POP Plan Description

Note to Employer: The United States Department of Labor (DOL) requires this summary, or a copy of it, be distributed to eligible employees.

Employer's Plan Name:			
Plan Year: [mo/day/yr - mo/day/yr]			
Plan Sponsor (Employer), Plan Administrator and Agent for Legal Service			
Employer/Plan Sponsor Name:			
Contact Name:		**Phone Number:**	
Employer Address:		**Federal Tax Id:**	
		Plan Number:	
Plan Administrator accepts service of legal process.			

PURPOSE

Your Employer has adopted this Flexible Compensation Plan to allow you to select from among benefit options made available under the Flexible Compensation Plan and pay for the selected benefits for yourself, your spouse, and your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" benefits in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code, and the benefits you elect will be excluded from your income under Section 125(a).

The following qualified benefit plans are offered by the Employer and can be funded under this Flexible Compensation Plan. Refer to the Summary Plan Description or Plan Description for each benefit regarding the coverage provided under these plans, the cost sharing term such as deductibles, copayments, limitations and exclusions, and if applicable your rights under ERISA. These descriptive materials are available from your Employer.

BENEFITS OFFERED TO EMPLOYEES
> Select Benefit Type
> Select Benefit Type
> Select Benefit Type
> Select Benefit Type
> Select Benefit Type

This Flexible Compensation Plan allows you to reduce your taxable income in direct proportion to (a) your contribution to the cost of your elected benefits, and (b) your contribution to any account based tax advantaged plan or fringe benefit plan offered by your Employer that is governed by the Internal Revenue Service (IRS) Code.

ELIGIBILITY REQUIREMENTS

The benefits offered above are available to the following employees as stipulated below**:**

• Full or part-time employees regularly scheduled to work at least _____ hours per week:	**> Select one & enter hours at left**
• Members of bargaining unit:	**> Select one**
• Seasonal employees regularly working less than _____ months within a year:	**> Select one & enter months at left**
• Employees under _____ years of age:	**> Select one & enter age at left**
• **Participant Entry and Probationary Period:**	**>Select one**

This Plan defines a Plan-eligible employee to be an individual classified by the Employer as a common-law employee who is on the Employer's W-2 payroll. Employees do not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Existing Employees. If you are employed by the Employer on the Plan's effective date, you shall be eligible to participate on the later of the Plan's Effective Date or on the date you satisfy the Eligibility Requirements stated above.

New Employees. If your employment begins after the Plan's Effective Date, you will be eligible to participate on the entry date noted above for Probationary Employees, following the date you satisfy the Eligibility Requirement stated above.

Re-employment of Former Employees. A former employee rehired within thirty (30) days of termination will immediately be reinstated into their original elections. A former employee rehired after thirty (30) days of termination may make new elections after re-satisfying Plan eligibility requirements.

Age Requirement. No maximum age requirement may be imposed for participation in the Plan.

GENERAL INFORMATION

This Flexible Compensation Plan allows you to pay your cost for the benefit plans you elected that are sponsored by your Employer through a Salary Reduction Agreement. This lowers your federal and state taxes. Under this Flexible Compensation Plan two types of benefit plans offered by your Employer may be funded by your salary reduction: premium benefits and reimbursement benefits. Premium benefits are the actual payments made to secure your participation in insurance plans. These are payments made from your Employer's general assets to an insurance company or a third-party administrator. Reimbursement benefits are benefits paid under an agreement to reduce your salary by the amount you elected to defer and pay you tax free benefits for certain qualified medical and dependent care expenses, as authorized under the Internal Revenue Code.

Administration. Your Employer or appointed Plan Administrator is responsible for the administration of your Employer Sponsored General Welfare Plans. Should you need to see any records or have any questions regarding these Plans, contact the Plan Administrator. The Plan Administrator has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. A health insurance issuer is not responsible for the Plan's administration (including payment of claims).

The Plan Administrator appoints TASC as a Service Provider to maintain certain Plan records and to be responsible for the Plan's day-to-day administration. TASC is not a Plan Administrator and has no discretionary authority regarding the Plan.

Plan Termination or Amendment. The Employer, or appointed Plan Administrator, has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time. Upon the termination or partial termination of the Plan, Participants have no Plan benefits except with respect to covered events giving rise to benefits occurring prior to the date of Plan termination or partial termination, except as otherwise expressly provided in writing by the Employer.

Excess Payments. Upon any benefit payment made to a Participant in error under the Plan, said Participant will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Participant's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid claim upon request is not provided. The Employer may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and subtracting from future benefit reimbursement(s) the amount paid in error.

No Continued Employment. No provisions either of the Plan or of this Summary shall grant any employee any rights of continued employment with the Employer or shall in any way prohibit changes in the terms of employment of any employee covered by the Plan.

Non-Assignment of Benefits. No Participant or beneficiary may transfer, assign or pledge any Plan benefits except as may be required pursuant to (a) a "Qualified Medical Child Support Order" (which provides for Plan coverage for an alternate recipient), (b) other applicable law, or (c) electronic payment made directly to a healthcare provider.

