



PRIORITY HEALTH MANAGED BENEFITS, INC.
FLEXIBLE BENEFITS PLAN FOR SMALL EMPLOYERS

ADOPTION AGREEMENT

By execution of this Adoption Agreement the Employer adopts or amends this plan for the benefit of the eligible Employees with the terms and features specified herein and in the Priority Health Managed Benefits, Inc. Flexible Benefits Plan.

A. SPONSORING EMPLOYER AND PLAN ADMINISTRATOR

Name _____

Address _____

Telephone Number _____

Employer Identification Number (EIN) _____

If there are other Related Employers adopting this Plan, each must complete Attachment A to this Adoption Agreement. A Related Employer must be a member of the same controlled group or affiliated service group (under IRS rules) as the Sponsoring Employer.

Sponsoring Employer is: [] Corporation
[] S-Corporation
[] Other _____

B. GENERAL PLAN INFORMATION

1. Plan Name: _____ Flexible Benefits Plan

2. Adoption of Plan.

The Employer

- [] adopts this new Plan by executing this Adoption Agreement.
[] amends its existing Plan by executing this Adoption Agreement.

3. Effective Date.

The Effective Date of this Plan is _____

4. Plan Year. The Plan Year is the 12-consecutive month period beginning each _____.

5. Plan Number: 5 _____

6. Claims Administrator.

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

C. COMPONENT PROGRAMS

Component Programs that employees may elect:

- Pre-Tax Premium Program
- HSA Contributions Program
- Health Flexible Spending (FSA) Program
- Dependent Care Program

D. EXCLUDED EMPLOYEES

In addition to those individuals excluded under section 2.7 of the plan document, the following are not eligible to participate in this Plan:

- Collectively bargained employees
- Independent contractors
- Leased employees
- Temporary/contract workers
- Other: _____

E. CONTRIBUTIONS AND FUNDING

1. Will Employer contributions (in addition to pre-tax employee salary reduction) be made to:

- | | | |
|----------------------------------|------------------------------|-----------------------------|
| Health Flexible Spending Program | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HSA Contributions Program | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

2. If Employer contributions are made, they will be made on the following basis (e.g., \$XX each pay period):

3. If Employer contributions are made, the contribution for an Employee who becomes a Participant after the beginning of the Plan Year

- will be prorated for each __week __month __calendar quarter the Employee is a Participant.
- will not be prorated (full annual contribution).
- other: _____

F. HSA CONTRIBUTIONS PROGRAM Yes No

1. Eligibility. Provided they are HSA-Eligible Individuals, the following Employees are eligible to participate in the HSA Contributions Program:

- Only Employees who are covered by the Employer's High Deductible Health Plan (HDHP)
- Employees covered by any HDHP
- Employees who are covered by any HDHP, but Additional Employer Contributions (if any) will be limited to those covered by the Employer's HDHP.

G. PRE-TAX PREMIUM PROGRAM Yes No

1. Benefit Programs. Benefit programs offered under this Pre-Tax Premium Program include:

- Medical
- Dental
- Vision
- Life insurance*
- AD&D

- Specific disease or hospital indemnification (e.g., AFLAC) insurance
- Short-term disability**
- Long-term disability**
- Other _____

*Premium for coverage may be paid on a pre-tax basis. However, the cost of coverage over \$50,000 (as determined under IRS Code section 1.79-3(d)(2), Table I) will be taxable to the Participant.

**Note that benefits are taxable if premiums for coverage are paid through Pre-Tax Premium Program.

2. Eligibility. The following Employees are eligible to participate in the Pre-Tax Premium Program:

- Employees enrolled in one of the above-selected Benefit Programs
- Other: _____

3. Additional Cash in Lieu of Coverage (Opt-Out Payment).

The Employer will pay additional cash compensation in lieu of group health coverage. Yes No

If yes, the Employee must have alternative health coverage: Yes No

If yes, the Employee is required to:

- Certify to his/her alternative health coverage Yes No
- Provide proof of his/her alternative coverage Yes No

4. Automatic Enrollment. An election for coverage under the Employer's medical plan or other Benefit Program designated in G.1. will be automatically considered an election of coverage on a pre-tax basis under the Pre-Tax Premium Program. Yes No

5. Duration of Election. Elections under the Pre-Tax Premium Program will be valid:

- only for the Plan Year.
- for the Plan Year and automatically for each subsequent Plan Year unless the Participant files a new election form during the annual enrollment period.

H. HEALTH FLEXIBLE SPENDING ARRANGEMENT (FSA) Yes No

1. Eligibility. The following Employees are eligible to participate in the Health FSA:

- Employees who are regularly scheduled to work at least ____ hours per week

2. Participation Date. Eligible employees can become participants as follows:

- Employees who have completed ____ days of employment with the Employer will participate
 - on following day
 - first day of following month
- Other: _____

3. Limited Purpose Option. (Complete only if Employer also offers HSA.) In order to allow HSA Participants to participate in the Health FSA, the Employer authorizes a "limited purpose" FSA option.

- Yes No

(Reimbursable expenses under the limited purpose medical reimbursement program include: dental, vision and preventive care expenses and any Medical Care expenses incurred after the annual deductible under the Participant's HDHP has been satisfied.)

If yes, will the HDHP/HSA be the employer's only medical plan?

- Yes No

If yes, only a limited purpose FSA is offered; if no, both general and limited purpose FSA will be offered.

4. Elective Contribution Limits. The maximum annual Elective Contribution under the Health FSA is:

- \$1,000
- \$1,500
- \$2,000
- \$2,500
- \$3,000

I. DEPENDENT CARE PROGRAM Yes No

1. Eligibility. The following Employees are eligible to participate in the Dependent Care Program:

- Employees who are regularly scheduled to work at least ___ hours per week

2. Participation Date. Eligible employees can become participants as follows:

- Employees who have completed ___ days of employment with the Employer will participate
 - on following day
 - first day of following month
- Other: _____

J. SIGNATURES

This Adoption Agreement is executed by the Employer for the purposes, and subject to the terms and conditions, specified herein and in the Flexible Benefits Plan for Small Employers.

Date: _____, 20__

By _____

Its _____

Adopting Employer

ATTACHMENT A

ADOPTION BY RELATED EMPLOYER

(Complete and attach one copy for each adopting Related Employer)

The following Related Employer hereby adopts the plan:

Related Employer: _____

Address: _____

Employer Identification Number (EIN): _____

Related Employer is:

- Corporation
- S Corporation
- Other _____

Effective Date of Adoption: _____

Date _____

By _____

Its _____