan. Change in dependent care benefits under another employer plan.

WHAT ARE THE NOTICE REQUIREMENTS FOR A MID-YEAR ELECTION CHANGE?

If you wish to change your election for any reason permitted above, you must notify the Plan Administrator within 30 days of the event. All changes will apply at the beginning of the following month except that if you gain a new dependent by birth, adoption or placement for adoption, the change will be effective as of the date of the birth, adoption or placement.

In rare cases, your election may be restricted so that the Plan will satisfy nondiscrimination rules imposed by the Internal Revenue Service.

HOW DO I MAKE A CLAIM UNDER THE DEPENDENT CARE PROGRAM?

You must file a benefit claim with the Claims Administrator, together with a bill, receipt, or other satisfactory proof of the expense from your dependent care provider and any additional information required by the Claims Administrator. Your Employer will have benefit claim forms available for your use. All claims for expenses incurred during a plan year must be filed no later than 90 days after the end of the Plan

Year or, if earlier, 90 days following termination of your employment. Generally, your claim will either be paid or denied within 30 days of submission.

WHAT IF MY CLAIM IS DENIED?

You (or your representative) have the right to appeal denial of a claim in writing to the Plan Administrator within 60 days after receiving the notice of denial. Your written appeal should state the reasons you believe your claim should not have been denied. Decisions of the Plan Administrator concerning your appeal are final and binding. You will be required to repay any expense or cost incurred due to the payment of a benefit which should not have been reimbursed.

No legal action may be brought against the Plan until you have exhausted these claims and appeals procedures. If you have exhausted these procedures and you decide to bring legal action against the Plan, you must do so within one year of the date of the final denial or appeal.

WHAT IS THE DEADLINE FOR SUBMITTING CLAIMS?

Claims incurred during the plan year must be submitted no later than 90 days following the end of the plan year or, if earlier, 90 days following termination of your employment.

WHAT IF MY EMPLOYMENT ENDS?

Your pre-tax contributions to the Plan terminate on the day your employment ends. However, you may continue to submit claims for eligible dependent care expenses incurred prior to employment termination up to the amount of funds remaining in your account.

If your participation in this Plan ends because your employment has terminated, but you are rehired within the same plan year and within 30 days of termination, your prior election will remain in effect. If you are rehired more than 30 days after termination, you will make a new election for the remainder of the plan year.

WHAT HAPPENS IF I TAKE AN UNPAID LEAVE OF ABSENCE?

If you take an unpaid leave of absence, you may continue to submit claims under the Dependent Care Program through the end of the plan year as long as funds remain in your Dependent Care Account, but your pre-tax contributions will cease while you are on unpaid leave since you will not be receiving a paycheck.

If you intend to take a leave of absence for military service, contact the Plan Administrator. You will be provided more detailed information, including your payment options and any notices you are required to provide if you intend to continue coverage under the Plan during your leave of absence.

APPENDIX A

I. GENERAL INFORMATION

Employer, Plan Sponsor, and Plan Administrator

Name:_____
Address:_____
_____
Phone:_____

☐ The plan is maintained pursuant to a collective bargaining agreement with _____. Upon written request to the Plan Administrator, you will be provided a copy of the collective bargaining agreement. (You may be charged a reasonable fee.) A copy of the agreement is also available for your review at the office of the Plan Administrator during regular business hours.

Employer Identification Number

_____

Plan Number

_____

Plan Year

The 12-month period beginning each _____ and ending each _____.

Service of Legal Process

Service of legal process may be made upon the following:

_____
_____
_____
_____

Service of process may also be made upon the Plan Administrator.

Related Participating Employers

List or indicate "None" _____.

II. Pre-Tax Premium Program

Benefit Programs

☐ Group health insurance ☐ medical ☐ dental ☐ vision.

☐ Group-term life insurance. Note: If you elect group-term life insurance coverage in excess of $50,000, the cost of the coverage in excess of $50,000 (as determined under IRS regulations section 1.79-3(d)(2), Table I), less the amount of any after-tax contributions for the coverage is includible in your gross income on your W-2.

☐ AD&D.

☐ Specific disease or hospital indemnification insurance (e.g., AFLAC).

☐ Long-term disability insurance. Note: If premiums for long-term disability benefits are paid on a pre-tax basis under the Pre-Tax Premium Program, any disability benefits provided under the policy will be taxable when paid to you.

☐ Short-term disability insurance. Note: If premiums for short-term disability benefits are paid on a pre-tax basis under the Pre-Tax Premium Program, any disability benefits provided under the policy will be taxable when paid to you.

☐ Other. _____.

Enrolling in the Plan

☐ **Option 1**: **Affirmative Enrollment**

When you first become eligible for the Plan, you will receive an election form. Using the election form, you may select your benefit coverages and authorize salary withholding for the corresponding premiums. You will become a participant on the date specified by the Plan Administrator after you have timely filed the election form with the Plan Administrator.

There will be an annual enrollment opportunity for each subsequent plan year. Select one of the following:

☐ Your election for pre-tax payment of premiums will continue in force for each succeeding plan year unless you file a new election form during the enrollment period.

☐ You must timely file a new election form each year. If you do not do so, your premiums for the coverage you elect will be paid on an after-tax basis.

You cannot change your election during the plan year unless you have a change in status described in "Can I Change My Elections During the Plan Year?"

Whether or not you participate in this Plan is entirely your decision. If you participate, your compensation will be reduced by the total amount you have elected on your election form. Each paycheck you receive during the plan year will be reduced in a substantially equal amount.

☐ **Option 2**: **Automatic Enrollment**

If you elect coverage under any of the Benefit Programs listed on Appendix A, you will be automatically enrolled in the Pre-Tax Premium Program and your Employer will withhold from your pay on a pre-tax basis the premium contributions for the insurance coverage you have elected. You will continue to be a participant in the Pre-Tax Premium Program as long as you are enrolled in a Benefit Program listed on Appendix A.

III. Health Flex Spending Program

Eligibility requirements for HSA participation

To be eligible for the HSA Contributions Program you must be an HSA-eligible individual. You are an "HSA-eligible individual" if you meet all of the following requirements:

(i) Select one: ☐ you elect coverage under your Employer's high deductible health plan (HDHP). or ☐ you are covered under a qualifying high-deductible health plan;

(ii) you are not covered by any disqualifying non-high deductible health coverage (including coverage under a traditional Health FSA account or a spouse's non-high deductible health plan);

(iii) you cannot be claimed as another person's tax dependent; and

(iv) you are not enrolled in Medicare.

Eligibility – You must be a _____ employee regularly scheduled to work at least _____ hours per week to participate in the Health FSA. You will be eligible to participate on the first _____ following _____ days of continuous service with the Employer.

Maximum Annual Employee Contribution - $_____ This amount will be pro-rated if you are not a participant at the beginning of the plan year. ☐ Yes ☐ No.

Employer Contributions? ☐ Yes ☐ No

Maximum Annual Employer Contribution - $_____.

IV. Dependent Care Program

Eligibility – You must be a _____ employee who is regularly scheduled to work at least _____ hours per week to participate in the Dependent Care Program. You will be eligible to participate on the first _____ following _____ days of continuous service with the Employer.