CONTRIBUTIONS AND ENROLLMENT

Participant Contributions. By participating in the Plan, you agree to have your annual compensation reduced by the total cost of the Plan benefits you elected.

Employer Contributions and Enrollment Elections. At its election, your Employer may pay part of the insurance premiums or other qualified benefits made available through this Plan. The annual enrollment materials will include: (1) the amount of any Employer contributions for the various Plans offered by the Employer that allow you to make pre-tax contributions, (2) the rules defining how the Employer contributions may be used, and (3) the enrollment procedures to make annual elections for your pretax contributions. These enrollment materials are incorporated in this Summary Plan Description by reference.

The various benefit plans offered by your Employer may operate under different plan years. For instance, an Employer may enter into an annual contract with an insurance company (to provide benefits to employees) under a contract year that differs from the Plan Year established for this Flexible Compensation Plan. If this is the case, different Plan benefit entry dates will apply.

If you are not eligible to participate in this Plan but are allowed to participate in another benefit plan offered by your Employer, under the eligibility terms of that Plan, your costs will be paid with taxable income, and your compensation will not be reduced by the Employer.

QUALIFYING CHANGE IN STATUS EVENTS

The laws governing Flexible Compensation Plans generally do not allow you to change your benefit and contribution elections during a Plan Year (except for Health Savings Account plans; see below). Your elections are irrevocable and this irrevocable election rule does not apply if you experience a qualifying change in status event, in which case the election change requested must be on account of and consistent with the qualifying event.

Any request to change your election must be submitted in writing within 30 days of any applicable qualifying event. The new benefit elections may start only after your change in status has taken place and the new paperwork has been filed.

A qualifying change in status event may be one of the following:

- A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
- The adoption, birth, or death of a child or dependent.
- Dependent satisfies or ceases to satisfy dependent eligibility requirements.
- The change in employment status of you, your spouse or dependent.
- Change in your residence.
- Beginning or ending adoption proceedings.
- Automatic changes upon cost increases or decreases.
- Significant cost increases.
- Significant curtailment of coverage.
- Addition or elimination of similar benefits package option.
- Change in coverage of a spouse or dependent under an employer plan.
- FMLA.
- HIPAA special enrollment rights.
- COBRA qualifying event.
- Loss of group health coverage sponsored by governmental or education institution.
- A judgment, decree or order requiring coverage for a spouse or child.
- Medicare or Medicaid entitlement.
- Termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage.
- Eligibility for Employment Assistance under Medicaid or SCHIP.
- Exchange Event – A loss of eligibility under the terms of the plan due to a reduction in hours (less than 30) – even when the Employer allows the coverage to continue in effect during the 'Stabilization Period' to satisfy the Affordable Care Act coverage requirements.
- Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period.

If you are making tax free contributions to a Health Savings Account (HSA) under this Plan, you do not need a 'change in status' event to change your HSA election. You may prospectively change your HSA election at any time during the Plan Year.

Under the qualifying events of Termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of a Participant in a group health plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits. Participants may obtain, without charge, a copy of the Plan's procedures from the Plan Administrator.

LEAVE OF ABSENCE

Family and Medical Leave Act (FMLA). If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your benefit package options providing health coverage (including the Medical Expenses Reimbursement Plan) on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contribution to the extent you opt to continue coverage). Your Employer may require you to continue coverage while you are on paid leave (as long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave.

If your coverage ceases while on FMLA leave, you will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as you had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which you did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave. If you are going on unpaid FMLA leave and you opt to continue your Medical and Dental Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways:

(1) Prepay. Your share of contributions due during your leave may be paid either pre-tax or after-tax before your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.

(2) Pay-as-you-go. Your share of contributions will be paid on the same schedule as if you were not on leave or under another schedule. Per the Department of Labor regulations, if you fail to make payments under this option, your Employer is not required to continue coverage. If your Employer chooses to make payment and thereby continue coverage, your Employer is entitled to recoup these amounts from you after you return from leave.

(3) Catch-up. Your Employer may advance your share of contributions while you are on leave. Upon your return from leave, your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with your Employer to determine if this option is available under your Plan.

Non-FMLA Leave. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave. If you take a leave of absence due to military service, you may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

TERMINATION OF PARTICIPATION

Participants are enrolled in the Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be a Participant on the earliest of the following dates:

a. Your death, resignation or termination of employment with the Employer;
b. The date the Plan terminates;
c. The date on which you fail to pay any required premium (including payment by salary reduction) under the Plan;
d. The date you no longer meet the requirements for eligibility in the Plan; or,
e. The date you revoke your election under a qualifying change in status event.

CLAIM DENIALS

Medical and Dental Insurance Benefits. The applicable insurance company will determine your claim in accordance with its claims procedures.

NOTICES REQUIRED BY LAW

Special Rights on Childbirth. Under Federal law, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for (either mother or newborn child) to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above period. In any case, under Federal law a provider may not be required (by Plan or insurer) to obtain authorization from the plan for prescribing a length of stay up to 48 hours (or 96 hours).